I. State Information

State Information

Plan Year

Federal Fiscal Year 2017

State Identification Numbers

DUNS Number 796567790

EIN/TIN 26-0600313

I. State Agency to be the Grantee for the PATH Grant

Agency Name Pennsylvania Department of Human Services

Organizational Unit Office of Mental Health and Substance Abuse Services

Mailing Address PO Box 2675 OMHSAS Bureau of PPPD, Commonwealth Towers, 11th Fl

City Harrisburg

Zip Code 17105

II. Authorized Representative for the PATH Grant

First Name Dale

Last Name Adair

Agency Name Office of Mental Health and Substance Abuse Services

Mailing Address PO Box 2675, Commonwealth Towers 11th Floor

City Harrisburg

Zip Code 17105

Telephone 717-772-7424

Fax

Email Address dadair@pa.gov

III. State Expenditure Period

From 7/1/2017

To 6/30/2018

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

Title Human Services Program Specialist

Organizational Unit Name PA OMHSAS

First Name Michelle

Last Name Baxter

Telephone 717-346-0752

Fax 717-772-7964

Email Address mibaxter@pa.gov

Footnotes:

I. State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.
PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.
As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C.

§470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

Dr. Dale Adair, MD

Title

Deputy Secretary (Acting)/Chief Medical Officer

Organization

Office of Mental Health and Substance Abuse Services

Signature: Date:

Footnotes:

I. State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false stat ements, or receiving stolen property;

c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance wit h 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--

   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employ ees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--

   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted empl oyee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?

   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph, regarding agency notificati on of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D

Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any pe rson for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-C hildren Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name

Dr. Dale Adair, MD

Title

Deputy Secretary (Acting)/Chief Medical Officer

Organization

Office of Mental Health and Substance Abuse Services

Signature: Date:

Footnotes:

I. State Information

Funding Agreement

FISCAL YEAR 2017
PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) AGREEMENT
I hereby certify that the State of Pennsylvania agrees to the following:

Section 522(a)
Amounts received under the PATH Formula Grant Program will be expended solely for making grants to political subdivisions of the State, and to nonprofit private entities for the purpose of providing the services specified in Section 522(b) to individuals who:

- Are suffering from serious mental illness;
- Are suffering from serious mental illness and have a substance use disorder; and
- Are homeless or at imminent risk of becoming homeless.

Section 522(b)
Entities receiving grants under the PATH Formula Grant Program will expend funds for the following services:

- Outreach;
- Screening and diagnostic treatment;
- Habilitation and rehabilitation;
- Community mental health;
- Alcohol or drug treatment;
- Staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where homeless individuals require services;
- Case management services, including:
  - Preparing a plan for the provision of community mental health services to the eligible homeless individual involved, and reviewing such plan not less than once every 3 months;
  - Providing assistance in obtaining and coordinating social and maintenance services for eligible homeless individuals, including services relating to daily living activities, personal financial planning, transportation services, habilitation and rehabilitation services, prevocational and vocational services, and housing;
  - Providing assistance to eligible homeless individuals in obtaining income support services, including housing assistance, food stamps, and supplemental security income benefits;
  - Referring eligible homeless individuals for such other services as may be appropriate; and
  - Providing representative payee services in accordance with Section 1631(a)(2) of the Social Security Act if the eligible homeless individual is receiving aid under Title XVI of such act and if the applicant is designated by the Secretary to provide such services.
- Supportive and supervisory services in residential settings;
- Referrals for primary health services, job training, education services and relevant housing services;
- Housing services [subject to Section 522(h)(1)] including:
  - Minor renovation, expansion, and repair of housing;
  - Planning of housing;
  - Technical assistance in applying for housing assistance;
  - Improving the coordination of housing services;
  - Security deposits;
  - The costs associated with matching eligible homeless individuals with appropriate housing situations;
  - One-time rental payments to prevent eviction; and
  - Other appropriate services, as determined by the Secretary.

Section 522(c)
The State will make grants pursuant to Section 522(a) only to entities that have the capacity to provide, directly through arrangements, the services specified in Section 522(b), including coordinating the provision of services in order to meet the needs of eligible homeless individuals who are both mentally ill and suffering from a substance abuse disorder.

Section 522(d)
In making grants to entities pursuant to Section 522(a), the State will give special consideration to entities with a demonstrated effectiveness in serving homeless veterans.

Section 522(e)
The state agrees that grants pursuant to Section 522(a) will not be made to any entity that:

- Has a policy of excluding individuals from mental health services due to the existence or suspicion of a substance abuse disorder; or
- Has a policy of excluding individuals from substance abuse services due to the existence or suspicion of mental illness.

Section 522(f)

Not more than 4 percent of the payments received under the PATH Formula Grant Program will be expended for administrative expenses regarding the payments.

Section 522(g)

The State will maintain State expenditures for services specified in Section 522(b) at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying to receive such payments.

Section 522(h)

The State agrees that:

- Not more than 20 percent of the payments will be expended for housing services under section 522(b)(10); and
- The payments will not be expended:
  - To support emergency shelters or construction of housing facilities;
  - For inpatient psychiatric treatment costs or inpatient substance abuse treatment costs; or
  - To make cash payments to intended recipients of mental health or substance abuse services.

Section 523(a)

The State will make available, directly or through donations from public or private entities, non-Federal contributions toward such costs in an amount that is not less than $1 for each $3 of funds provided in such payments. The amount of non-Federal contributions shall be determined in accordance with Section 523(b).

Section 523(c)

The State will not require the entities to which grants are provided pursuant to Section 522(a) to provide non-Federal contributions in excess of the non-Federal contributions described in Section 523(a).

Section 526

The State has attached hereto a Statement

- Identifying existing programs providing services and housing to eligible homeless individuals and gaps in the delivery systems of such programs;
- Containing a plan for providing services and housing to eligible homeless individuals, which:
  - Describes the coordinated and comprehensive means of providing services and housing to homeless individuals; and
  - Includes documentation that suitable housing for eligible homeless individuals will accompany the provision of services to such individuals;
- Describing the source of the non-Federal contributions described in Section 523;
- Containing assurances that the non-Federal contributions described in Section 523 will be available at the beginning of the grant period;
- Describing any voucher system that may be used to carry out this part; and
- Containing such other information or assurances as the Secretary may reasonably require.

Section 527(a)(1), (2), and (3)

The State has attached hereto a description of the intended use of PATH Formula grant amounts for which the State is applying. This description:

- Identifies the geographic areas within the State in which the greatest numbers of homeless individuals with a need for mental health, substance abuse, and housing services are located; and
- Provides information relating to the program and activities to be supported and services to be provided, including information relating to coordinating such programs and activities with any similar programs and activities of public and private entities.

Section 527(a)(4)

The description of intended use for the fiscal year of the amounts for which the State is applying will be revised throughout the year as may be necessary to reflect substantial changes in the programs and activities assisted by the State pursuant to the PATH Formula Grant Program.

Section 527(b)

In developing and carrying out the description required in Section 527(a), the State will provide public notice with respect to the description (including any revisions) and such opportunities as may be necessary to provide interested clients, such as family members, consumers and mental health, substance abuse, and housing agencies, an opportunity to present comments and recommendations with respect to the description.

Section 527(c)(1)(2)

The services to be provided pursuant to the description of the intended use required in Section 527(a), have been considered in the preparation of, have been included in, and are consistent with the State Plan for Comprehensive Community Mental Health Services under P.L. 102-321.

Section 528(a)

The State will, by January 31, 2018, prepare and submit a report providing such information as is necessary for:

- Securing a record and description of the purposes for which amounts received under the PATH Formula Grant Program were expended during

fiscal year 2017 and of the recipients of such amounts; and

- Determining whether such amounts were expended in accordance with the provisions of Part C- PATH.

Section 528(b)

The State further agrees that it will make copies of the reports described in Section 528(a) available for public inspection.

Section 529

Payments may not be made unless the State agreements are made through certification from the chief executive officer of the State.

Charitable Choice Provisions:

The State will comply, as applicable, with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Charitable Choice statutes codified at sections 581-584 and 1955 of the Public Health Service Act (42 U.S.C §§290kk, et seq., and 300x-65) and their governing regulations at 42 C.F.R part 54 and 54a respectively.

Name

Dr. Dale Adair, MD

Title

Deputy Secretary (Acting)/Chief Medical Officer

Organization

Office of Mental Health and Substance Abuse Services

Signature: Date:

Footnotes:

I. State Information

Disclosure of Lobbying Activities

To print a Standard Form - LLL if required for submission, click the link below.

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

Footnotes:

I. State Information

State PATH Regions

Name	Description	Actions
Central Region	This region encompasses rural, urban and suburban counties. Counties included in this region include, Blair, Dauphin, Franklin-Fulton, Huntington-Mifflin-Juniata, Lancaster and York-Adams.	
Northeast Region	This region encompasses rural, urban and suburban counties. There are three PATH counties in the region; Lehigh, Luzerne-Wyoming and Schuylkill.	
Southeast Region	This regions is located in the southeast corner of the state. It encompasses primarily urban and suburban counties. The PATH counties in this region include Bucks, Delaware, Montgomery and Philadelphia.	
Western Region	Encompasses Urban, rural and suburban counties. These counties are Allegheny, Armstrong-Indiana, Butler, Cameron-Elk, Clarion, Crawford, Erie, Fayette, Forest-Warren, Greene and Mercer.	

Add Region

Footnotes:

II. Executive Summary

1. State Summary Narrative

Narrative Question:

Provide an overview of the state's PATH program with key points that are expanded upon in the State Level Sections of WebBGAS.

Footnotes:

The Pennsylvania Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) contracts with the 24 County MH/ID program offices listed below to provide PATH services. These 24 County MH/ID offices, which encompass 36 of the state's 67 counties, are local government entities. Many of the MH/ID program offices that receive the PATH grant then sub-contract with local community sources to provide PATH services. The Local Provider Intended Use Plans (IUPs) will identify those county MH/ID programs that sub-contract with community providers and those that do not. While most of the PATH programs provide services to all PATH eligible adults ages 18 and over, some focus on transition-age youth that meet the PATH eligibility criteria. The counties and contracted providers have developed innovative PATH programs to best serve the needs of the SMI homeless population in their geographical areas. Some recent awardees have adopted evidence-based practices such as Critical Time Intervention (CTI). In general, the services provided for PATH-eligible individuals include: outreach, screening and diagnostic treatment, habilitation/rehabilitation, community mental health services, alcohol and/or drug treatment, staff training, case management, supportive and supervisory services in residential settings, referrals for primary health, job training, educational services and allowable housing services.

II. Executive Summary

2. State Budget

Planning Period From **7/1/2017** to **6/30/2018**

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**$ 51,040**	**$ 0**	**$ 51,040**	**State PATH Contact**

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 51,040	100.00 %	1.00	$ 51,040	$ 0	$ 51,040	State PATH Contact salary

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**85.59 %**	**$ 43,684**	**$ 0**	**$ 43,684**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
d. Equipment	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
e. Supplies	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
f1. Contractual (IUPs)	**$ 2,271,369**	**$ 788,698**	**$ 3,060,067**	
f2. Contractual (State)	**$ 0**	**$ 0**	**$ 0**	
No Data Available				

Category	Percentage	Federal Dollars	Matched Dollars	Total Dollars	Comments
PATH housing costs are limited to 20% and can only be PATH allowable costs. Personnel who are considered to be a housing cost should be entered here and not included in the Personnel line item. For questions, call your Program Officer.					
g1. Housing (IUPs)	**0.00 %**	**$ 0**	**$ 0**	**$ 0**	
g2. Housing (State)		**$ 0**	**$ 0**	**$ 0**	
No Data Available					

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i minus g1)	$ 2,366,093	$ 788,698	$ 3,154,791	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	
l. Grand Total (Sum of j and k)	$ 2,366,093	$ 788,698	$ 3,154,791	
Allocation of Federal PATH Funds	**$ 2,366,093**	**$ 788,698**	**$ 3,154,791**	

Source(s) of Match Dollars for State Funds:

Footnotes:

II. Executive Summary

3. Intended Use Plans

Expenditure Period Start Date: **07/01/2017** Expenditure Period End Date: **06/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

Primary IUP Provider	Provider Type	Geographic Service Area	Allocations	Matching Funds	Estimated # to Contact	Estimated # to Enroll	# Trained in SOAR	# Assisted through SOAR
Allegheny County	Social service agency	Western Region	$461,734	$153,911	103	103	0	0
Allegheny County - Community Human Services Corporation	Social service agency	Western Region	$0	$0	30	30	3	0
Allegheny County - Operation Safety Net	Social service agency	Western Region	$0	$0	500	200	0	0
Allgheny County - Three Rivers Youth, Inc.	Social service agency	Western Region	$0	$0	25	2	0	0
Armstrong-Indiana County	Social service agency	Western Region	$45,258	$15,086	0	0	0	0
Armstrong-Indiana County - Armstrong County Community Action Agency	Social service agency	Western Region	$0	$0	45	30	5	2
Armstrong-Indiana County - Indiana County Community Action Agency	Social service agency	Western Region	$0	$0	100	25	2	0
Blair County - Home Nursing Agency	Community mental health center	Central Region	$47,087	$15,696	100	80	0	0
Bucks County - Penndel Mental Health Center	Other mental health agency	Southeast Region	$51,680	$17,227	175	130	2	2
Butler County	Social service agency	Western Region	$81,903	$27,301	0	0	0	0
Butler County - Catholic Charities	Social service agency	Western Region	$0	$0	200	175	0	0
Butler County - The Grapevine Center, Inc.	Consumer-run mental health agency	Western Region	$0	$0	18	8	0	0
Cameron-Elk Behavioral and Developmental Programs	Social service agency	Western Region	$64,421	$21,474	92	46	2	0
Clarion County - Center for Community Resources	Social service agency	Western Region	$34,814	$11,605	75	60	1	0
Crawford County - CHAPS	Consumer-run mental health agency	Western Region	$47,087	$15,696	90	60	1	0
Dauphin County	Social service agency	Central Region	$83,480	$27,827	0	0	0	0
Dauphin County - Case Management Unit	Social service agency	Central Region	$0	$0	20	20	1	5
Dauphin County - Downtown Daily Bread	Shelter or other temporary housing resource	Central Region	$0	$0	250	155	0	0
Dauphin County Mental Health and Intellectual Disabilities Program	Social service agency	Central Region	$0	$0	150	125	0	0
Delaware County	Social service agency	Southeast Region	$131,919	$43,973	0	0	0	0
Delaware County - Horizon House	Social service agency	Southeast Region	$0	$0	200	100	1	27
Delaware County - Mental Health Partnerships	Community mental health center	Southeast Region	$0	$0	110	20	5	0
Erie County - Erie County Care Management	Social service agency	Western Region	$90,821	$30,274	150	125	2	0
Fayette County - City Mission - Living Stones, Inc.	Other housing agency	Western Region	$58,392	$19,464	450	55	2	8
Forest-Warren - Warren Forest Economic Opportunity Council	Social service agency	Western Region	$34,816	$11,605	70	56	2	0
Franklin-Fulton County Mental Health/Intellectual Disabilities/Early Intervention	Social service agency	Central Region	$54,558	$18,186	90	45	1	13
Greene County Department of Human Services	Social service agency	Western Region	$31,802	$10,601	55	30	9	7
Huntingdon/Mifflin/Juniata County - Service Access and Management, Inc.	Social service agency	Central Region	$31,859	$10,620	28	6	0	0
Lancaster County	Social service agency	Central Region	$91,098	$30,366	0	0	5	10
Lancaster County - Community Services Group	Community mental health center	Central Region	$0	$0	35	30	2	5
Lancaster County - Tabor Community Services	Social service agency	Central Region	$0	$0	220	140	1	1
Lehigh County - Lehigh County MH/ID/D&A /HealthChoices Program	Social service agency	Central Region	$51,680	$17,227	125	40	0	0
Luzerne-Wyoming County - Community Counseling Services	Community mental health center	Northeast Region	$51,680	$17,227	450	125	0	16
Mercer County	Social service agency	Western Region	$56,180	$18,727	0	0	0	0
Mercer County - Community Counseling Center	Community mental health center	Western Region	$0	$0	95	45	1	0
Mercer County Behavioral Health Commission	Social service agency	Western Region	$0	$0	28	28	5	0
Montgomery County - Access Services, Inc.	Social service agency	Southeast Region	$79,998	$26,666	250	125	0	0
Philadelphia County	Social service agency	Southeast Region	$438,674	$194,221	0	0	0	0

Primary IUP Provider	Provider Type	Geographic Service Area	Allocations	Matching Funds	Estimated # to Contact	Estimated # to Enroll	# Trained in SOAR	# Assisted through SOAR
Philadelphia County - Project HOME	Social service agency	Southeast Region	$0	$0	1,730	150	0	0
Philadelphia County - RHD (Cedar Park)	Community mental health center	Southeast Region	$0	$0	55	55	0	0
Philadelphia County - RHD (Kailo Haven)	Community mental health center	Southeast Region	$0	$0	60	60	0	0
Philadelphia County - RHD (La Casa)	Community mental health center	Southeast Region	$0	$0	25	25	0	0
Schuylkill County - Service Access and Management, Inc.	Social service agency	Northeast Region	$34,816	$11,605	300	90	0	0
York County - Bell Socialization Services	Social service agency	Central Region	$115,612	$22,113	150	24	4	0
		Grand Total	$2,271,369	$788,698	6,649	2,623	57	96

** IUP with sub-IUPs*

Footnotes:

1. Allegheny County

1 Smithfield St.

Pittsburgh, PA 15222

Contact: James Turner

Contact Phone #: 4123505164

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: 001

State Provider ID: 4201

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.
* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 461,734	$ 153,911	$ 615,645	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 461,734	$ 153,911	$ 615,645	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 461,734	$ 153,911	$ 615,645	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 461,734	$ 153,911	$ 615,645	

Source(s) of Match Dollars for State Funds:

Allegheny County Office of Behavioral Health will receive $13,303 in federal and state PATH funds.
Allegheny County overall will receive $615,645 in state and federal PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 103

Estimated Number of Persons to be Enrolled: 103

Estimated Number of Persons to be Contacted who are Literally Homeless: 10

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES
OFFICE OF BEHAVIORAL HEALTH

PATH COMPREHENSIVE INTENDED USE PLAN
FY 2017-2018

Provide a brief description of the provider organizations receiving PATH funds including name, type of organization, services provided by the organization and region served.

Allegheny County Department of Human Services (DHS) is responsible primarily for administering different funding streams to County Provider Agencies. In turn, these agencies provide services such as Mental Health/IDD, Drug & Alcohol, homeless prevention, children services, forensic, etc., to any eligible resident in Allegheny County.

Specifically, the County PATH Program is administered through DHS as monitored by the County PATH Coordinator. The coordinator is primarily responsible for overseeing the three PATH Provider agencies (listed below).

In addition, the County PATH coordinator oversees the PATH Contingency Fund Program (explained later), coordinates conference calls with PATH provider agencies, is the liaison between State PATH Coordinator and County PATH agencies, coordinates site visits, completes the Annual Intended Use Plan and generates PATH Annual reports, etc.

Listed below are the three County PATH Recipient Agencies:

Operation Safety Net

Operation Safety Net (a program through Mercy Behavioral Health) is a social service and medical street outreach program to the homeless in the City of Pittsburgh and Allegheny County. The services include: Medical, Case Management and Housing, etc.

Community Human Services Corp. (CHSC)

CHSC is a private non-profit human service provider that offers an array of services to the homeless/at risk homeless population. CHSC services the South Oakland Community and throughout Allegheny County.

Three Rivers Youth (T.R.Y.)

Three Rivers Youth is an agency designed to provide comprehensive services to a challenging group of youth. The agency services Allegheny and Washington County areas.

Each program will provide a more detail description within their individual Intended Use Plans.

Listed below are the amounts allocated (approximate) for each PATH Recipient Agency:

	Allocations	Federal	+	State Match
A. Operation Safety Net	$152,139	($114,104	+	$38,035)
B. Community Human Services	$ 26,675	($ 20,006	+	$ 6,669)
C. Three Rivers Youth	$ 41,317	($ 30,988	+	$10,329)
D. Allegheny County DHS	$ 13,303	($ 10,000	+	$ 3,303)
TOTAL	**$233,434**	**($175,098**	**+**	**$58,336)**

Included in Operation Safety Net's allocation is the PATH Contingency Fund. The amount for FY 2017 – 2018 will be $29,936. These funds are used to provide monetary assistance for the mental health homeless/at-risk homeless population. The funds can be applied towards rent/security deposits or utility bills. Each applicant is entitled to a maximum of $200.00 and can be eligible for the funds every two (2) years.

As an added note, during the fiscal year 7/1/15 to 6/30/16, 103 eligible PATH consumers benefitted from utilization of PATH funds.

47	Consumers - Utilities
32	Consumers - Rent
22	Consumers - Security Deposit
0	Consumers - Other
103	**Total Consumers**

PATH Providers Name and Addresses

James Turner
Allegheny: Allegheny County Office of Behavioral Health – **PA: 001**
One Smithfield Street, Human Services Building, 3rd Floor
Pittsburgh, PA 15222
Telephone: 412.350.5164
Fax: 412.350.4245
E-mail: james.turner@alleghenycounty.us

Rebecca Labovick
Allegheny: Community Human Services – **PA: 035**
2525 Liberty Avenue
Pittsburgh, PA 15222
Telephone: 412.246.1641
Fax: 412.697.2049
E-mail: rlabovick@chscorp.org

Tia Carter
Allegheny: Operation Safety Net – **PA: 040**
249 S. 9th Street, 2nd Floor
Pittsburgh, PA 15203
Telephone: 412.232.7224
Fax: 412.246.0709
E-mail: tcarter@pittsburghmercy.org

Freida Reid
Allegheny: Three Rivers Youth – **PA: 045**
6117 Broad Street
Pittsburgh, PA 15206
Telephone: 412.441.5020 ext. 217
Fax: 412.441.5021
E-mail: freida.reid@threeriversyouth.org

Collaboration with HUD Continuum of Care Program

As in previous years, all PATH providers are an integral part of the Allegheny County Continuum of Care Program. As mentioned in the CHS IUP, the CEO remains active on the Homeless Advisory Board. In addition, The DHS County Housing Supervisor (Mental Health Residential Programs) attends the LHOT meetings on a regular basis. In regards to coordinated entry, all the PATH providers utilizes Allegheny LINKS as contact to shelters and bridge-housing, etc.

Collaboration with Local Community Organizations

As an ongoing practice, both the County PATH Coordinator and PATH provider agencies maintain contact with local service organizations through outreach/linkage. As an example, Three Rivers Youth (TR-Y) expanded their outreach through correspondence with school districts and First Step Recovery Program, etc.

In overseeing the PATH Contingency Fund, the County PATH Coordinator has established a good rapport with utility companies and landlords. As a result and at the request of the County PATH Coordinator, utility companies and landlords have extended the shut-off dates and eviction notices respectively, per request made by the County PATH Coordinator.

Service Provisions

Through outreach/linage, all three PATH provider agencies are diligently assisting the PATH eligible consumer in preventing chronic homelessness.

In addition to the PATH Contingency Funds, agencies such as urban League; Catholic Charities; LIHEAPP; Dollar Energy Funds, etc., are utilized for rental utilities assistance. PATH eligible consumers can be connected to SSI/SSDI Outreach, Access, Recovery (SOAR) in regards to SSI process. Section 8, upon open enrollment, is an important housing resource for PATH consumers. As an added note during the Thanksgiving Holiday, a local news station has a Turkey Drive Fund to help needy families, especially those families that are struggling between paying rent or buying groceries.

Needless, to say gaps in services has been and continues to be ongoing issues. Gaps would include:

A. Lack of affordable housing;
B. Inadequate medical coverage
C. Prolonged SSI appeal process;
D. Inability to qualify for housings programs due to lack os income, criminal background, etc.
E. Budget restraints has sorely effected many social services agencies, limiting their ability to provide services.

Service Provisions "con't"

Dual-diagnosed consumers are referred to programs such as MISA/CRR, halfway and ¾ housing, NA and AA programs, etc. Department of Human Services (DHS) has a Drug/Alcohol (D&A) program that can provide support from the administrative level.

Currently, in Allegheny County, there is a rise in opiate users. As a result this epidemic can add to the already existing strain on D&A services.

As Allegheny County PATH providers (Homeless Management Information System (HMIS) continues to be an integral part of our data collection system. PATH providers are encouraged to request technical assistance when needed. The state PATH coordinator also encourages the PATH providers to participate in PATH conference calls and trainings on HMIS by attending the upcoming PATH conference at Penn State University this June 2017.

Housed within DHS is the D&A Administration office. The Director/Staff are aware of the CFR part 2 regulations. The have the capability to handle any issues experienced by the D&A contracted providers.

Allegheny County DHS has a Justice Related Service (JRS) program designed to assist the mentally ill population that are involved with the legal system. Specific components of JRS include:

a. Drug Court
b. Mental Health Court
c. Support Specialist
d. Diversion Specialist

Just to name a few. JRS Specialists will assist the consumer in connecting to a variety of services needed.

Data

The three PATH providers are all part of the HMIS system. As previously stated, providers are encouraged to remain conscience of any updates regarding HMIS

Alignment of PATH Goals

The PATH providers and County PATH Coordinator continue to focus on ultimately preventing homelessness. Outreach and case management continues to be the initial process in servicing/linking consumers to appropriate services.

Alignment with State Mental Health Services Plan

Through our Hunger/Homeless Program, any homeless plans (National, State or Local) are their primary focus. Their funding streams help maintain operations of homeless shelters, soup kitchens, etc. The PATH providers work in conjunction to these plans to ultimately end the cycle of homelessness. Allegheny County DHS has a countrywide Standard Emergency

Alignment with State Mental Health Services Plan "cont"

Response Plan for all its designated locations. In addition, each location has its own "in-house" plan for staff and consumer safety.

Alignment with State Plan To End Homelessness

As previously mentioned in the IUP, ongoing outreach and case management is the first step to ending the cycle of homelessness. Whatever the State Plan recommends, Allegheny County is ready to adhere to them.

Other Designated Funds

Allegheny County DHS is slated to receive $615,645 in total PATH Funds for FY 2017-2018. $233,434 from that amount will be divided amongst our three existing PATH providers, as well as the County PATH position. DHS will allocate $382,211 to OSN (Mercy Behavioral Health) for expenditures in the Wellspring Center Program. (See Budget Narrative)

Programmatic and Financial Oversight

The PATH providers are required to submit quarterly financial reports to the County PATH Coordinator who in turn submits them to the state PATH Coordinator. The County PATH Coordinator also keeps records of the use of the PATH Contingency Funds.

SSI, SSDI, Outreach, ACCESS, Recovery (SOAR)

Each PATH provider agency can refer consumers to the SOAR Program (operated out of Mercy Behavioral Health). The interested in SOAR training can contact Mercy Behavioral Health.

SOAR's Coordinator Shawn Kostiuk stated that he currently has four trained staff members. He also stated that from May 1st, 2016, April 30th, 2017, there were (97) SOAR applicants. Mercy Behavioral Health responded to an RFP for SOAR and was awarded to contract.

Housing

PATH providers continues to assist consumers overcome barriers to obtain safe affordable housing. Many consumers are referred to the residential program. In turn, many of our residential programs have good rapport with landlords.

Allegheny County continue to have a centralized residential referral process. This process accepts housing referrals for the 24/7 residential programs. Various referrals would include the forensic, drug & alcohol, TAY population, all with the common denominator of mental health diagnoses.

Housing "cont"

Examples of residential programs are:
CRR-(Community Residential Rehabilitation)
SSH-(Specialized Supportive Housing)
CMHPCH-(Comprehensive Mental Health Personal Care Home)
LTSR-(Long Term Structured Rehabilitation)
24/7-Supportive Housing

Coordinated Entry

Allegheny County has established what is called Allegheny LINKS. It provides information on services available to persons who are homeless or at risks 9of becoming homeless. This centralized intake system is available to anyone throughout Allegheny County. VA-SPDAT is the tool used to gather intake data. It is with understanding that this service may be currently under revision.

Justice Involved

In addition to having the JRS program, several police stations have participated in the Crisis Intervention Training (CIT). It is with anticipation that police involvement will increase through participation in CIT.

Staff Information

Each PATH recipient agency has addressed this item in their perspective IUP.

The County PATH Coordinator has been involved with the program for nearly 25 years. This position averages and FTE of .25 hours per week in fulfilling PATH related responsibilities.

As County PATH Coordinator, anyone with a mental health diagnosis, as well as, homelessness/at risk homelessness can qualify for the PATH Contingency Program regardless of race, creed, ethnicity, sexual preference (LGBTQ), etc.

Client Information

Please refer to Provider Agencies IUP's.

The County PATH Coordinator projects that during the fiscal year 2017-2018, 137-140 consumers will need PATH contingency funds. Demographic data is maintained on the PATH applications. During the time frame from July 1, 2015 to June 30, 2016, the following data was recorded.

Female applicants	76
Male applicants	27
Age Range:	
17-under	3 consumers
18-23	5 consumers
24-30	13 consumers
31-50	39 consumers
51-61	35 consumers
62-→	8 consumers
Total	103 consumers

There is an expectancy that there will be 8 – 10 PATH Contingency Fund applicants that will be deemed as literally homeless for FY 2017-2018.

Consumer Involvement

Consumers are encouraged t complete satisfaction surveys which allow them to make recommendations regarding services. Also, consumers are encouraged to become Peer Support Specialist in providing support and encouragement for other consumers.

Family members ae encourage to participate in treatment team meetings (with consumer's permission).

Public hearing that involve County budget, are held at DHS and obviously opened to the public for feedback.

Behavioral Health Disparities Impact Statement

- It is estimated that 20-25 TAY individuals will apply for PATH Contingency Funds during FY 2017-2018.
- An estimated $4,000-$4,500, will be spent to assist TAY individuals.
- Types of service would include utility costs first time rents, security deposits, etc.
- The use of illegal drugs/alcohol appears to be the prominent health disparity amongst this TAY population.
- Stressful circumstances (peer pressure, social media, bullying, breakdown of family unit, etc.) channels youth to do drugs/alcohol.

Behavioral Health Disparities Impact Statement "cont"

- To further complicate matters, there is an opioid epidemic in Allegheny County. As a result schools, news media, service agencies, etc., are on board to provide resource/treatment**.** Narcan is a topic of discussion regarding administering of the medication on persons that overdosed on opiates.
- Allegheny County DHS is on board with discussion on the administering/training on Narcan. The rise of HIV/AIDS is also considered a health disparity with the TAY population.

Other disparities would include:

a) Increased gun violence
b) Teenage pregnancies
c) Suicide
d) Automobile fatalities
e) Date rape

Limited English Proficiency

Allegheny County is known for its culturally diverse population. Throughout Allegheny County you can still find "pockets" of neighborhoods that still maintain their ethnicity from their native homeland. With such culture language diversity, DHS as well as our PATH providers, are sensitive and respectful to the needs of such a diverse population. Within DHS there are many employees from diverse backgrounds, that are proficient in the English language.

Any consumer that falls under the 15 non-english languages, will be assisted with an interpreter, if needed.

As an added note, the hearing impaired can be provided with a sign language interpreter or referred to the Hearing Deaf Program.

Budget Narrative

Wellspring center, a program of Operation Safety Net, is a drop-in center that provides service connections through outreach. Such services would include hot meals, recovery topics, resources for gaining income and housing, health resources (including health insurance), etc. Case Management and nursing services are available on site. $382,211 from the PATH FY 2017-2018 allocation will be used to cover the expenditures at the center.

FY PATH Allocation 2017-2018

A. Operation Safety Net	$534,350	($152,139 + $382,211)
B. Community Human Services	$ 26,675	
C. Three Rivers Youth	$ 41,317	
D. Allegheny County DHS	$ 13,303	
TOTAL	**$615,645**	

Allegheny County Department of Human Services
PATH Program
Fiscal Year 2017-2018

Line Item	Annual Salary	PATH Funded FTE	PATH Funded Position	Total
County PATH Coordinator	$42,681	.075	$13,303	$55,984
Fringe Benefits	0	0	0	0
Travel	0	0	0	0
Equipment	0	0	0	0
Supplies	0	0	0	0
Other	0	0	0	0

There is a State match of $3,303 of the $10,000 allocation.

The Allegheny County PATH Coordinator's position is allocated $10,000 annually. The responsibilities of the PATH Coordinator are to monitor the PATH provider agencies, provide PATH technical Assistance, attend PATH related trainings, participate in PATH conference calls and complete the IUP's and the PATH annual report.

Each PATH provider agency has included a budget narrative in their IUP's.

Allegheny County Department of Human Services
PATH Program
Comprehensive Budget
Fiscal Year 2017-2018

LINE ITEM	OSN	CHS	TRY	COUNTY	TOTAL
Salary Path Funded	79,284	24,204	22,792	0	126,280
Fringe Benefits	32,507	866	4,111	0	37,484
Travel	2,412	0	0	0	2,412
Equipment	3,000	0	2,000	0	5,000
Indirect Cost	5,000	0	600	0	5,600
Contingency Fund	29,936	0	0	0	29,936
Rent Expense	0	400	9,886	0	10,286
Administrative Cost	0	1,205	1,928	0	3,133
County PATH position	0	0		13,303	13,303
TOTAL	**$152,139**	**$26,675**	**$41,317**	**$13,303**	**$233,434**

2. Allegheny County - Community Human Services Corporation

1975 Fifth Ave

Pittsburgh, PA 15213

Contact: Rebecca LaBovick

Contact Phone #: 4122461641

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-035

State Provider ID: 4235

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Allegheny County's Community Human Services will receive $26,675 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 30

Estimated Number of Persons to be Enrolled: 30

Estimated Number of Persons to be Contacted who are Literally Homeless: 30

Number staff trained in SOAR in grant year ending in 2017: 3

Number of PATH-funded consumers assisted through SOAR: 0

Section C: Local Provider Intended Use Plans

LOCAL PROVIDER INTENDED USE PLAN

PATH Funds – Community Human Services Corporation (CHS)

2017-2018

Local Provider Description

CHS is a private non-profit human service provider. The agency uses a multi-service approach to provide holistic supportive services throughout Allegheny County.

CHS holds a contract with Allegheny County Office Behavioral Health to provide PATH services for individuals who are homeless or at imminent risk of becoming homeless and have a serious mental illness or co-occurring disorder. These PATH services including outreach, assessment and service referral as part of the housing programs provided by the agency. This fund supports the psychiatric clinic at The Residences at Wood Street (formerly Wood Street Commons).

To ensure the highest quality of service provision, CHS has made revisions including: centralized/coordinated intake process, increased ability for self-referral, elimination of clean time requirements services, expanded life skills and psycho-educational training, expanded rental assistance, partnerships with local subsidized housing providers, and expanded use of harm reduction and housing first approaches.

CHS centralized the majority of its programming, except residential programs, in an office that is easily accessible by public or private transportation in the Strip District of Pittsburgh. The agency's new location address is: CHS, 2525 Liberty Avenue, Pittsburgh, PA 15222.

Name of Provider as it appears in PATH PDX:
Allegheny: Community Human Services
2525 Liberty Avenue
Pittsburgh, PA 15222
t: (412) 246-1641
f: (412) 697-2049
e: rlabovick@chscorp.org

For 2017-2018, the agency anticipates receipt of $26,675 (of which $6,669 are base funds) in Federal PATH funds allocated through the Allegheny County Department of Human Services Office of Behavioral Health which will provide for psychiatrist time for the behavioral health clinic at The Residences at Wood Street three hours per week to adult individuals (18 years of age and above). Service costs have made it necessary to increase the portion of PATH money dedicated to the psychiatric clinic at Wood Street Commons. $6,669 and $20,006 will be used

respectively to support the psychiatric nurse and psychiatrist at this clinic. Please reference the Budget Section and Budget Template attached for further detail.

Collaboration with HUD Continuum of Care (CoC) Program

CHS is one agency within the Allegheny County HUD CoC. The Chief Executive Officer of CHS is active on the Homeless Advisory Board and remains one of the original LHOT members. The Director of CHS's Therapeutic Programs, who is also the mental health clinic clinician, was active in the development of a local Ten Year Plan to End Homelessness as well as being engaged in its implementation, and offers a variety of trainings (inclusive of Mental Health First Aid – 8 hour certification course for both Adult and Public Safety) to agencies within the HUD/Homeless continuum of care. CHS' staffs, attend the Allegheny County Homeless Alliance and its subcommittees as meetings are scheduled. Through these committees, providers are identifying and addressing the causes of homelessness, its perpetuation and the delivery of service throughout the homeless provider network and mainstream resources. Staff attends regular meetings with local providers, Homeless Advisory, Allegheny County-Department of Human Services-Offices of Behavioral Health and Homeless Services. They use these forums to stay connected to community wide housing and supportive service efforts, county staff and new resources in the community. This regular contact allows staff to share resources and appropriately make and coordinate referrals. CHS has remained directly involved in the Pittsburgh Housing-Healthcare Integration (H2) Plan Draft and Leadership Team.

Collaboration with Local Community Organizations

CHS works with a multitude of Allegheny County agencies. The following is a small sampling of agencies that may/may not be PATH funded but provide support to PATH eligible consumers. This support is provided through supportive services and housing:

1. **The Residences at Wood Street (Wood Street Commons)** is a part of CHS's continuum of care. Housing, both temporary and long term is available. CHS manages a 32 bed shelter program, a 15 bed CMI Bridge Housing program, a 20 bed permanent HUD funded housing program and a 6 bed program specifically for individuals currently in the probation system. CHS community support specialists work with building residents to secure and maintain affordable housing. Both Medical and Mental Health services are available on site. **The psychiatrist at the mental health clinic at Wood Street Commons is funded by CHS's PATH allocation.**
2. **Housing Authority:** All clients of CHS complete applications for City of Pittsburgh and Allegheny County Housing Authorities with their community support specialist. CHS also works with the housing authorities to prevent evictions of particularly vulnerable tenants (medical/mental health issues).
3. **Veterans Administration Healthcare for the Homeless Program** provides medical care and supportive services for homeless veterans referred by CHS staff.
4. **North Side Common Ministries** is a collaborative partner that provides both shelter and food pantry services. This agency has also assisted CHS in providing bathing and laundry services for unsheltered homeless men.

5. **Bethlehem Haven** is a collaborative partner. Staff assisted women in the shelter to connect with housing and other services. Bethlehem Haven provides shelter, Drug and Alcohol based housing, a modified safe haven program for women, transitional homeless housing and essential clinical services.
6. **Drop in Centers & Feeding sites** throughout Allegheny County provide outreach sites for CHS staff and also provide socialization opportunities for homeless consumers.
7. **Alma Illery Medical Center – Healthcare for the Homeless** provides on-site medical care at The Residences at Wood Street (Wood Street Commons). The clinic works collaboratively with the PATH funded psychiatric outreach staff to ensure comprehensive primary and behavioral health supports to homeless individuals.
8. **Department of Aging** has provided housing and service assistance for frail elderly homeless individuals. The Department of Aging also uses CHS's services to provide in home care, life skills training, housing location assistance and case management.
9. **Mercy Behavioral Health/Operation Safety net** provides primary medical care to individuals living on the street while CHS provides tangible assistance to those clients. CHS and Mercy Behavioral Health (Operation Safety Net) engage in collaborative outreach efforts to ensure people on the streets have access to more comprehensive services.
10. **Western Psychiatric Institute and Clinic** has a full range of homeless housing and mental health services within their homeless continuum.
11. **University of Pittsburgh Schools of Pharmacy, Social Work, Public Health, Nursing, Occupational Therapy and Psychology** have the ability to place intern rotations within the CHS programs, providing crucial project and services to individuals served within the agency. Interns consistently are placed within the CHS programs and at the Residences at Wood Street (Wood Street Commons).
12. **UPMC Health Plan/Community Care Behavioral Health Organization** and CHS work collaboratively and are contracted to provide shelter plus care permanent HUD homeless housing services to greater than 25 medically compromised individuals.
13. **Allegheny Health Network** and CHS work collaboratively and are contracted to provide housing services to medically compromised individuals in a pilot medical respite program.

Service Provision

PATH services are provided in conjunction with CHS housing programs which include case management and housing service programs, psychiatric assessment and behavioral health referrals, opportunities for socialization, transportation assistance, survival provisions (food, clothing, blankets) an information/referral service to appropriate housing and support services through CHS's organizational components and throughout the larger social service community. While PATH funds do not cover any service costs entirely, the following PATH services are provided by the PATH supported staff: outreach, screening and assessment, community mental health services, and referrals. The larger agency housing programs, which PATH funds are a part of, provide a comprehensive continuum of care (in accordance to the Allegheny County Continuum of Care) to address the needs of homeless individuals and families. Not all components of the housing programs receive PATH funds but PATH eligible consumers are able to access the array of services provided through the different housing program components.

CHS maximizes the use of PATH funds by leveraging use of other available funds internally and externally. Internally, individuals can be referred through CHS centralized intake to be screened for internal and external referral needs. The referrals can be to a vast array of services that may include internal resources, such as CHS Early Head Start (Family Foundations), CHS housing services, CHS food pantry and many other programs. External referrals may include, but are not limited to, Veterans Administration, Department of Public Welfare, Social Security Administration, and Allegheny County centralized intake through Allegheny Link. The mission of the Allegheny Link is to simplify and streamline access to services and supports in an effort to help individuals and families maintain their independence, dignity and quality of life.
The Allegheny Link provides a wide array of services to Allegheny County residents

- with a disability
- over the age of 60 with or without a disability
- who are experiencing or at risk of homelessness

and professionals in the human services systems.

- Several **gaps** exist in the current service delivery system. These have not changed over the last decade and have become direr.

First, there are not enough funds to meet the ever growing demand for health/behavioral services and housing. Secondly, traditional services continue to take longer periods to access once an individual is able to willingly accept and engage. It is not atypical for an individual to wait for 4-6 months from the initial intake appointment with traditional outpatient mental health services to be seen by a psychiatrist.

There is a lack of affordable housing available in our community. The local wages do not meet housing costs. Additionally, the National Recession continues to affect individuals and families not typically seen in homeless services in the past. The housing wage in Allegheny County is over $18/ hour which is out of reach for the overwhelming majority of PATH consumers. In addition, monies to local Housing Authority are often cut each year making less affordable housing available. Applications for this housing become more and more competitive.

The numbers of working poor continues to increase. Lack of health care often forces individuals to go without prophylactic treatment, even with access to affordable health care through the Affordable Care Act (ACA). The system is difficult to navigate, poorly understood and under-accessed. These individuals work until they end up in medical crises. At this time, their situation is drastic and they miss large amounts of work resulting in termination from employment. They cannot pay medical bills, housing costs, purchase food or afford transportation. This results in homelessness and reliance on community based "free" services which are over burdened and underfunded.

Allegheny County does not have an engagement center site and/or a "wet/damp" shelter. This makes it difficult for persons who are actively using drugs or alcohol to make an entrance into the homeless system. This is particularly true when their goal is not treatment or sobriety. The majority of local HUD funded programs for homeless individuals implement sobriety requirements before individuals are even considered for housing. In addition, the majority of those programs will terminate individuals in the program if they are found to be using.

Individuals who are LGBTQI have extreme difficulty accessing shelter and often includes transitional age youth (TAY). Shelters are typically designated for one gender. Many local providers refuse to take an individual whose gender is unclear. Shelters that have plans in place in ensuring safety, sensitivity and security to transgendered individuals using the shelter facilities are limited. CHS has a very small scale, three bedroom house that is being utilized as an atypical shelter program for this specialized population of individuals. CHS also operates a youth program, Project Silk, which is specifically focused on LGBTQI youth (TAY) that focuses on inclusion, education, screening, referral and access to services. Most youth served are marginally housed.

Many shelters are not fully handicapped accessible. Affordable accessible units in the open market are extremely hard to find. There is no respite facility available for persons who are not ambulatory.

Each time the number of homeless individuals is calculated, that total exceeds available housing. This is especially true for homeless youth. The one local shelter providing housing for this group was forced to reduce their spaces. Male heads of household also have limited options for shelter, bridge, transitional and permanent housing within the homeless system.

Limited shelter stays also create a barrier to stability. Individuals can only rely on housing for thirty-sixty days but there is a waiting list for the Housing Authorities of 6 months to a year or longer, individuals are forced onto the streets or into crowded and/or unsafe living situations. In addition, almost all homeless programs (bridge, transitional, permanent) have waiting lists that exceed the maximum shelter stay.

- To ensure the highest quality of service provision, CHS has made revisions including: centralized/coordinated intake process, increased ability for self-referral, elimination of clean time requirements services, expanded life skills and psycho-educational training, expanded rental assistance, partnerships with local subsidized housing providers, and expanded use of harm reduction and housing first approaches. The mental health clinic at The Residences at Wood Street (Wood Street Commons) provides direct service to adult individuals with serious and persistent mental health needs. Referral can be made for drug and alcohol services to outside providers.

- CHS agency PATH funds are not utilized for training staff. Alternate agency funds are utilized and free trainings are explored. The primary staffs funded by PATH funds are both with professional licenses and have a bi-annual requirement for expectation on training hours ongoing, which are consistently satisfied.

- CHS utilizes Allegheny County's HMIS system for PATH. A full time Behavioral Health Administrative Coordinator (BHAC) completes all necessary funding based data entry, which includes Allegheny County HMIS and CIPS. This position is not funded by the PATH funds received. See more information following under Data. Regarding 42 CFR Part 2, CHS is not a funded/licensed substance use provider.

- CHS operates a housing program, FUSE, which is solely focused on frequent users of the criminal justice system. This program assists with housing and ongoing service coordination.

Data

CHS utilizes Allegheny County's HMIS system for PATH. A full time BHAC completes all necessary funding based data entry, which includes Allegheny County HMIS and CIPS. This position is not funded by the PATH funds received. CHS has additional staff who are available and prepared to data enter HMIS activity as the agency uses the HMIS system routinely within many of the funded homeless programs. Allegheny County Department of Human Services provides training at no cost to providers utilizing both HMIS and CIPS platforms.

Alignment with PATH Goals

CHS is in alignment with PATH Goals throughout the internal homeless continuum and via referral to and from appropriate other agencies. The funds are utilized to provide neither direct street outreach nor case management, but internal and external agency programs are relied on for this resource. The funds provide direct mental health services to individuals who are homeless.

Alignment with State Mental Health Services Plan

CHS PATH funds provide direct mental health services to individuals who are homeless. The Director of CHS's Therapeutic Programs, who is also the clinician in the PATH funded clinic, has played an active role in the development of an all hazards plan at The Residences of Wood Street (Wood Street Commons). This has included greater than two years of active evacuation planning and drills in the building that houses 259 individuals. Additionally, The Director assisted in the implementation of the CHS Safety Committee and remains an active committee member. The committee is entering its fifth year of charter. The Director is active within the Allegheny County Medical Reserve Corp and Pennsylvania's SERVPA, volunteering for drills and deployment. Both Allegheny County Medical Reserve Corp and Pennsylvania's SERVPA offer ongoing training related to disaster and emergency preparedness that would be inclusive of homeless individuals and families, with any disability, within Allegheny County.

Alignment with State Plan to End Homelessness

CHS PATH funds are utilized to provide neither direct street outreach nor case management, but internal and external agency programs are relied on for this resource. The funds provide direct mental health services to individuals who are homeless. Referrals are readily accepted from internal and external agency staff for homeless individuals needing this service.

To ensure the highest quality of service provision, CHS has made revisions including: centralized/coordinated intake process, increased ability for self-referral, elimination of clean time requirements services, expanded life skills and psycho-educational training, expanded rental assistance, partnerships with local subsidized housing providers, and expanded use of harm reduction and housing first approaches. CHS has also centralized the majority of its

programming, except residential programs, in an office that is easily accessible by public or private transportation in the Strip District of Pittsburgh. The agency's location address is: CHS, 2525 Liberty Avenue, Pittsburgh, PA 15222. Individuals can be referred through CHS centralized intake to be screened for internal and external referral needs. The referrals can be to a vast array of services that may include internal resources, such as CHS Early Head Start (Family Foundations), CHS housing services, CHS food pantry and many other programs. External referrals may include, but are not limited to, Veterans Administration, Department of Public Welfare, Social Security Administration, and Allegheny County centralized intake through Allegheny Link. The mission of the Allegheny Link is to simplify and streamline access to services and supports in an effort to help individuals and families maintain their independence, dignity and quality of life.

The Allegheny Link provides a wide array of services to Allegheny County residents

- with a disability
- over the age of 60 with or without a disability
- who are experiencing or at risk of homelessness

and professionals in the human services systems.

Other Designated Funds

CHS PATH funds are utilized to provide neither direct street outreach nor case management, but internal and external agency programs are relied on for this resource. The PATH funds provide direct mental health services to individuals who are homeless. The internal and external programs often are not funded by PATH, but through a variety of grant sources including, but not limited to: HUD grants, Emergency Solutions Grants (ESG), Rapid Rehousing, Foundation Grants, and other private grants. CHS is also entering in to traditional billable service for mental health service rendered with our local Medicaid Behavioral Health Organization. Part of these billable services will augment existing internal PATH funding.

Programmatic and Financial Oversight

CHS holds a contract with Allegheny County Office Behavioral Health to provide PATH services for individuals who are homeless or at imminent risk of becoming homeless and have a serious mental illness or co-occurring disorder. These PATH services including outreach, assessment and service referral as part of the housing programs provided by the agency. This fund supports the psychiatric clinic at The Residences at Wood Street (formerly Wood Street Commons).

For 2017-2018, the agency anticipates receipt of $26,675 (of which $6,669 are base funds) in Federal PATH funds allocated through the Allegheny County Department of Human Services Office of Behavioral Health which will provide for psychiatrist time for the behavioral health clinic at The Residences at Wood Street three hours per week to adult individuals (18 years of age and above). Service costs have made it necessary to increase the portion of PATH money dedicated to the psychiatric clinic at Wood Street Commons. $6,669 and $20,006 will be used respectively to support the psychiatric nurse and psychiatrist at this clinic.

PATH monitoring occurs through a variety of methods to ensure quality and fiduciary prudence.

- Annually, Allegheny County PATH programs are monitored by State of Pennsylvania oversight.
- Quarterly fiscal reports are submitted to Allegheny County and Pennsylvania State.
- CHS contracts an external agency, Maher Duessel – Certified Public Accountants, to complete a full fiscal audit and annual fiscal report.

SSI/SSDI Outreach, Access, Recovery (SOAR)

CHS currently have several staff within the housing departments that are SOAR trained. One staff member trained is the Psychiatric Nurse Clinician who manages the Wood Street Commons Mental Health clinic. Most clients served in the clinic are already in the process of appeals relating to SSI/SSDI applications, have applied through standard means and are utilizing legal representation. One individual was assisted to apply via SOAR SSI application during 2013-2014 by the nurse clinician in the mental health clinic. There were many barriers at the Social Security Administration related to the SOAR process not being handled appropriately per guidelines. The local SOAR Coordinator was made aware and assisted to problem solve with the specific SSA office involved. In completing SOAR SSI applications, barriers are noted: The average SOAR SSI application has a 60-day deadline requirement, the average application requires a minimum of six hours weekly to complete and agencies have experienced reductions in funding without dedicated positions to complete the SOAR SSI process. Statistics show agencies that are effective in being able to complete SOAR process have at least one staff member who is dedicated to completing the SOAR process with individuals. Agencies that have this dedicated staff member are often making use of an AmeriCorps member to fill this position and complete this process. CHS did not have an AmeriCorps Member during the year 2016-2017 and do not anticipate that an AmeriCorps Member will be present during the 2017-2018 year. External resources are utilized for SOAR specific referral, inclusive of Allegheny HealthChoices, Inc. and Mercy Behavioral Health.

Housing

CHS' housing programs and PATH services rely on a team approach to service. The agency has established a full continuum of services that are made available to all consumers entering any program at the agency. It is the philosophy of CHS to engage individuals where they are physically and emotionally. This means that we begin the service relationship with rapport building that is non-intrusive. This allows the individual to divulge information they are comfortable sharing in the time frame that is acceptable to them. Cases remain open for six months to a year, even if contact has not been made. Cases are not closed until the outreach staff and psychiatric nurse attempt to locate the consumer to re-engage in services. Additionally, missed clinic appointments at the Wood Street Commons Mental Health Clinic are re-scheduled automatically in an effort to keep the individual engaged in services, unlike outpatient treatment programs who do not automatically re-schedule missed appointments. Traditional treatment programs leave the responsibility to the individual who did not appear to schedule appointments.

Services are provided through harm reduction approaches. We recognize that individuals do not always intend on suspending harmful behaviors or may not be able to do so immediately. We attempt to help them manage the harmful consequences of those behaviors without requiring abstinence. Staffs develop goal plans that are reflective of the consumer's needs and wants.

CHS maintains a Housing Response Team to respond to housing crises by making appropriate referrals internally and externally. There is a staff member on crisis on-call 24 hours a day/365 days per year. The staff member has ability to contact the Director of Therapeutic Services/Psychiatric Nurse for consult/referral as indicated.

A full continuum for homeless individuals and families exists within CHS. In addition, the agency works closely with the list detailed under Collaboration with Local Community Organizations.

Individuals who are experiencing ongoing mental health issues often have experienced migratory life styles. Housing may be lost due to inability to pay rent, rejection by family members, misunderstood behaviors, inability to assimilate to community profile, and/or liability of mood/desires. It is critical when assisting individuals in attaining and retaining housing to accurately identify what the consumer wants for themselves and realistically discuss what type of housing they can afford, access and maintain. It is the responsibility of CHS staff to ensure appropriate housing is investigated. This entails keeping current information on local housing options making in person visits to sites and programs to ensure it is appropriate for a given individual.

CHS works with Allegheny County Department of Human Services to administer an emergency housing unit which provides atypical shelter to individuals who cannot access traditional shelter because of LGBTQI issues.

CHS has a long history of housing assistance within Allegheny County. Over time, the agency has been able to develop positive relationships with local landlords by being responsive to their needs and the needs of the consumers being served by the agency. Staff and administration performs outreach with these landlords to educate them about issues tied to homelessness (poverty, mental and behavioral health issues, physical and cognitive limitations, the impact of trauma, etc.). The agency provides ongoing support for individuals in the housing and maintains close relationships with the landlord to avoid a cycle of eviction. Building a relationship of trust with private market housing providers has allowed CHS to access housing that may not typically be available to PATH consumers.

The Housing Assistance Programs (formerly Homeless Assistance Programs) have established permanent housing program for homeless individuals/families with a disability. CHS is investigating housing options in the Pittsburgh - Oakland Community to serve individuals with mental health needs. CHS continues to explore the development of additional mental health programs to provide supports that will make living in an independent community setting available to a larger number of PATH consumers.

Coordinated Entry

CHS relies on Allegheny County's centralized intake system, Allegheny Link, for coordinated entry for individuals in housing crises. Additionally, CHS has internal, coordinated, centralized intake, which not only screens for housing crises, but also for other internal and external referral

resources available to the individual/family. CHS intake utilizes the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) as part of their intake process.

Justice Involved

CHS strives to minimize and foster all individuals served who have a criminal history in all agency programs. Criminal history is not a barrier, necessarily, but can be a challenge. Many housing sources in the county may not accept individuals based on criminal background. CHS will explore the criminal background the nature of charges, how far in the past they occurred, work around the barriers and potentiate advocacy. This may include referral to internal and external agency such as Allegheny County Justice Related Services. Internally, CHS has two programs that directly serve individuals with criminal histories and involve housing crises. Greater than 50% of individuals involved in the PATH program have criminal histories.

Allegheny County and the City of Pittsburgh have Crisis Intervention trained public safety officers. It is anticipated that less than 50% of law enforcement is trained within Allegheny County. CHS has two Mental Health First Aid (MHFA) trainers specialized in training Public Safety courses. To date, two trainings have been completed and two further are scheduled in September 2017. It is anticipated that this will capture approximately #74 public safety/law enforcement individuals. The trainers have received feedback from law enforcement officers who have received CIT training. The feedback was that MHFA training was a wonderful refresher and went in to more detail on items than CIT training did.

Staff Information

CHS takes staff hiring very seriously. Staff is not only hired based upon education and experience but also personality, compassion and sensitivity to cultural differences. Staffs of CHS represent a range of ages, racial and ethnic backgrounds. Both men and women serve PATH consumers. In addition, staff receives training on cultural diversity/sensitivity and service provision within the agency through their new hire orientation and ongoing during employment. Staffs are involved in organized trainings at low or no cost through internal and external resources. Staffs are involved annually in agency Town Halls to assist in building on the agency strategic plan, improvement of quality service and improvement of processes/job satisfaction.

Following is a small list of internal CHS trainings that are incorporated in to orientation at hire and are encouraged ongoing as refresher trainings: Trauma Informed Care, Motivational Interviewing, Corporate Culture, Customer Service, Harm Reduction, Housing First, Family Violence, Mission/Vision/Values and Cultural Sensitivity. Quarterly, Mental Health First Aid (Adult – USA) is offered and an annual competence for all staff is to attend Comprehensive Crises Management.

A client's racial, gender, socioeconomic and cultural needs are assessed at intake. These needs are incorporated in goal planning for consumers. Cases may be discussed at weekly staff meetings where group planning and resource materials are utilized to provide the highest quality service planning. CHS has over forty years of history and experience working with individuals and families across all genders, races, ethnicities and socioeconomic strata.

CHS utilizes a centralized electronic record system and database to track all program participants enrolled within programs. This record system complies with HIPAA, is secure and every user has password protection. Outcomes are tracked via this system and include services received, referrals and linkages offered, race, ethnicity, LGBTQI and age. Language needs can also be tracked via this system, but Allegheny County has not experienced an enormous language related barrier. When encountered, local resources for language services are located and utilized, this may be through local churches, cultural centers and universities. PATH funds are not utilized within the agency to measure, track or respond to these disparities, but are used to provide direct behavioral health services to individuals within this disparity population.

Description of Services offered and Client Information:
The program expects to provide PATH funded services to approximately 30 unduplicated individuals during 201-2018. 100% of those individuals are anticipated to be homeless at enrollment. Enrollment is 100% of individuals within mental health outreach/mental health clinic. 100% of these individuals are with behavioral health issues. It is anticipated that at least 50% of these individuals may also suffer co-occurring substance abuse issues. **The ultimate goal for substance abuse treatment is for the individual to be referred on to the most appropriate level of services in traditional care, such as a drug and alcohol outpatient program (Western Psychiatric Institute and Clinic – CPCDS, Mercy Behavioral Health, etc).**

Client Information

Below is a table outlining 2016-2017 statistics regarding Ethnicity/Race/Gender/Age, these statistics are based solely on reporting obtained from Allegheny County HMIS:

ETHNICITY/RACE	UNDUPLICATED NUMBER OF CLIENTS	GENDER/AGE	UNDUPLICATED NUMBER OF CLIENTS
Black	11	Male	15
White	22	Female	17
Asian	1	Transgendered	2
		18-30 years of age	6
		31-34 years of age	4
		35-64 years of age	21
		65-74 years of age	2
		>75 years of age	1

2017-2018 statistics are expected to remain relative to the year 2016-2017. Unduplicated individuals served annually were anticipated at 50 per year and 34 unduplicated individuals were served. This is due to the large number of individuals who are seen ongoing through the mental health services offered through CHS. Over the years, there has been a rise in care cost related to the contracted psychiatrist in the mental health clinic. Additionally, there are only three hours weekly of psychiatrist direct time. Individuals seen through these services tend to be with

serious and persistent mental illness. Traditional services are taking even longer than anticipated periods to access once an individual is able to willingly accept and engage. The average wait time for an outpatient intake appointment is 4-6 weeks. Following intake, wait time to see a therapist can exceed 4 weeks and the wait time to see a psychiatrist can exceed 6 months.

Consumer Involvement

In all of CHS's programs, consumers are the driving force behind treatment and service planning. If there are family members involved, they are encouraged to participate dependent on the consumer preference. Unfortunately, there are a large percentage of individuals who are estranged from their family support system due to multi-faceted issues. Random quality assurance calls are placed to consumers regarding their satisfaction with services. Satisfaction surveys are administered for each program. Each individual entering the programs offered by CHS are given contact information for the Program Director. They are encouraged to contact supervisory staff with concerns or suggestions. Advocacy is a core value at CHS and individuals participating in all programs are encouraged to participate in formal and non-formal advocacy endeavors. In addition, CHS has become more involved in activities sponsored by various agencies such as the Mental Health Association, the Department of Public Welfare and various educational institutes such as University of Pittsburgh, Carlow University and Duquesne University.

PATH eligible consumers are employed by the agency and act as volunteers in a wide range of programs. Consumers are invited to provide input on the organization and its management. The CHS Board of Directors has representation of local community members with diverse backgrounds. Consumer representation is encouraged by the Board. The Board reviews programs, budget/fiscal issues and has input into program leadership, implementation and development.

Life skills or psycho educational groups offered are followed by consumer input surveys. Support groups are provided based on consumer suggestions and feedback. Participants in these groups are surveyed regarding satisfaction and additional areas of interest for future groups are ascertained.

Health Disparities Impact Statement

Health and Behavioral Health Disparities are previously addressed in Section **Service Provision** of this intended use plan, with the exception of transitional age youth (TAY). Transitional age individuals, 18-30 years of age, are served through the mental health clinic. **The unduplicated number decreased during 2016-2017 at 6 unduplicated individuals annually, which accounts for approximately 18% of the clinic caseload.** PATH funds are not utilized directly for assistance to TAY individuals, but towards the service provided to the individuals through the mental health clinic equating to approximately $3,900 of PATH funding to date for the 2016-2017 year. Referrals may be received from external sources who work with transitional age youth, such as Family Links, but The Residences at Wood Street (Wood Street Commons) houses 259 individuals 18 years of age and above. Statistically, tenancy of individuals who are

18-30 years of age has grown in recent years. Additionally, TAY individuals are eligible for referral to any internal CHS programs, inclusive of CHS Youth Programs.

Limited English Proficiency

Services throughout the CHS are available regardless of literacy levels, primary language, etc. Individuals are assessed holistically and any barriers are addressed as indicated, such as interpreters/translators if language is a barrier. To date, this has not been an issue. The predominant language barrier identified has been Spanish and CHS has a working relationship with the Latino Community at St. Regis Church in Oakland and also have access to internal staff that is proficient in Spanish. CHS has been uniquely creative in attaining language interpreters as indicated. This has included Cambodian and Turkish speaking interpreters. CHS has a longstanding collaboration with Hearing and Deaf Services (HDS). HDS has interpreters fluent in American Sign Language as well as a plethora of spoken interpretation services.

Budget narrative:

For 2017-2018, the agency anticipates receipt of $26,675 (of which $6,669 are base funds) in Federal PATH funds allocated through the Allegheny County Department of Human Services Office of Behavioral Health which will provide for psychiatrist time for the behavioral health clinic at The Residences at Wood Street three hours per week to adult individuals (18 years of age and above). Increased service costs have made it necessary to increase the portion of PATH money dedicated to the psychiatric clinic at Wood Street Commons. $6,669 and $20,006 will be used respectively to support the psychiatric nurse and psychiatrist at this clinic.

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Psychiatric Outreach Nurse	$62,497.50	14.7%	$9,187.00	$9187.00
Psychiatric Physician	$125/hour	3 hrs weekly-sub contracted position	$15,017.00	$15,017.00
Sub-total			**$24,204.00**	**$24,204.00**
Fringe Benefits				
FICA Tax			$515.00	$515.00
Health Insurance			$32.00	$32.00
Retirement			$135.00	$135.00
Life Insurance			$81.00	$81.00
Workers' Comp. Ins.			$103.00	$103.00
Staff Development			$ -	$ -
Sub-total			**$866.00**	**$866.00**

Travel				
Local Travel for Outreach	n/a			
Travel to training and workshops	n/a			
Sub-total			**$ -**	**$ -**
Equipment				
(list individually)	n/a			
Sub-total			**$ -**	**$ -**
Supplies				
Office Supplies	n/a			$ -
Consumer-related items	n/a			$ -
Sub-total			**$ -**	**$ -**
Other				
Staff training	n/a			
Communications	n/a			$ -
One-time rental assistance	n/a			
Security deposits	n/a			
Postage	n/a			
Rent Expense (Office Rent)			$400.00	$400.00
Administration			$1,205.00	$1,205.00
Sub-total			**$1,605.00**	**$1,605.00**
Total PATH Budget			**$26,675.00**	**$26,675.00**

PERSONNEL:

This line item includes partial salary costs for one Psychiatric Outreach Nurse (14.7% of full time at $9,187 through base funds) and one hourly Clinic Physician at Wood Street Commons ($15,017).
PATH funds are not utilized for any purpose other than personnel costs with a minimal portion allocated to rent expense to offset cost of office space that is approximately 91.7 square foot.

91.7 sq ft x $0.84 = $77/month for actual rent expense, but this has been capped at $400/year based on budget constraints.

3. Allegheny County - Operation Safety Net

1518 Forbes Ave

Pittsburgh, PA 15219

Contact: Lynetta Ward

Contact Phone #: 4122325896

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-040

State Provider ID: 4240

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Operation Safety Net will receive a total of $534,350 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 500

Estimated Number of Persons to be Enrolled: 200

Estimated Number of Persons to be Contacted who are Literally Homeless: 375

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Pittsburgh Mercy
Operation Safety Net
2017-2018 Intended Use Plan

Local Provider Description –
Operation Safety Net is Pittsburgh Mercy's award-winning, innovative medical and social services outreach program for the unsheltered homeless population in Allegheny County. Operation Safety Net strives to address the circumstances which undermine the mental and physical health of persons served by creating avenues and opening doors for the homeless population to access housing, medical and other social services that are necessary to help improve their overall quality of life.
Since being founded in 1992, Operation Safety Net has reached approximately 13,000 homeless individuals with more than 69,000 visits where they live. Operation Safety Net makes it a priority to meet the client where they are in camps along the riverbanks, in alleyways, beneath the bridges and highway overpasses. These visits have been crucial in assisting more than 300 individuals who were once homeless find their own safe and stable housing.

Pittsburgh Mercy's Operation Safety Net is a non-profit organization in Allegheny County. The total amount of PATH funds received in 2016 was $152,139. Our official address is:
Pittsburgh Mercy
1200 Reedsdale Street
Pittsburgh, PA 15233

Contact person for PATH provider is:
Leane Merrill
Pittsburgh Mercy
700 Wood Street
Pittsburgh, PA 15221

Tia Carter
Pittsburgh Mercy
249 S.9th Street
Pittsburgh, PA 15203

Collaboration with HUD Continuum of Care (CoC) Program-
Pittsburgh Mercy's Operation Safety net places a high value on collaboration with Allegheny County and the other valuable members of the CoC. Meetings are held quarterly with the CoC and Operation Safety Net ensures staff is present at all meetings.
Operation Safety Net's staff are current valued members of other organizations that assist the homeless population in Allegheny County. Our staff currently sit on the Homeless Advocacy Committee, H2- a committee to assist with coordinating case management and health care, Homeless Outreach Coordinating Committee and the Homeless Advisory Board. Through these committees our staff is able to give their insight on program specifics such as PATH and provide ideas, suggestions and collaborate on bettering the way we serve others.

Operation Safety Net also collaborates with organizations that mission is to assist in the termination of chronic homelessness in Allegheny County such as the Stand Down planning group, Veterans Boot Camp push to end Veteran's homelessness in 2017.

Collaboration with Local Community Organizations-
PATH eligible clients who are connected with Operation Safety Net are fortunate to have access to many of our other services offered through Pittsburgh Mercy such as Outpatient Behavioral Health, Pittsburgh Mercy Family Health Center, Operation Safety Net housing programs, and street outreach services. We continue to foster relationships with substance abuse providers in the community to assist the ever growing number of clients that suffer with addiction. These services include in-patient, outpatient and group therapy services for clients who request these services.
Operation Safety Net has an entire team of outreach workers who help identify the street homeless population in our area, engage them, offer medical and service coordination services to them where they reside, and assist them with reaching a safe haven. The below is a list of available resources/services that PATH clients have access to from the time of street engagement:

Housing:

1. Western Psychiatric Institute and Clinic- Neighborhood Living Project
2. Allegheny County, City or Pittsburgh, and City of McKeesport Housing Authorities
3. Government subsidized senior housing
4. Allegheny YMCA-SRO
5. Various landlords
6. Various housing programs through Operation Safety Net and the county

Operation Safety Net provides permanent, and rapid rehousing programs for eligible clients

Primary Health:

1. Pittsburgh Mercy Family Health Center (PMFHC)
2. North Side Christian Health Center
3. East Liberty Family Health Center
4. Catholic Charities Free Health Care Center
5. Health Care for Homeless Clinics

Mental Health:

1. Pittsburgh Mercy
2. Western Psychiatric Institute and Clinic
3. Health Care for Homeless Mental Health Clinic
4. H2O

Substance Abuse:

1. Pittsburgh Mercy

2. White Deer Run
3. Pyramid
4. Gateway
5. Coveforge
6. Greenbriar

Employment:

1. Office of Vocational Rehabilitation
2. East End Cooperative Ministries Work Readiness Program
3. Pennsylvania Career Link
4. Pittsburgh Trade Institute

Additional Collaborative Services:

1. Project HELP
2. Allegheny County Health Department – HIV/TB testing
3. FOCUS
4. Pittsburgh Mercy Benefit Coordination
5. SOAR
6. Pittsburgh Aids Taskforce
7. Pittsburgh Dream Center

Service Provision-

Operation Safety Net case managers assess clients and refer them to services based off of their individual needs. Our case managers maintain professional relationships with the free behavioral, physical and dental health clinics in the area and refer clients to these organizations as needed and as appointments become available. PATH clients are also linked with mental health services in the form of outpatient mental health services and coordination. In the event it is determined that a higher level of care is needed for a client referrals are made to service coordination, IDDT or services identified by a mental health professional.

There are a plethora of services available to clients with dual diagnosis, mental health and drug and alcohol issues. The services that are frequently utilized for these clients include Pittsburgh Mercy Outpatient and Pittsburgh Mercy Family Health Center. There is a consulting psychiatrist on staff that often provides a bridge for services during the time that it may take for a client to begin treatment. We utilize several outpatient drug and alcohol service programs such as Pyramid and Cove Forge as well as outpatient services through Pittsburgh Mercy.

It is critical that Pittsburgh Mercy's Operation Safety Net's staff is continuously trained in target areas such as mental health and drug and alcohol. Pittsburgh Mercy provides evidence-based practice trainings in these areas as well as others that are provided free of cost to our case

managers and other team members. Operation Safety Net staff are encouraged to take advantage of any and all training offered by our training and development department.
In order for OSN staff to stay up to date on data entry and the operating system our staff is able to attend HMIS training conducted by the Department of Human Services of Allegheny County on an as-needed basis. In the event that any new information is handed down by the Department of Human Services all staff are required to attend in order to ensure their skill set is up to date.

Gaps In Current Service System-
As a part of the PATH criteria clients have to be homeless and have a mental health diagnosis. The later of the two continues to be an issue due to being unable to obtain documentation. As a result there is a large amount of client self-reported disorders. Unfortunately, there is a large lapse in time from the point of referral for a psychiatric evaluation and for the client to actually begin their services.

Services Available To Clients With Serious Mental Illness And Substance Use Disorder-
The reality we face daily is that the majority of our PATH clientele have a dual diagnosis disorder. Knowing this is imperative as Operation Safety Net's goal is to ensure that each client has access to the individually necessary services. In order to better assist our clients Operation Safety Net has developed and works off of a tier system to ensure our clients are receiving the most necessary services in a timely manner. This system has been put in place to assist our case managers, outreach team, and service providers with the ability to identify the most vulnerable clients, provide services and ensure safety all while continuing to address the needs of the less severe clients.
After a client is assessed and it is determined that they are in need of a higher level of care, our case managers begin the process of referring these individuals to service coordination, IDDT, Enhanced Clinical Services, in-patient rehabilitation facilities, and in-patient mental health services as needed. We strive to provide the highest quality of care to our clients in the least restrictive environment for their individualized needs. Our case managers often serve as a bridge for the client while they are waiting for the referred service to begin. Our case managers ensure personal safety and stability until the referral process can be completed and services can be rendered to the client.
We ensure that our PATH-funded clients are linked with our in house benefits coordinator through Pittsburgh Mercy, physical and mental health treatment through Mercy Family Medical Center and housing with the assistance of the PATH case manager and other housing programs.

Training And Development-
Operation Safety Net believes that training and development is an integral part in being able to ensure our staff is able to best serve the needs of our clients. Pittsburgh Mercy offers our staff extensive training opportunities in various subject matters such as trauma, mental health, and drug and alcohol addiction.

Our staff is trained at the time of hire on entering information into the HMIS system, how to navigate the information, and how to accurately interpret the data. These trainings are offered several times throughout the course of the year but are also available on an as needed basis. Specialized trainings are held when new process for HMIS are rolled out, these trainings are mandatory for all staff members to ensure everyone is up to date with HMIS.

Data-

Operation Safety Net utilizes the Homeless Management Information System (HMIS) in order to collect, store, and generate data on the clients that are being served by various programs throughout our organization and county. However, Operation Safety Net does have an issue with running reports for all of the programs using the HMIS system, specifically the PATH program's reports are unable to be generated.

Operation Safety Net along with the other PATH providers for Allegheny County utilize Jim Turner of the Department of Human Services along with Andy Uphill the HMIS director for Allegheny County in order to ensure that each data target is met, information is entered correctly, and reports are accessible. Our staff is trained on HMIS at the time of hire, additional trainings are available on an as needed basis and specialized trainings are held when new processes are rolled out for the HMIS system to ensure all staff are up to date.

Our case managers, administrators and street outreach team utilize HMIS in order to capture the information of each client. Operation Safety Net also utilizes a separate electronic database that allows our staff to maintain a living document for each client served. These documents are constantly updated with information regarding medical conditions, treatments, services provided, location of the client, and any and all evaluations that the client may have undergone. The utilization of these two systems allows our staff to have a comprehensive overview of each of the clients that we serve and allows us to make informed decisions about the next steps in their services.

Alignment With PATH Goals-

In order to be eligible for PATH service clients must have a behavioral health diagnosis and meet the HUD definition of "literally homeless." Operation Safety Net's street outreach team makes contact with 150-200 unduplicated individuals a year. Of these 150-200 people, 90% of these clients can be classified as "literally homeless" while 10% of clients are at imminent risk of being homeless. The clients who our outreach team identifies as being at imminent risk of being homeless are serviced separately by generalized case management through Operation Safety Net as opposed to being serviced by the PATH case manager.

PATH funds are utilized solely to provide case management, outreach, drop in centers, housing, referrals to all necessary medical and behavioral health services, financial and rental assistance, client supplies and any other necessary as needed service for clients who meet the necessary criteria.

Alignment With State Mental Health Service Plan-

There is a state initiative to end homelessness, it is in this notion that we find our goals and motives for utilizing the PATH funding. Our PATH funds are used in order to assist those who have a behavioral health diagnosis in securing funds for a security deposit, rental assistance and eviction prevention. We strive to assist clients who are homeless in obtaining safe and stable housing by removing barriers, obtaining resources, and navigating the housing system. We also utilize PATH funding in order to keep those clients who have been housed, housed. We strive to ensure that our clients who are housed have the skills, resources and understanding to maintain their own safe and stable housing with minimal assistance from outside services.

Alignment With State Plan To End Homelessness-

Operation Safety Net utilizes the PATH funding to serve those clients who meet the definition of literally and chronically homeless. Our outreach teams and case managers are meeting these clients in the areas in which they call home. Our teams are sent out to homeless camps under bridges, in the woods, alleyways and other areas that are not meant for human habitation. It is within these visits that we engage with the clients, explain the services that are available to them and begin building a rapport with these individuals. Our outreach team begins building the rapport with these clients but assisting them with basic immediate needs such as socks, food, and water.

Case managers are able to continue to assess the ongoing needs for the clients identified by the outreach team and assist in finding housing, linking to other necessary social services, and providing the client with the necessary skills to maintain their own housing once housing is successfully obtained.

Other Designated Funds-

Operation Safety Net currently has an Enhanced Case Management that receives funds through the mental health block grant. In the event that a PATH funded clients meets the criteria for a higher level of care a referral is often made to this program to assist the client with meeting their individualized specific needs. These funds are not specifically for PATH funded clients however, if the service is deemed appropriate for the client it is a resource that the client can utilize.

SSI/SSDI Outreach, Access, Recovery (SOAR)-

Pittsburgh Mercy has a SOAR office in house. Being fortunate enough to have this service available to our clients in house has proven to be an integral part of streamlining this service for our clients. PATH staff and outreach members are trained on the criteria or a potential SOAR applicant. It is with this training that our staff is able to identify, refer and work with the in house SOAR representative to assist our clients. The number of PATH-funded consumers assisted in 2016-2017 was approximately one in every five or 17% of our total PATH SSO population. Most of the clients enrolled in PATH have some sort of established income upon their intake into the program. For those individuals who do not, our case managers and outreach staff work with

the client in order to obtain the necessary documentation in order to make a successful SOAR application.

Housing-

Operation Safety Net constantly strives to gain additional funding for housing for our clients. Along with additional funding our staff is always working toward building and maintaining relationships with landlord, housing resource providers and additional housing programs.

Operation Safety Net maintains approximately 150 beds and has an ESG rental assistance program. We strive to utilize all of the housing programs available in the county in order to place as many of our homeless clients into mainstream housing as soon as possible.

We are fortunate to have several programs in which our PATH clients meet the criteria for. Operation Safety Net utilizes permanent supportive housing programs, emergency shelters, and transitional housing to house PATH clients.

Operation Safety Net does have the ability to access all of the housing programs that are offered through Allegheny County however, all of the referrals for these programs are funneled through the Allegheny County Link and access to these programs are assessed by need by performing a SPDAT on each client. Our staff, upon engaging with a homeless client ensures that they are referred to the LINK and that the referral process is completed to ensure their status on the housing program lists.

Coordinated Entry-

Operation Safety Net does utilize coordinated entry; however it is not done for entry into the PATH program. Our coordinated entry is monitored through the Allegheny County Bureau of Homeless Services. PATH clients are typically encountered on the street by an outreach team member. It is through several contacts that a rapport is built and the client is prepared to meet with the case manager. Case managers are able to enroll clients into a program and complete an intake assessment on them. Each client is assessed for their housing needs and is placed on a waiting list for their specific level of housing. In the event that an emergency shelter is identified for a client the client previously would have to contact the Allegheny County Link daily to ensure that their spot on the wait list was secured, however, as of March 15, 2017 this process has changed and all shelters in Allegheny County are no on a first come first serve basis.

Justice Involved-

Operation Safety Net has access to a forensic liaison that assists our case managers and outreach team on coordinating services for clients who become incarcerated while they are enrolled as a PATH client. We also have a network of landlords that are familiar with the population of persons we serve and their subsequent histories.

Staff Information-

1. Operation Safety Net Staff is comprised of 17 Caucasian, 9 African American, 9 Male and 16 Female staff. Each year we participate in internships to countless nursing, pharmacy, social work and medical students from all different ethnicities, races and cultural backgrounds. We work tirelessly to promote inclusion and understanding to our staff regarding racial, religious and sexual orientation differences. We believe this makes us better able to serve our clients and support their individual needs.
2. Our staff and volunteers are experienced in working with the culturally diverse street population. Operation Safety Net staff has educational and training background in social services and are trained to deliver culturally competent services to this population group.
3. Pittsburgh Mercy mandates Cultural Competency as a part of our annually required trainings.

Client Information-

Operation Safety Net's target population continues to be the unsheltered street population, those who are literally and chronically homeless as well as those who are imminent risk of being homeless. Over the last 2 years our street population that was served was 56% African American, 44% Caucasians, <4% Hispanic, Asian or Pacific Islander; 15% female and 85% male.

The projected number of individuals that PATH (Street Outreach and Supportive Services) will serve in the fiscal year 2017-2018 is estimated at 200. This number is based off of the census of Allegheny County's targeted population. Of all clients that are actively served by Operation Safety Net approximately 75% of them are defined as literally and chronically homeless.

Consumer Involvement-

Operation Safety Net takes pride in the fact that we actively employ several of our former clients. We have watched these clients come full circle and believe they are some of the best vessels to engage with our client population as they have literally been in our client's shoes, experienced the struggles, and have utilized services to help overcome and succeed.

Operation Safety Net has also implemented a Homeless Advisory Board where the clients that we serve come together to voice their opinions on matters that may have led to their homelessness is a way to not only actively engage in their own services but help make a change for others. This client driven board currently meets quarterly.

We strive to have our clients families involved in the process as much as possible. It is important for Operation Safety Net to ensure that our clients have a solid and caring support system around them as it is imperative for them to be successful once the our staff is no longer involved.

Our case managers along with doing ongoing assessments of the client's needs, assist the clients with the development of a service plan with obtainable goals set by the client on it. These service plans serve as a blue print for the client's successful completion of the program with the end goal

of obtaining safe and stable housing of their own and alleviating the circumstances that lead to their homelessness in the first place.

Health Disparities Impact Statement-

Pittsburgh Mercy Operation Safety Net works with all clients and their children 18 and up. The unduplicated number of TAY individuals expected to be served using with PATH funds can be estimated at 25. The total dollar amount expected to be expended can vary on the individual's need, however we are expected to spend less than $100 per client. Our goal will be assist the youth in transitioning from the streets to housing and assist with helping them to build a foundation. A foundation needed to develop employment and educational skills, which is helpful in having them feel as if they have a purpose each day.

PATH case manager will continue to provide TAY with supportive housing services, life skills training, budgeting, linkage to transportation resources, referrals to education and job training and legal assistance. We will also work with Family Links and other community programs that assist with this population. PATH will fund case management needed for identifying, assessing, and connecting to services and our PATH street outreach worker will work at identifying this population on the street and encouraging them to get services. PATH case manager will access for need, make appropriate referrals, connect with additional services and track progress towards goals.

To help decrease the disparities amongst the TAY population the ways in which we communicate with this population may need to change. We plan to implement groups that cater to the indicated age group as to create a more inviting atmosphere. Groups that focus on resume, job training, and ways to keep this population from going back to the streets will be discussed. The goal is to while serving those 31- and up, we will explore non-traditional environments that have been proven to hopefully increase the TAY we serve here at Pittsburgh Mercy OSN.

Limited English Proficiency –
Pittsburgh Mercy Operation Safety Net does not discriminate or turn away clients due to language barrier and provides the necessary assistance to ensure that client needs are addressed. Currently in our PATH program we have yet to utilize language interpreter services. However, across many of Pittsburgh Mercy Operation Safety Net programs there has been an increase in those that speak little or no English. We utilize phone, and face-to-face interpreting (when available) to assist clients during the intake process or other important meetings where this is necessary.

Budget Narrative-
Operation Safety net will receive a total of $152,139.00 in PATH dollars from the Allegheny County Office of Behavioral Health. The Office of behavioral Health will coordinate and provide PATH oversight to this organization as a part of its contract with PA DPW/OMHSAS.

- $32,058.00 will fund a part-time physician experienced in mental and physical health. This individual will provide medical care to clients who are not connected to traditional medical care. This care will be given in the areas in which the clients reside, drop in centers and during scheduled home visits at the request of the case managers.
- $22,949.53 will fund a supervisor responsible for ensuring that all HMIS PATH street outreach information is being entered in a timely and accurate manner. This supervisor is also responsible for ensuring that the case manager is meeting the needs of each of the identified clients.
- $41,682.42 (benefits inclusive) will fund one full time PATH outreach worker who is responsible for locating the most vulnerable and literally homeless population. Responsible for engaging and documenting all contacts into HMIS, the PATH outreach worker is the link between the client and the case manager.
- $20,896.00 (benefits inclusive) will fund a full-time case manager/outreach worker who will provide assistance to clients by engaging on the streets and in walk-in centers. The PATH case manager will be responsible for assessing and fulfilling client's immediate needs, connecting clients with necessary services and securing income and housing.
- $29, 936 will serve as the county-wife contingency fund. This fund provides stipends of up to $200 to homeless clients in need of assistance with security deposits, rental assistance or eviction prevention.
- $4,615.96 will fund consumer supplies for birth certificates, id vouchers, bus tickets, water and socks.

Pittsburgh Mercy
Operation Safety Net
Allegheny County
PATH Program
FY 2017-2018 Budget

PATH	**80-204-13**					
Proposed Budget 17-18		***July-June***				
With 41% Benefits		Salary	Per Hour	Hours		Benefits
31,869.55	Marlena A	22,602.52	15.46	1462	75%	9,267.03
35,765.13	Chris R	25,365.34	20.02	1267	65%	10,399.79
30,618.43	Leane M	21,715.20	18.56	1170	60%	8,903.23
7,908.97	Dan K	5,609.20	15.16	370	19%	2,299.77
5,628.78	Tia C	3,992.04	25.59	156	8%	1,636.74
2,400.00	Staff Travel					
5,000.00	Consumer supplies					
3,000.00	Staff supplies					
122,190.86						
29,936.00	Contingency Loans - JT					
(152,139.00)	Budget					
(12.14)						

4. Allgheny County - Three Rivers Youth, Inc.

26th & Smallman Streets

Pittsburgh, PA 15222

Contact: Mary Jo McCarrick

Contact Phone #: 4123380883

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-045

State Provider ID: 4245

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Three Rivers Youth will receive a total of $41,317 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted:	25	Estimated Number of Persons to be Enrolled:	2
Estimated Number of Persons to be Contacted who are Literally Homeless:	15		
Number staff trained in SOAR in grant year ending in 2017:	0	Number of PATH-funded consumers assisted through SOAR:	0

Three Rivers Youth Intended Use Plan 2017-2018

Local Provider Description

Three Rivers Youth, Inc., (PA045 Allegheny: Three Rivers Youth) located at 6117 Broad Street, Pittsburgh, PA 15206, is a 501(c)(3) organization that has a history of providing services to young people and their families for over 137 years. Three Rivers Youth's mission is to preserve and unite families, combat homelessness, enhance educational opportunities and build life skills for at risk youth. Three Rivers Youth provides a comprehensive, integrated spectrum of educational, community based, behavioral health, drug & alcohol, and in-home programs for youth and families whose lives have been damaged by abuse, neglect, abandonment, school failure, early pregnancy and drug and alcohol abuse.

Three Rivers Youth offers various effective comprehensive programming to address the needs and challenges of high risk youth and their families. These services include cutting-edge programming and the establishment of linkages with other agencies and organizations to meet the needs of today's complex youth. Three Rivers Youth serves Allegheny and Washington counties. Three Rivers Youth anticipates receiving an allocation of $48,195 to provide case management and outreach to homeless youth with mental health issues.

As an organization, Three Rivers Youth strives to be the leader in innovative and model programs, providing excellent, comprehensive service for at-risk youth and their families.

Collaboration with HUD Continuum of Care Program

Three Rivers Youth was a member of both the Continuum of Care and Health Services Delivery for the Homeless committees. The Continuum of Care is a group of homeless providers that receive Bureau of Hunger and Housing Services. The Health Services Delivery for the Homeless is a sub-committee of the Continuum of Care that specifically focuses on the unique health care needs of targeted homeless population. As needed, the Hub staff would utilize information and resources from this forum to access additional services and housing opportunities. Consumers in need of Mental Health assessments and treatment were seen through a contracted psychiatrist. Three Rivers Youth offers Drug and Alcohol treatment as well as Behavioral Health, therefore, individuals can receive these services without accessing another facility. Three Rivers Youth participates in the Children's Homeless Education Fund and attends these meetings quarterly. Three Rivers Youth will continue to collaborate with agencies involved in the Children's Homeless Education Fund. During the next fiscal year, Three Rivers Youth will become active with the Continuum of Care and Health Services Delivery for the homeless communities. Three Rivers Youth hopes to join the Homeless Action and PA Network "HAPPN." a network of homeless providers, volunteers, consumers and advocates working together to prevent and end homelessness in Pennsylvania. They take action to advance proven, local, cost-effective solutions to ensure that every Pennsylvanian has a home within their reach.

HAPPN is part of the Housing Alliance of Pennsylvania, a statewide coalition that provides leadership and a common voice for policies, practices and resources to ensure that all Pennsylvanians, especially those with low incomes, have access to safe, decent, accessible and affordable homes. Upon connecting with them, we will determine how often they meet and will attend their meetings, trainings, etc.

Collaboration with Local Community Organizations

The Path Case Manager/Outreach Coordinator coordinates the delivery of services for clients with local community organizations. The Case Manager/Outreach Coordinator works closely with Allegheny County Behavioral Health staff in coordinating community-based mental health services and connecting clients as needed. When applicable, the Case Manager/Outreach Coordinator will participate in interagency meetings with clients to ensure effective coordination and referral process with other service providers including Supportive Housing Programs. The Case Manager/Outreach Coordinator reaches out to other teams in order to the meet the specific needs of clients served. For example, when someone is in need of housing, the Case Manager/Outreach Coordinator will reach out to agencies that offer housing to homeless individuals through Allegheny Link, Allegheny County's centralized housing service.

Three Rivers Youth – The Hub offers psychiatric services- mental health assessments and ongoing medication monitoring as needed. The Mental Health Assessments and treatment can occur at Three Rivers Youth or via referral to an outside agency if the individual prefers. The Hub maintains collaborative partnerships with other community mental health providers such as Mercy Behavioral Health and WPIC. Also, as needed, Three Rivers Youth offers Drug and Alcohol assessments and treatment, however, if the individual prefers, an outside referral is made for this treatment as well.

The Path Case Manager/Outreach Coordinator maintains regular contact with emergency shelter providers, including the Cold Weather Shelter during winter months, to ensure that clients requiring emergency shelter are able to receive services when necessary. The targeted goal and an outcome measure for a Path client is permanent housing. The clients and Case Manager/Outreach Coordinator work collaboratively to identify interventions and action plans to reach their goal of housing. The Case Manager/Outreach Coordinator also seeks appropriate linkages and supports to assist clients with their needs and/or barriers. The Case Manager/Outreach Coordinator connects clients to employment opportunities, job fairs and workshops that will address employment issues such as criminal records. The Case Manager/Outreach Coordinator has had some recent connection with First Step in Mckeesport, PA and has been able to directly contact employers for assistance for these individuals.

Service Provision

How will services be provided

The goals of the program are to respond to the immediate needs of homeless youth and young adults up to the age of 30 and to provide them with access to

needed services while reducing the possibility of further physical or sexual exploitation. The services include provision of emergency food, clothing, assessment, counseling, crisis intervention, and case management services that includes referrals to in-house and community linkages. In terms of the latter, Three Rivers Youth has the capability of providing behavioral health and drug and alcohol services without referring outside of the agency. With these services Three Rivers Youth is able to provide a greater scope of services to clients served and can be delivered in-house without referrals to other providers. Three Rivers Youth offers an array of integral services for young adults through the Agency's Runaway and Homeless Youth Programs. A component of the Agency's Runaway and Homeless Youth Program is the Hub Drop in Center located in East Liberty, PA. The Hub is an outreach and drop-in center for runaway and homeless youth and adults up to the age of 30 that is a safe haven with the opportunity to receive employment services including job assistance, mental health services, and advocacy for mental health consumers.

Three Rivers Youth through the use of PATH funding provides the following services: case management of individuals receiving mental health care, development of Individual Service Plans, medication tracking, appropriate referrals to community resources, liaison with outside community agencies, group counseling with clients around mental health issues, street outreach to locate clients who have not returned to the drop-in center for follow-up care, and data collection and monthly reporting to the PATH Manager. There has been a push to service transition age youth in our local school districts including charter schools, especially at this time when many area seniors are preparing for graduation. Three Rivers Youth continues to target students in local school districts through mailings that list services available to students who are 18 years of age and older. Additional outreach services have been provided on local bike trails on the Monongahela and Allegheny Rivers where homeless individuals in the targeted age range have been observed.

Specific Examples of how the agency maximizes the use of PATH funds by leveraging use of other available funds for PATH services

Three Rivers Youth will partner with the in-home Family Partnership Program and Drug & Alcohol program to provide services to individuals who are facing homelessness. However, to date, we have not serviced any of these individuals.

Gaps in service

A gap continues to exist in services for transitional living arrangements for males ages 18-21 in Allegheny County. There are several short term (60 day) emergency shelters, however, long term transitional housing is needed, but extremely limited.

Services to dual diagnosed clients

Clients with a verified mental health diagnosis that admit to substance abuse, are assessed by the Case Manager and receive a referral to Three Rivers Youth Drug and Alcohol program or their choice of community drug and alcohol facility. The client also has the ability to have a Psychiatric Evaluation performed by a contracted psychiatrist and if medication is needed, the psychiatrist will provide a prescription and monitor the medication. Referrals for community based mental health services or in-house behavioral health services further client's ability to access quality services including counseling and support.

Trainings

The PATH Clinical Manager and or Director attends the annual PATH technical assistance and training conference to obtain current information, work within the HMIS system, and collaborate with other providers across the state. The PATH clinical manager attended an outreach meeting held on 11/17/16, training on client information and payment systems (CIPS) and continued trainings regarding the use of the HMIS system. Three Rivers Youth has a comprehensive staff development training program available for all staff. Three Rivers Youth staff are required to complete various trainings each fiscal year in order to enhance their knowledge and provide them with the tools to meet the needs of their clients. The Hub staff attends the yearly Homeless Children's Education Fund Summit and Quarterly Homeless Education Network Meetings. Also, staff receives ongoing supervision and outside trainings that address such issues as outreach techniques, education, job-readiness, housing, collaboration, homeless trends, community trends, drug and alcohol issues, mental health issues, racial and ethnic, diversity, gender diversity, and positive youth development. The Manager of Clinical Services oversees and manages the HMIS system at Three Rivers Youth. All current clients and new enrolled clients are entered into the HMIS system upon enrollment in PATH services consistent with best practices.

Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

42 CFR Part 2 regulations implement federal law that protects the confidentiality of substance misuse records of any person who has applied for or been given a diagnosis of, or treatment for, alcohol or drug misuse at a federally assisted program. The drug and alcohol program at Three Rivers Youth is not a federally assisted program although it adheres to the strictest levels of confidentiality consistent with federal, state, and county standards to ensure those regulations would be followed.

Data

Three Rivers Youth's Clinical Manager and or Director attends the annual PATH training and technical assistance training and has received ongoing training in HMIS. Three

Rivers Youth has implemented the use of the HMIS system for data services. Although both the Director and Clinical Manager have received training in HMIS, the Clinical Manager collects and inputs the data into HMIS. Three Rivers Youth will continue to enter all client information into the HMIS system as required. Any new staff hired in this program will be required to participate in the HMIS training. Three Rivers Youth is willing to participate in any ongoing trainings/refreshers related to HMIS to enhance programming, data collection and outcomes.

Alignment with PATH goals

The goal of the PATH Program is to reduce or eliminate homelessness for individuals with serious mental illness or co-occurring substance use or disorders who are at imminent risk of becoming homeless. Three Rivers Youth targets street outreach and case management as priority services by reaching out to the most vulnerable adolescents and adults who are chronically homeless. Three Rivers Youth provides information to these individuals about where they access services such as education, resume writing, employment assistance, etc. and also provides them with care packages to include but not limited to: hygiene products and non-perishable food.

Alignment with State Mental Health Services Plan

Three Rivers Youth supports the efforts of the state to reduce/eliminate chronic homelessness in the state. We are utilizing PATH funds to assist with the outreach so that we can support the population of homelessness who range in ages 17-30. Three Rivers Youth provides Mental Health Assessments and treatment and Drug & Alcohol assessments and treatment. Additionally, if requested, outside referrals for Mental Health and Drug & Alcohol treatment are made. We also assist in education endeavors and provide linkages to shelters.

Three Rivers Youth recognizes the importance of disaster preparedness and emergency planning in the realm of continuity of care planning. Therefore, we are prepared to respond to localized and general emergencies. Three Rivers Youth has a policy that details all staff responsibilities for various emergency scenarios. Therefore, it is critical that all of the clients in the PATH program take into consideration the different responses necessary to address emergencies that may affect them. Three Rivers Youth will provide training to all of its Transitional Age Youth and other clients who are registered in our PATH Program.

Alignment with State Plan to End Homelessness

Three Rivers Youth utilizes the PATH funds to target street outreach and case management, thus maximizing serving the most vulnerable adults who are literally and chronically homeless. Three Rivers Youth reaches out to individuals who are on the street, under bridges, in shelters, etc. to provide them with information about the services that are offered. These services include assistance with education, assistance with obtaining social security cards and birth certificates, assistance with locating housing, assistance with obtaining employment, referrals to county Mental Health Centers,

provision of Mental Health Assessments and treatment, referrals to Three Rivers Youth Drug & Alcohol program for Assessments and treatment if necessary, and any additional assistance that can be offered.

Other Designated Funds

Three Rivers Youth does not receive any additional revenue funds designated specifically for serving people who are experiencing homelessness and serious mental illness.

Programmatic and Financial Oversight

The Manager of clinical services at Three Rivers Youth provides programmatic oversight for the HUD program. This oversight includes the supervision of the Outreach and case management for the program. James Turner, Mental Health Housing Specialist of Allegheny County Office of Behavioral Health has also provided programmatic support. During this fiscal year, James has supported Three Rivers Youth by visiting our office and auditing some of the files approximately six times. The Vice President of Finance provides financial oversight by keeping the Director and Manager appraised of available funds.

SSI/SSDI Outreach, Access, Recovery (SOAR)

During this fiscal year, Three Rivers Youth did not have the opportunity to have staff trained in SOAR. Three Rivers Youth continues to be receptive to having one staff member trained in this process, however, due to the inconsistency of staff and staff turnover, we have not been able to move forward in this process. It is our goal to have the new Case Manager/Outreach Worker trained in this process during the upcoming grant year. During this current year, Three Rives Youth did not have any consumers receive services from SOAR. The Three Rivers Youth Case Manager/Outreach Worker and Clinical Manager or Director will make referrals to the SOAR Project Coordinator and consult on any issues of concerns as needed. In addition, the Case Manager will assist with the SSI/SSDI application and follow-up process as needed.

Housing

The Hub Program continues to build partnerships with community based organizations to ensure suitable housing is made available for our consumers. Partnerships have been formed with the following agencies: Action Housing, Family Links and Community Human Services and Allegheny Link.

Coordinated Entry

Three Rivers Youth is not affiliated with any coordinated entry program. Although the information about our clients is entered into HMIS, other agencies are not able to see the information as it is considered a closed system in Allegheny County.

Justice Involved

Three Rivers Youth has met with the Allegheny County Jail to discuss the homeless population who are released from jail. We introduced our program to provide exposure about the services we offer to those who are released and in need of Mental Health/Drug & Alcohol Assessments and treatment, Housing assistance and Education assistance.

Staff Information

The current staffing pattern for the PATH program at Three Rivers Youth consists of a part-time Case Manager/outreach worker; a part-time Clinical Manager. The demographics include 2 male -1 Caucasian and 1 African American.

The Clinical Manager has a Master's degree with significant experience in working with dual diagnosed young adults and at risk youth/young adults from various backgrounds and sectors. He is also trained in HMIS. He is also trained in cultural competency. All staff who work in the PATH program must attend a mandatory Cultural Competency training that is offered at Three Rivers Youth and they must attend this training each year that they are employed. The training comprises of some of the health disparity standards as defined in the national Culturally and Linguistically Appropriate Services (CLAS) standards.

Client Information

The PATH Program targets 25 homeless clients between the ages of 17-30 each program year. The clients move between homeless status and at imminent risk of homelessness throughout their participation in the program. The Program anticipates that of the 25 clients, 40% will be at imminent risk of homelessness and 60% will be "literally" homeless at the time of entry into the program.

Consumer Involvement

The Homeless consumer and their families have the opportunity for involvement at the organizational level in the planning, implementation and evaluation of PATH-funded services. We have employed a PATH funded individual as an Outreach Coordinator during this fiscal year. Homeless consumers are also encouraged and welcomed to volunteer for any speaking engagements and outreach efforts as needed. Additionally, the consumer is involved in the evaluation of the program. PATH enrolled client's complete feedback surveys to obtain their overall satisfaction with services. The data compiled from surveys is used to refine and enhance services to clients.

Health Disparities Impact Statement

	Total	FY1	FY2	FY3	FY4
Direct Services: Number to be served	100	25	25	25	25
By Race/Ethnicity					
African American	70	10	20	20	20
American Indian/Alaska Native	<10	<2	<3	<2	<3
Asian	0	0	0	0	0
White	20	5	5	5	5
Hispanic or Latino	10	2	3	2	3
Native Hawaiian/Other Pacific Islander	n/a	n/a	n/a	n/a	n/a
Two or more Races	Unknown	Unknown	Unknown	Unknown	unknown
By Gender					
Female	25	5	10	5	5
Male	75	10	15	25	25
By Sexual Orientation/ Identity Status					
Lesbian	Unknown	Unknown	Unknown	Unknown	Unknown
Gay	Unknown	Unknown	Unknown	Unknown	Unknown

Bisexual	Unknown	Unknown	Unknown	Unknown	Unknown
Transgender	Unknown	Unknown	Unknown	Unknown	Unknown

Limited English Proficiency

To date, Three Rivers Youth has not encountered any individuals who have English as a second language or who have limited English proficiency. However, if we should encounter someone with limited English proficiency, we will either make referrals to the OCR, (Office for Civil Rights) or HHS (Health and Human Services). The University of Pittsburgh also has a program for International Studies that has established new translation and interpretation services/ The Clinical Manager and the Outreach Staff has downloaded free translation apps on their phone in the event that service is needed immediately. Lastly, through previous experience, the Clinical Manager has a contact at the Allegheny Intermediate Unit (AIU) who can assist if there is a need for any language translation other than Spanish.

ALLEGHENY COUNTY

THREE RIVERS YOUTH

PATH Program

FY 2017-2018 Budget

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
Position A	$31,200	..25	$10,792	$10.792
Position B	$46,000	..25	$12,000	$12,000

Fringe Benefits			$4,111	$4,111
Equipment			$2,000	$2,000
Supplies			$600	$600
Other- (occupancy)			$9,886	$9,886
Admin			$1,928	$1,928
Total			$41,317	$41,317

Budget Narrative:

Personnel:

$10,792 Cost associated with a portion of the salaries for the Hub Case Worker who will provide the direct service provision.

$12,000 Cost associated with a portion of the Manager who provide direct supervision to the CTI Worker.

Fringe Benefits:

$4,111 Cost associated with a portion of fringe benefits that include employer shared taxes, worker compensation insurance and unemployment insurance for each of the above funded position.

Supplies:

$600 Costs associated with office supplies needed to do day to day business.

Other:

$9,886 Purchased services would be the professional services the organization needs to maintain their computer technology associated with direct service provision, audits required by contract and regulations and other outsourced services to support the program under the agency. Communication cost would include telephone, cell telephone and internet access associated with direct service

provision. Utilities are costs that include electric, gas, oil, trash removal, water and sewer associated to the office space used by the direct service staff. Office rent is the rent allocated to the program for space utilized by the direct service staff. Insurances would include professional liability, umbrella, property insurance and other liability insurance.

Administrative costs

$1,928 would be allocated indirect costs associate with implementing the PATH funded program, max 4%. These include salaries and benefits of the indirect or support staff allocated in administrative support of the PATH funded program.

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5. Armstrong-Indiana County

124 Armsdale Road

Kittaning, PA 16201

Contact: Tammy Calderone

Contact Phone #: 7245483451

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-032

State Provider ID: 4232

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 45,258	$ 15,086	$ 60,344	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 45,258	$ 15,086	$ 60,344	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 45,258	$ 15,086	$ 60,344	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 45,258	$ 15,086	$ 60,344	

Source(s) of Match Dollars for State Funds:

Armstrong/Indiana Co's PATH project will receive a total of $60,344 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

Estimated Number of Persons to be Contacted who are Literally Homeless: 0

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Armstrong-Indiana Behavioral and Developmental Health Program
Summary Intended Use Plan
FY 2017-2018

Local Provider Description

The Armstrong-Indiana Behavioral and Developmental Health Program (the AIBDHP), located in rural West/Central Pennsylvania, is the county government agency created by the Mental Health Procedures Act of 1966 to serve as the administrative entity and oversight authority of all Behavioral/Mental Health, Intellectual Disabilities, and Early Intervention services in both Armstrong and Indiana Counties. Our office also serves as the primary oversight entity for the Health Choices Program. The AIBDHP has maintained administrative oversight for the PATH Program in each county since 2009. In fiscal year 2012-2013, the AIBDHP began partnering with the Armstrong County Community Action Agency (ACCAA) and the Indiana County Community Action Program (ICCAP) to administer the PATH Program. Contact information for the AIBDHP and each PATH provider agency is provided below.

AGENCY NAME	MAILING ADDRESS	PROVIDER PDX NAME
Armstrong-Indiana Behavioral and Developmental Health Program	124 Armsdale Road Suite 105 Kittanning, PA 16201	Armstrong-Indiana MH/MR Program
Armstrong County Community Action Program	705 Butler Road Kittanning, PA 16201	Armstrong County Community Action Agency
Indiana County Community Action Program	827 Water Street Indiana, PA 15701	Indiana County Community Action Program

For FY 2017-2018, we anticipate receiving a Federal allocation of $45,258 and a State match of $15,086. Our total allocation for the Armstrong-Indiana Behavioral and Developmental Health Program will be $60,344. The total allocation will be divided equally between each PATH provider, with the Armstrong County Community Action Agency receiving an allocation of $30,172 and the Indiana County Community Action Program receiving an allocation of $30,172. Along with this Intended Use Plan for the AIBDHP, plans will also be submitted from each respective Community Action Agency/Program.

Collaboration with HUD Continuum of Care Program

The Armstrong-Indiana Behavioral and Developmental Health Program continues its ongoing relationship with HUD's Continuum of Care Program through our receipt of PATH funding and use of the Homeless Management Information System (HMIS). Although the AIBDHP is not a member of the local PA-601 Western Continuum of Care, (CoC), our office does have a strong working relationship with the Armstrong County Community Action Agency and the Indiana County Community Action Program (our PATH Providers) who are very active with the PA-601

Western Pennsylvania Continuum of Care. These agencies serve as each respective county's Local Lead Agency, and house our Behavioral Health Housing Liaisons/PATH Case Managers. Even though the AIBDHP's interaction with Continuum of Care program is limited, staff from the AIBDHP serves on the Armstrong County Homeless Advisory Board and the Indiana County Housing Consortium that meet quarterly in each county. Updates from the Continuum of Care meetings are shared at each of these meetings. Staff from AIBDHP also attends meetings and quarterly conference call meetings with the Office of Mental Health and Substance Abuse Housing staff. State and federal updates are provided at those meetings as to what opportunities exist to provide housing options to those with serious and persistent mental illness.

Despite not working directly with the Western PA Continuum of Care, the AIBDHP does maintain a strong partnership with the local housing lead groups. Furthermore, the AIBDHP fully intents on becoming an active partner, as needed, in the Coordinated Entry process in each county. It is our duty to ensure that the seriously and persistently mentally ill have access to a variety of housing options while being able to access any mental health services that they may need to help them maintain that housing. While the implementation of the CE process is in it's infancy in our counties, we anticipate that our Behavioral Health Housing Liaisons will become very helpful partners in the process. Our liaisons possess strong skills not only in accessing housing and providing education and case management, but they are also skilled in assessing individuals to determine if behavioral health services would be helpful. Once a determination that behavioral health services would be helpful, the liaisons can work directly with the individuals to help them access those services. They can also provide follow up with the individual and service providers, to address any concerns that may arise. With everyone working together, we would anticipate that many barriers to housing that our behavioral health consumers and families experience will be lessened.

Collaboration with Local Community Organizations

As stated previously, the Armstrong-Indiana Behavioral and Developmental Health Program has a long standing history of developing and maintaining collaborative agreements with local community/human service agencies. These partnerships are crucial to providing the best overall care of those with mental health, intellectual disabilities and early life developmental challenges. It is through these partnerships that several creative and successful initiatives have been developed and implemented to help consumers overcome and eliminate barriers that many consumers experience involving service and housing access. The main housing partnerships that have been created and maintained in each county stem from collaboration with the Armstrong County Homeless Advisory Board and the Indiana County Housing Consortium. These groups bring all of the various housing providers (including each county's Housing Authority), service providers, and human service agency leads to the table. As each county presents its own unique challenges in developing and maintaining safe and affordable housing options, each agency partner also brings unique expertise and funding resources to make those options possible. The following are a few examples of activities and initiatives of each group:

- Establishment of a homeless program using PHARE dollars
- Fair Housing training
- Prepared Renter Program (PREP) training
- Local landlord workshops/education

- Development and implementation of behavioral health housing plans

Along with the above initiatives to better the housing services/options for individuals of our two counties, active work has been done to improve the overall coordination of and access to outreach services. A key in this effort has been the employment of our Behavioral Health Housing Liaisons/PATH Case Managers in each county. These staff, who also serve as our lead PATH personnel, have been working to improve the coordination efforts between housing services and drug and alcohol services, justice related services, and behavioral health services (including crisis and mobile medication services). Through their work with our consumers and families, they ensure that those in need of these services are linked to them. They have also worked to educate the outreach based service providers such as crisis, as to what emergency housing options are available. The consumers, in turn, have received comprehensive care and support while addressing their housing situations. These supports help to alleviate and eliminate some of the barriers to accessing housing. In addition to providing open and ongoing education and communication with service providers in the area, the housing liaisons/case managers also provide community education about our PATH program, as well as other housing programs available in the counties.

Another recent initiative that has improved the coordination with outreach teams is the newly formed Behavioral Health Senior Care Task Force, which was formed in early 2017. The task force, which serves both Armstrong and Indiana Counties, is focused on improving the collaboration and communication between senior care providers in our catchment area. The task force exemplifies the wiliness for many agencies to collaborate to drive improvements. The members of the task force are experts in providing service to the elderly population and represent agencies such as our Community Action Programs, our behavioral health crisis provider, Aging Services, mental health providers, the AIBDHP and the Armstrong-Indiana-Clarion Drug and Alcohol Commission to name a few. Current areas being addressed include improving relationships between local physicians and behavioral health care providers, providing outreach to individuals and their families as to how to access behavioral health services, providing possible education and training to personal care/nursing home care staff, developing a better system for crisis planning/management, and improving assessment tools aimed at identifying mental health symptoms in the elderly population. Providing education and training will most likely be the first things to be accomplished by the task force.

Along with local partnerships and attendance at local meetings, the AIBDHP also participates in various Health Choices committees with our managed care organization, Value Behavioral Health of Pennsylvania. By having representation on committees such as Physical Health/Behavioral Health, Member's Oversight, Clinical Advisory and Quality Management (to name a few), the AIBDHP is able to expand our system collaboration to include our MCO and surrounding counties. This has enabled our office to expand our service network which enables our consumers/families to access needed services that our counties do not offer.

To summarize the AIBDHP's strong collaboration with other local organizations, a partner agency list is provided below. The list represents Human Service Agencies, the Criminal Justice System, Employment Services, Behavioral and Physical Health Care, Drug and Alcohol

Services, Veteran Services and Client Benefit Services. Through this network, our PATH clients are able to access a wide array of services to address their needs.

- Department of Human Services and Office of Mental Health and Substance Abuse Services
- Aging Services
- Probation and Parole Services
- Public Defender Services
- The Armstrong/Indiana/Clarion Drug & Alcohol Commission
- Local D&A Providers
- Local Mental Health Providers
- Local Developmental Disability Providers
- Office of Vocation Rehabilitation
- Career Link
- Career Track
- The County Assistance Offices
- Veteran Services
- County Planning and Development Programs
- Social Security Administration
- The Armstrong and Indiana County Jails
- Indiana Regional Medical Center
- Armstrong County Memorial Hospital
- Indiana Regional Medical Center
- Physical Health Care Providers
- Open Door Crisis Program

Service Provision

Overview of the Armstrong-Indiana PATH Program

Providing comprehensive services to behavioral health consumers who are eligible to receive PATH services is a top priority of the Armstrong-Indiana Behavioral and Developmental Health Program. In order to improve the overall coordination of services, the AIBDHP made the decision in 2012 to partner with each county's community action program/agency to transfer the day to day activities of the PATH program. Both the Armstrong County Community Action Agency and the Indiana County Community Action Program are the main/lead housing agencies in each of our counties. The bulk of most housing services are available through these agencies which made them the perfect choice to operate our PATH Program. To further support our consumers and our PATH Program, the decision was made to hire a Behavioral Health Housing Liaison (BHHL)/PATH Case Manager for each county, to be an employee of each CAP. The positions are funded using Health Choices Reinvestment dollars in conjunction with PATH dollars. These staff members are responsible for the overall coordination of our PATH program. By providing outreach/engagement, education and case management, they are responsible for ensuring that the goals of the PATH Program are met on a daily basis. Coordinating the most comprehensive care is achieved through developing plans with consumers and their families to

locate safe, affordable and permanent housing and accessing all services that will help PATH clients maintain their stable housing. While the AIBDHP no longer is responsible for the daily PATH activities, our office continues to maintain total oversight for the program and will work closely with the housing liaisons/case managers to monitor the program and provide supportive assistance as needed.

Armstrong-Indiana PATH Outreach/Engagement, Education and Case Management Services

Street Outreach and Education

Outreach to individuals who are homeless or are at risk of becoming homeless presents in Armstrong and Indiana Counties is challenging. The rural nature and terrain of our counties, makes it extremely difficult to locate those most vulnerable and most in need. Further complicating efforts is the fact that often times clients "couch surf" from one situation to the next and are not present in common areas where outreach takes place. In order to help overcome these obstacles, the outreach effort of the Behavioral Health Housing Liaisons/PATH Case Managers will continue to be a priority this year. In 2016, PATH began concentrating outreach efforts in areas where those with mental health challenges are known to receive services or spend their leisure time. Increased efforts included partnering with the local drop-in centers so that the BHHL/PATH Case Managers are on the monthly schedules at the center. This allows consumers to know when staff will be there if they would like to meet with them in person. The liaisons also visit the peer support providers in each county on a regular basis to meet with consumers there. Outreach to the Blended Case Management departments in each county has also increased and has improved the overall coordination between BHHL/PATH Case Managers and other case managers. The housing liaisons/case managers will also continue to conduct homeless street outreach in areas such as local parks, Community Support Program meetings, Suicide Task Force meetings, stores, churches, homeless shelters, domestic violence shelters, veteran service locations, hospitals and other community settings. Outreach in our counties also continues through contacts/referrals from other social service agencies, corrections, and law enforcement. Another function carried out by PATH Case Managers/housing liaisons is to provide education to consumers, families, and local human service agencies. Education not only includes informing individuals about what the PATH Program can offer, but also what behavioral health services are available in the counties to assist in eliminating barriers clients face in finding and maintaining housing. In addition to providing PATH clients with service education, they also conduct educational presentations in the community. Each housing liaison/case manager presents about PATH and community services at the local Drop-in Centers, CSP meetings, agency/systemic trainings, NAMI meetings and other community events in hopes of reaching as many vulnerable individuals as possible. To further education about PATH services, in 2016, our Armstrong County Behavioral Health Housing Liaison developed a short training specific to the PATH Program. Overall the training has been well received by local agency staff, according to training evaluations each individual is asked to complete after receiving the training.

Case Management Services:

The third key part of our PATH program is the case management services offered by the Behavioral Health Housing Liaisons/PATH Case Managers. These individuals are responsible for linking clients and their families to all needed community based services that will be the most helpful in overcoming barriers that lead to locating and maintaining safe and affordable housing. One of the first steps the housing liaisons do (after finding emergency housing if needed) is to help clients obtain their vital documents such as photo identification, birth certificates and social security cards. They help consumers obtain medical assistance coverage and social security benefits as well. Case management activities then can move on to linking consumers with housing options and support services by completing referrals to those services. Service coordination is also a key. The BHHL/PATH Case Managers are responsible for ensuring that all service providers are working together to accomplish consumer identified goals. In addition, case management also entails helping PATH clients develop and maintain a monthly budget, mediate consumer/landlord issues, and ensuring that all housing found can be sustained by the consumer. Finally, built into our PATH program is an allowance for limited transportation for clients to get to necessary appointments to help them gain and maintain stability in the community.

Maximizing PATH funds

Throughout the years of overseeing the Armstrong-Indiana PATH Program, the AIBDHP has drawn from Health Choices reinvestment funds and Community Hospital Integration Project Program (CHIPP) funds to help support PATH clients. Reinvestment money has been used to fund a contingency fund to help PATH clients with expenses such as security deposit assistance, rental assistance, back utility payments and one-time rental assistance to avoid eviction. CHIPP funds can be used to provider Intensive Supportive Housing services to those individuals who are at risk of becoming homeless because of failure to comply with the mental health treatment they are prescribed. Finally, when an individual does not quality for Medical Assistance coverage, the AIBDHP can use mental health base funding to pay for limited services for PATH clients. It should be noted that most behavioral health treatment and recovery services are paid through Pennsylvania's Health Choices Managed Care Program. It should be noted that most of those who are eligible for PATH in both Armstrong and Indiana Counties usually already have obtain Social Security and Medicaid benefits prior to becoming involved in the PATH Program.

Service System Gaps

Despite the number of behavioral health and housing services available to residents of Armstrong and Indiana Counties, gaps do remain. For example, currently no emergency shelter is available for Armstrong County residents. In both counties, there is a significant gap in services for individuals or heads of households who have credit issues and need budget counseling who may have a criminal history, drug & alcohol issues, or past landlord concerns. An individual with a mental health diagnosis could have had one or more of these concerns at any time on their road to recovery, making their housing needs more precarious if a provider or landlord does not understand and support recovery. Further complicating things is PATH clients live on a very limited income and cannot afford rentals available in the community. For example,

Section 8 programs will often experience lengthy waiting lists which also limit safe and affordable permanent housing options for PATH clients. One other easy to identify gap in services in both counties is regarding the Transition Age Youth (TAY) population. Currently, there is no specific treatment or housing system available to individuals 18-30 years of age. Many times, the TAY population does not "fit" into traditional adult services but are too old to access children/adolescent services. Our PATH program will continue to focus a great deal of effort on trying to work with these individuals to help eliminate barriers they currently experience. Finally, as Armstrong and Indiana are primarily rural communities and both counties have limited resources, transportation continues to be a major barrier and concern. The lack of reliable transportation makes the road to recovery for an individual who is homeless even more challenging. Limited public transportation makes accessing community mental health services a challenge for many consumers as well.

Available Services in Armstrong and Indiana Counties

Despite the gaps in the local service systems identified above, a wide array of behavioral health services does exist in each county. Below is a table showing the core services in both the mental health and substance use/abuse programs in our two counties that are available to individuals 18 years of age or older. These services include inpatient and outpatient treatment opportunities, recovery oriented services, residential services, and crisis services.

ARMSTRONG/INDIANA BEHAVIORAL HEALTH SERVICES

Adult Mental Health Services	Child/Adolescent Mental Health Services	Drug and Alcohol Services
• Screening and Assessment Services • Psychiatric Evaluation • Medication Management • Partial Hospitalization • Inpatient Hospitalization • Intensive Outpatient Services • Mobile Medication Program • Clozapine Support Services • Blended/Targeted Case Management • Psychiatric	• Screening and Assessment Services • Psychiatric Evaluation • Medication Management • Partial Hospitalization • Inpatient Hospitalization • Intensive Outpatient Services • Individual/Family/Group Therapy • Blended/Targeted Case Management • Behavioral Health Rehabilitation Services • Strength Based Treatment • Family Based Services • Multi-Systemic Therapy • Community Residential Rehabilitation Services • Residential Treatment	• Screening/Assessment Services • Inpatient Treatment • Intensive Outpatient Treatment • Outpatient Treatment • Support Groups • Recovery Support Services • Prevention and Education • Tobacco Prevention/Cessation Services • Drug Court (Indiana) • Drug-Free Communities Coalition • Student Assistance Program • Halfway Houses

Rehabilitation (mobile and site based) • Peer Support Services • Vocational Services • Drop-in Centers • Consumer/Family Satisfaction Team • Supported Living • Community Residential Rehabilitation Services (Maximum and Minimum) • Intensive Permanent Supportive Housing Program (CHIPPS) • Long Term Structured Residence • Emergency PHARE housing • 24/7 Walk-in Crisis Services • 24/7 Mobile Crisis Services • 24/7 Telephone Crisis Services • Medical Assistance Transportation Program	Facilities • Early Intervention Services • Student Assistance Program • Consumer/Family Satisfaction Team Program • 24/7 Walk-in Crisis Services • 24/7 Mobile Crisis Services • 24/7 Telephone Crisis Services • Medical Assistance Transportation Program <u>Early Intervention Services</u> • Community Development • Social or emotional Development Screening • Self-Help or Adaptive Development Screening • Cognitive Development Screening	• Oxford House Program • Consumer/Family Satisfaction Team Program • 24/7 Walk-in Crisis Services • 24/7 Mobile Crisis Services • 24/7 Telephone Crisis Service • Medical Assistance Transportation Program

PATH Staff Training

Both the Armstrong County Community Action Agency and the Indiana County Community Action Program are encouraged to use a portion of their PATH funding to provide each housing liaison with training opportunities. In addition to using PATH funds to help pay for staff training, our PATH Providers are encouraged to take advantage of the many free trainings offered by local human service agencies within our counties. These trainings usually cover a wide range of topics such as mental health, substance abuse, co-occurring disorders, intellectual

disabilities, Fair Housing and the Prepared Renters Program (PREP), Mental Health First Aid, and cultural diversity training. In addition to training, the Armstrong –Indiana PATH provider staff are required to participate in local housing consortium meetings, regional meetings and state-wide housing conferences to remain current on all housing initiatives. The BHHL/PATH Case Managers are also required to attend all relevant HMIS trainings and keep updated on any changes to the system. Finally, to help build a quality program, PATH staff is also encouraged to attend any training offered by the AIBDHP which directly relates to evidence based practices and outcomes.

42 CFR Part 2 Regulations

The Armstrong-Indiana Behavioral and Developmental Health Program is the county level administrative entity for mental health, developmental disabilities and early intervention services in our two counties. We are not required to follow the 42 CFR Part 2 Regulations.

Behavioral Health/Criminal Justice Population

The Armstrong-Indiana Behavioral and Developmental Health Program is committed to supporting justice related services and re-entry initiatives in our communities. In 2016, the Behavioral Health Justice Related Services (JRS) Re-Entry Program became operational in Armstrong County. The program provides specialized outpatient treatment, case management and peer support services to behavioral health consumers involved in the criminal justice system. Expected outcomes of the program include the following:

- Increased involvement and tenure in treatment services and supports
- Decrease in homelessness
- Decrease in length of involvement with the criminal justice system
- Decrease in the amount of criminal recidivism
- Increase in the utilization of natural and community supports
- Increased coordination between the mental health and criminal justice systems

To tie the PATH Program into our JRS Program our Armstrong County Behavioral Health Housing Liaison/PATH Case Manager began working with JRS staff to assist those individuals presenting with housing issues who are enrolled in the JRS Program. The liaison meets with individuals and staff to conduct an assessment of the housing situation. Staff will assist in locating affordable rentals and/or will assist in helping clients apply for benefits and housing resources within the county, including our PATH Program. Once housing is located, the liaison can then offer case management services to the individuals to help them maintain their housing by providing ongoing support in such areas as finances and finding employment. And finally, as our Armstrong housing liaison, who is trained in SOAR, will be able to assist clients in applying or reapplying for Social Security benefits.

In addition to the Armstrong County JRS Program, our behavioral health housing liaisons/PATH case managers have been developing working relationships with the local jails, state correctional facilities, and local probation and parole offices. The liaisons have successfully case managed a number of individuals who have found permanent housing and have accepted behavioral

health/human service assistance. One of the greatest challenges presented to our PATH program staff our those individuals who are released from jail/prison with nowhere to live and who must report to the Pennsylvania State Police and register as a Megan's Law Sexual Offender. While behavioral health support services are available to assist these individuals, often times housing is not. These individuals not only face limited housing choices available in the county, but face landlords who are not willing to rent to this population even if support services are involved. It is hoped that by educating landlords and prospective landlords about services to help sex offenders, more housing resources/options can be secured. It is estimated that approximately an average of 40% of all individuals served by the Armstrong-Indiana PATH Program have some type of criminal history.

While expanding Justice Related Services to Indiana County is a future goal, the Armstrong-Indiana Behavioral and Developmental Health Program has taken the initiative to begin creating housing initiatives to better serve those with behavioral health challenges and criminal histories. In early 2017, the AIBDHP began collaborating with a subcommittee of the Indiana Housing Consortium to help identify housing needs for the behavioral health population in Indiana County. Through numerous discussions, one glaring need was identified; the need for safe and affordable housing for behavioral health consumers who have been involved in the Criminal Justice System. Part of the issue facing consumers with these challenges is that many local landlords remain reluctant to rent to this population. The AIBDHP wrote a new long range housing Health Choices Reinvestment plan (the Indiana County Housing Opportunities Plan) aimed at working directly with landlords. The plan would provide the opportunity to provide education to landlords to help reduce the stigma associated with the population we serve. Another part of the plan would be to create needed transitional and permanent supportive housing options. The plan also aims at also offering more support to individuals in their homes by increasing the capacity of our Supportive Living Program. Although individuals will not be required to accept this service, it is hopeful that if they do, this will provide landlords with more reassurance that agency staff is available and willing to help improve communication between the landlords and their tenants. Still in the approval phase, it is hoped that the implementation of the plan can begin in the fall of 2017.

Data

The Armstrong-Indiana PATH Program has fully implemented the transition to Pennsylvania's Homeless Management Information System (HMIS). The Armstrong-Indiana Behavioral and Developmental Health Program, as well as our contracted PATH Providers, are all registered and trained the system, and work collaboratively in data entry, completing required reports, and analyzing data collected for the two counties. The BHHL/PATH Case Managers are also in contact with the state PATH contact located at the Department of Human Services, as well as staff from Pennsylvania's Department of Community and Economic Development (DCED) to resolve any data entry and reporting issues. All BHHL/PATH Case Managers will be required to attend any new training offered on the HMIS. Any new BHHL/PATH Case Managers hired will receive HMIS training from supervisory staff and by accessing the online training materials available on DCED's HMIS website.

Alignment with PATH Goals

The AIBDHP strives to fulfill the goals of the PATH Program by continuing the focus on street outreach, engagement and education, and case management services. A detailed description of our program's components has been provided in the Service Provision section of this plan; however, more detailed information about our case management emphasis will be provided here. The AI PATH Program has a very heavy emphasis on providing timely and quality case management services. Case management can only occur once the client has engaged with the Behavioral Health Housing Liaison/PATH Case Managers. The housing liaisons/case managers are expected to provide quick assistance to those who are homeless or are at imminent risk of becoming so. The first step is to secure the individual and their family in safe emergency housing and to make sure than have adequate heat and food items to sustain them. Once the situation is no longer an emergency situation, a service plan is developed with each PATH client to find and sustain permanent housing and needed human services, including behavioral health services. The plans are detailed and outline action steps that need to occur to obtain housing. Case management then continues until housing and overall client stability is achieved. The liaisons/case managers provide ongoing case management services at that point by ensuring that clients engage in the services they identified as beneficial, by assisting in budgeting issues, by helping to work out disputes/concerns with landlords, and by providing encouragement to all PATH clients. Case management activities continue until it is mutually agreed upon by the housing liaison and the PATH client that services are no longer necessary. Services are slowly tapered as the individual regains their stability. This allows the liaisons/case managers to serve as many individuals as possible at any given time. It is clear that without the essential components (outreach, education and case management) provided in a quality fashion, the PATH Program would not be successful.

Alignment with State Comprehensive Mental Health Services Plan

The Office of Mental Health and Substance Abuse Services (OMHSAS) has required county behavioral health offices to complete County Mental Health Plans to demonstrate work being done to serve the mentally ill and to identify where system improvements need to be made. Over the last ten years, the state has shifted its focus from more of a treatment/medical model of care to the recovery and resiliency model. As part of this planning process, OMHSAS asked counties to develop a County Housing Plan in 2007. Counties are also required to submit a plan to the Commonwealth under the human services block grant initiative Although Armstrong and Indiana Counties have not yet opted to become block grant counties, the AIBDHP has begun working on aligning our services and programs with the block grant model. Housing is a vital part of that plan. It is through the guidance provided in these planning processes that the AIBDHP has begun to shift the focus of housing services to become more focused on recovery and resiliency. This has meant shifting core mental health residential services away from more traditional congregated living situations (i.e., group home living) to more of a Permanent Supportive Housing (PSH) approach. The PSH approach allows individuals to live in independent living situations that must be safe and affordable to them. To further the recovery philosophy, consumers are not required to accept services to live independently. The services they do choose to accept and participate in must be flexible and very individualized. The PATH Program has become an integral part in helping those transitioning out of integrated settings into their own independent living arrangements by providing support throughout the entire process.

In addition to shifting the focus of services to the recovery model, counties were also asked to create housing specialist positions and to develop a contingency fund to assist consumers find and maintain permanent housing options. To embrace this initiative, the AIBDHP created a Behavioral Health Housing Liaison position in each county and a Contingency/Stabilization Fund. The housing liaisons, who also serve as the county PATH Case Managers, work with individuals with behavioral health challenges who are homeless or at risk of becoming homeless with locating housing. The liaisons/case managers are able to use PATH and Contingency Funds as needed to secure and maintain housing. The liaisons are also the first staff to assist consumers and their families who are in crisis/emergency housing situations. Their thorough understanding of housing resources in the county, along with the strong relationships they have built with various local human service agencies, allow speedy assistance to those most in need. If a consumer or family member presents as being in a mental health crisis, the BHHL/PATH Case Managers will immediately contact the local MH/D&A Crisis Intervention service to seek further assistance. The BHHL/PATH Case Managers have a good working relationship with the Crisis provider. They will work with crisis staff to fully support the individual needing assistance.

Once an individual is enrolled in the PATH Program, the liaisons can provide education and case management services to clients to ensure they have everything they need to sustain their new housing. The PATH housing plans that the liaisons/case managers develop with the clients are very consumer driven/consumer focused. The plans are also flexible and are changed to meet the ever changing needs of the clients. Part of these plans is helping clients obtain necessary benefits. Further supporting the Commonwealth's Mental Health Services Plan, all PATH provider staff is SOAR trained and ready to assist individuals through the process of acquiring Social Security benefits.

Alignment with State Plan to End Homelessness

The PATH Program of Armstrong and Indiana Counties is designed to be an organized coordinated effort to eliminate homelessness of the most vulnerable individuals in our two counties. In alignment with Pennsylvania's Joint State Government Commission's Report "Homelessness in Pennsylvania: Causes, Impacts, and Solutions – A Task Force and Advisory Committee Report" which was released on April 5, 2016, the Armstrong-Indiana PATH Program provides street outreach, engagement, education and case management services to those who have a behavioral health disorder and are homeless or at risk of becoming so. As recommended by the advisory committee and task force, our PATH Program focuses on homelessness prevention by conducting street outreach in the hopes of identifying individuals in need before they become homeless. Educational sessions are also held in various meetings/outings/activities so that more individuals become aware of the PATH services available in Armstrong and Indiana County. These outreach and educational activities undertaken by PATH Case Managers/housing liaisons are successful due in large part to the collaborative efforts with various human services agency staff in each county. These staff members understand that being stable in housing is crucial to an individual achieving overall wellness and stability. The agency staff work closely together and are more than willing to assist the others and exchange information and knowledge to best serve the homeless and those at risk of becoming homeless. The collaboration and communication, however, does not end at this level.

Once individuals begin working with the housing liaisons/case managers, detailed and organized plans are developed to quickly address the homelessness (or risk of becoming) and to access needed services to address barriers to individuals maintaining their housing. Information contained in housing plans is shared with staff from other agencies who are working with the individual as well. All staff work together to help the individual turn their plan into success. PATH Case Managers/housing liaisons do this by providing a quality case management service which not only assists individuals in location and maintaining housing, but also by linking them to behavioral health and community support services available that will best help them achieve their recovery. The case management function of our PATH Case Managers/housing liaisons also allows for the opportunity to discuss funding and ways that funds/resources can be best leveraged to maximize PATH and contingency fund dollars. This leverage can benefit the other agencies by allowing them to stretch their funding as well. In addition to these attributes, ongoing collaboration also allows for good data collection and sharing. Collaboration helps ensure that the data our PATH providers enter into Pennsylvania Homeless Management Information System (HMIS) is as complete and accurate as is possible. The HMIS not only provides a central system of data collection on the homeless population, it also allows for the data to be shared in various reports across many programs.

With all of these components in place, the Armstrong-Indiana PATH program is able to reach and provide service to a number of subpopulations that exist within our two counties. The PATH Case Managers/housing liaisons (along with other staff from within their agencies) work with individuals who are involved in mental health/substance abuse system and in the Domestic Relations/Violence system, the Criminal Justice System, Veterans, and the Transition Age Population. It is because of our long standing history of having a multi-systemic collaborative process in each county, that individuals are identified and served as quickly as possible while maximizing all available resources to meet their needs. With all of these features in place, the Armstrong-Indiana Behavioral and Developmental Health Program and our PATH providers have begun laying the groundwork for continual quality improvement of PATH services resulting in best practice initiatives, interventions and outcomes as recommended by the Pennsylvania Joint State Government Commission.

Finally, the AIBDHP and our PATH Providers are all participating/partnering agencies with each county's respective Emergency Management System/Agency. It is through these partnerships that our PATH Program is also integrated into disaster planning, preparedness and response in each of our counties. The Behavioral Health Housing Liaisons/PATH Case Managers are expected to fully cooperate and assist residents in the event of a disaster. All PATH staff is encouraged to participate in local trainings and testing of the county's emergency response system. The BHHL/PATH Case Managers is also asked to attend Mental Health First Aid training, and participate in local planning meetings to learn about new services that are developed and to educate others about the Armstrong-Indiana County PATH Program.

Other Designated Funds

The Armstrong-Indiana Behavioral and Developmental Health Program has three funding resources available to assist individuals who are PATH eligible. The only one of the resources

specifically earmarked for the PATH Program is money provided through our PATH grant. This funding is considered to be the last resort, being used when no other funding resource can be located to assist someone who is homeless or at risk of becoming homeless. Another revenue source used to assist PATH clients is Health Choices Reinvestment funding. This funding is available through our housing reinvestment plan and is managed through our Contingency/Stabilization Fund. While it is not specifically earmarked per se to those in the PATH program, the fund is used to help fill in the gaps for people enrolled in PATH when needed. In order to access this fund, the individual has to be enrolled in Medical Assistance. The final source of other funding that can be used to help support the PATH program is our MH Base Funding. This funding, when needed, is primarily used to help support the overall cost of staffing for our PATH Program. It may also be used to fund services that are not covered by Health Choices or for individuals who do not qualify for Health Choices but whom are PATH eligible. Again, this money is not specifically earmarked for PATH services.

Program and Financial Oversight

AIBDHP Oversight

The Armstrong-Indiana Behavioral and Developmental Health Program staff maintains both programmatic and fiscal oversight over the Armstrong and Indiana County PATH Program. The AIBDHP fiscal staff work closely with PATH providers (both fiscal and program staff) on creating budgets for the program and fiscal report submissions. Regular program invoicing is also monitored on regular basis by fiscal staff. For programmatic oversight, the AIBDHP's Quality Management and Housing Coordinator monitors the overall functioning of the PATH program. The coordinator is responsible for maintaining regular contact with the Behavioral Health Housing Liaisons/PATH Case Mangers, conducting annual on-site case file reviews, and monitoring all reporting done through PDX and HMIS to ensure completeness and timeliness. The QM/Housing Coordinator also communicates frequently with the AIBDHP's fiscal staff concerning billing to ensure that funds are being allocated appropriately.

State Oversight

State oversight of the Armstrong and Indiana County PATH Program is provided by the Pennsylvania State Path Contact. The state PATH contact holds quarterly conference for all PATH grantees and providers. The purpose of these calls is to provide updated information regarding reporting and regulatory requirements as well as fielding questions from the various programs across the Commonwealth. All PATH Case Managers from Armstrong and Indiana Counties is required to participate in these calls. In addition to providing quarterly contact, the State PATH Contact also conducts regular site visits of each PATH Program. The visits include record reviews, staff interviews, and consumer interviews which provides very helpful feedback regarding the operation of our program. Finally, PATH Case Managers members from Armstrong and Indiana Counties have an extremely good working relationship with the Pennsylvania State PATH Contact. Our Contact is always readily available to address questions and concerns and which helps us continually improve the operation of our PATH Program.

SSI/SSDI Outreach, Access Recovery (SOAR)

Both of our Behavioral Health Housing Liaisons, who also function as our main PATH personnel, are trained in SOAR. In addition to our BHHL/ PATH Case Managers being SOAR trained and able to assist consumers, both Community Action Programs now have additional staff that have completed the SOAR training as well. The Armstrong County Community Action Agency now has a total of 5 workers trained in SOAR. The Indiana County Community Action Program has a total of 3. Both of our full-time Behavioral Health Housing Liaisons/PATH Case Managers are the two lead staff available to assist with SSI/SSDI applications. To date there have been no individuals have been assisted through the SOAR program. Most individuals, when begin working with our PATH Provider agencies, already have all the benefits they are permitted to access, thus keeping our numbers of SOAR assisted individuals extremely low.

Housing

The AIBDHP believes strongly that those with mental illness and/or co-occurring issues deserve the right to live in quality, de-segregated housing. In 2015, the AIBDHP implemented a Mental Health Residential Reform Project. With the support of staff from the Western Region Program Office of the Office of Mental Health and Substance Abuse Services, the AIBDHP worked with our residential provider to implement lengths of stay criteria on all MH residential beds. This has allowed more consumers to access these services which often serve as stabilizing programs for those who have had high inpatient admission rates, are stepping down from long term care institutions, or who have been become homeless in the community and need additional mental health support. All consumers now complete a Residential Transition Plan (RTP) with their plan manager. The BHHL/PATH Case Managers is able to assist with this plan and will be called upon to work with consumers as the end of their stays near to find more permanent housing options. The RTPs will outline the steps and supports necessary to have consumers transition successfully into permanent supportive housing. Two goals were accomplished through this transformation. One goal was to reduce our reliance on segregated housing options for our consumers, shifting the focus to more integrated/independent housing. The second goal was to give consumers the resources and support so that they can live successfully in their own home.

In addition to transforming our own MH residential services, the AIBDHP took steps to collaborate with local housing experts to assess the overall housing need for consumers and their families. The AIBDHP has partnered with local agencies in Indiana County to develop a new long range housing Health Choices reinvestment plan called the Indiana County Housing Opportunities Plan. A subcommittee of the Indiana County Housing Consortium was created to explore unmet housing needs for those receiving behavioral health services in Indiana County. Representatives from the Indiana County Office of Planning and Development, the Indiana County Community Action Program, the Indiana County Housing Authority, local MH residential provider I&A Residential Services, the Family Promise Program of Indiana County, assisted in the development of the plan, which consists of the following components:

- Bridge Subsidies
- Master Leasing
- Housing Support/Housing Liaisons
- Contingency Funds

The goal of the plan is to bring funding resources together to expand current housing and create new housing opportunities for all behavioral health consumers, including those who are homeless or at risk of becoming homeless. Part of the plan would be to create needed transitional and permanent supportive housing options. For example, the need for extended bridge housing was identified as a need. Extending the amount of time and individual and their family can stay in bridge housing will most likely increase their chances of obtaining permanent housing versus moving from one location to another until more permanent housing/Section 8 can be obtained. To follow then, more permanent supportive housing options like Master Leasing are need to be developed to allow consumers to achieve housing stability to help maintain recovery. The plan aims at also offering more support to individuals in their homes by increasing the capacity of our Supportive Living Program. Although individuals will not be required to accept this service, it is hopeful that if they do, this will provide landlords with more reassurance that agency staff is available and willing to help improve communication between the landlords and their tenants. The overall operation of the newly proposed housing programs will fall under the direction of the Indiana County Community Action Program. Supportive Living services will be provided by I&A Residential Services. The Behavioral Health Housing Liaisons (who are also our PATH Case Managers) will remain at each respective community action agency/programs. Finally, the plan also provides for support and education to local landlords/private housing providers in hopes that they will become more willing to rent to consumers who face a series of challenges such as substance abuse or criminal justice involvement. The implementation phase of the plan will begin once final approval is given. It is anticipated that work can begin in the fall of 2017. The target population will be Medical Assistance eligible adults (18 years and older) from Indiana County who are struggling with mental health and/or co-occurring (MH/D&A) disorders who are need of housing and support. The level of personal recovery may very per each individual, and they may also have a criminal background. It is anticipated that 10-20 individuals will be served annually.

It is because of these local partnerships that many housing options currently exist for our PATH clients. The chart provided below outlines all of the housing options currently available in both counties by provider agency:

HOUSING PROGRAM	PROVIDER AGENCY	AREA SERVED
Maximum Care Community Residential Rehabilitation Program/Enhanced Personal Care Home (24/7 supervision)	I&A Residential Services, Incorporated (funded by the AIBDHP)	Armstrong & Indiana Counties
Minimum Care Community Residential Rehabilitation Program (1 hour/day supervision)	I&A Residential Services, Incorporated (funded by the AIBDHP	Armstrong & Indiana Counties
Supported Living Program (1 hour/week supervision)	I&A Residential Services, Incorporated (funded by the	Armstrong & Indiana Counties

	AIBDHP	
Intensive Permanent Supportive Housing Program	Unity Home Partners	Armstrong & Indiana Counties
Domestic Violence Shelters	HAVIN Alice Paul House	Armstrong County Indiana County
Pathways Homeless Shelter	Indiana County Community Action Program	Indiana County
Family Promise of Indiana County	Family Promise of Indiana County	Indiana County
Section 8/ Low Income Rentals	Housing Authorities in each county	Armstrong & Indiana Counties
Meckling Shakely Veteran's Center	Veteran's Administration	Armstrong & surrounding Counties
Temporary Emergency Housing	Salvation Army, Red Cross, Local Ministries, PHARE/Armstrong County Community Action Agency	Armstrong & Indiana Counties
PA Homeless Assistance Program	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Bridge Housing	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Emergency Solutions Grant	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Homeowner's Emergency Mortgage Assistance Program	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Rental Properties	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Permanent Housing for the Disabled	Armstrong County Community Action & Indiana County Community Action	Armstrong & Indiana Counties
Armstrong/Fayette County Rapid Rehousing Program	Armstrong County Community Action	Armstrong County
Armstrong County Rapid Rehousing Program (formerly the Transitional Housing Program)	Armstrong County Community Action	Armstrong County
Armstrong County HUD-VASH Program	Butler County VA	Armstrong County

Indiana County HUD-VASH Program	Indiana County Housing Authority	Indiana County
Veterans Housing Project	NCCDC	Indiana County

Coordinated Entry

The Coordinated Entry initiative in both Armstrong and Indiana Counties is still in the final stages of implementation. Both Local Lead Agencies (Armstrong County Community Action Agency and the Indiana County Community Action Program) are working closely with the Western Pennsylvania Continuum of Care to ensure the implementation complies with program guidelines, including use of the Homeless Management Information System to track individuals through the Coordinated Entry Process. In serving the most vulnerable populations, the Armstrong-Indiana Behavioral and Developmental Health Program will continue its collaboration with each of our Local Lead Agencies to ensure that our consumers and families are receiving the assistance they need. The lead roles will be with the Local Lead Agencies with additional roles being spelled out as the process unfolds.

Justice Involved

The AIBDHP has supported offering training to local law enforcement and court-related personnel in hopes of providing more education and insight into mental illness and how it affects the day-to-day lives of our consumers and family members. Crisis Intervention Team training has been provided to law enforcement/court personnel in both of our counties. This includes CIT training for Veterans. Overall, the training has been very well received and attended. It is estimated that 25% of allow enforcement/court related personnel have received CIT training. Staff has represented a number of agencies such as the district magistrate offices, local police departments, local sheriff offices, local jails, district attorney offices, and the Pennsylvania State Police. Along with CIT Training, law enforcement/court-related personnel have also attended Mental Health First Aid Trainings (adult and youth) offered in our counties. Finally, the AIBDHP has also provided detailed training on the Mental Health Procedures Act to the law enforcement/court-related staff in each county. The AIBDHP will continue offering training and education in fiscal year 2017-2018.

Staff Information

The PATH Program staff employed by the Armstrong-Indiana Behavioral and Developmental Health Program is 100% Caucasian female. Both individuals hold Master Degrees and have been employees of the AIBDHP for nearly 20 years. With the experience has come the opportunity to work with a variety of individuals within our own counties and our surrounding counties. We have also had the opportunity to work with individuals who have moved into our area from other states and countries. Our office has worked with many persons who have varied cultural who have moved into the area to attend the Indiana University of Pennsylvania and other surrounding universities/colleges. The AIBDHP PATH staff is required to participate in all cultural diversity and cultural competency trainings as they are made available through various

resources. Currently, staff is participating in SAMHSA's Cultural Understanding and Culturally Responsible Services Spotlight Series that runs through August of 2017.

The demographics of the Armstrong County Community Action Agency (ACCAA)'s PATH Program staff are currently 100% Caucasian females. All staff members have received cultural competency and diversity training and have extensive experience working with all age groups and all nationalities of people. Staff members were specifically hired for PATH due to their knowledge and history assisting those with mental health challenges, and a working knowledge of the challenges presented to individuals in rural areas. All staff earned Bachelor degrees. In addition to these attributes, one staff member has a working proficiency of the Spanish language. Translation services, when needed, can be accessed through the Armstrong School District. All BHHL/PATH Case Managers are required to stay updated on cultural competency and diversity training.

The demographics of the Indiana County Community Action Program's (ICCAP) PATH Program staff are 100% Caucasian females. All staff members are trained in cultural competency and diversity. The Behavioral Health Housing Liaison/PATH Case Manager is supervised by the Community Services/Resource Development Director. This individual, along with our BHHL/PATH Case Manager, has an extensive work history and knowledge of the population of Indiana County, including having a vast history of assisting those with behavioral health and substance abuse issues. Indiana County consists primarily of English speaking citizens. Should the need arise for interpretative services; assistance will be obtained through other human services agencies, the Armstrong-Indiana Intermediate Unit and the Indiana University of Pennsylvania. All BHHL/PATH Case Managers will be required to stay updated on cultural competency and diversity training.

The Armstrong-Indiana Behavioral and Developmental Health Program, the Armstrong County Community Action Agency and the Indiana County Community Action Program do not discriminate on the basis of race, ethnicity, religious creed, disability, ancestry, national origin, sex, sexual orientation, age, political belief, familiar status, military services, genetic information or citizenship.

Client Information

Indiana and Armstrong Counties are lower income counties with more than a 95% Caucasian rate. Our counties are very rural and are located in Western Pennsylvania. Most of the population is English speaking. The population to be served by the PATH Program will be those who are 18 years of age or older, are homeless or at imminent risk of becoming homeless, suffer from a serious and persistent mental illness and live in Armstrong or Indiana counties. The overall projected number of those to be contacted is approximately 100-145 individuals, with at least 55 of these to be enrolled in PATH services. The total projected percentage of those who will be homeless or literally homeless in both counties is estimated to be 49%.

Consumer Involvement

The Armstrong-Indiana Behavioral and Developmental Health Program welcomes all stakeholder input in identifying service gaps and barriers to accessing both housing and treatment services. Stakeholder input is received through annual focus groups that are used to gather information for Pennsylvania Human Services Block Grant planning. Local Community Support Program meetings are also an avenue to facilitate discussions about systemic concerns and solutions. Multiple individual county meetings and ongoing discussions occur throughout the year to identify needs within the county, including having safe and affordable permanent housing options available to those with behavioral health challenges. The Armstrong/Indiana Consumer and Family Satisfaction Team also works closely with the AIBDHP to assist in assessing levels of need, including housing.

Another way that input is included in planning processes is by encouraging consumers and family members to sit on advisory and governing boards of various human service agencies. Consumer/family member representation is also part of the composition of the Advisory Board of the AIBDHP. The Board offers guidance into the overall mission of the AIBDHP. All behavioral health providers who contract with our office are strongly encouraged to have at least one consumer on their advisory or governing board and to afford them the same voice as all other board members.

Within our PATH Program itself, consumer input is gained throughout the process of assistance through program exit. PATH Case Managers members build plans *with* the clients not *for* the clients. PATH clients are invited and encouraged to provide input at state PATH site visit reviews conducted by Pennsylvania PATH personnel. At site visits, clients are able to explain how the program has helped them, what they feel has been helpful and what they feel has not. Finally, all PATH clients are encouraged to complete an exit survey to give input into what improvements they feel need to be made and what things they feel the program is doing successfully to help the homeless.

A new method of gathering consumer and family member feedback proposed in fiscal year 2017-2018 will be to work collaboratively with the Armstrong-Indiana Consumer/Family Satisfaction Team (C/FST). The AIBDHP Quality Management/Housing Coordinator and the Behavioral Health Housing Liaison/PATH Case Managers will work with the C/FST staff to create a questionnaire aimed at addressing consumer and family satisfaction with the PATH Program and the services provided by the housing liaisons. The feedback will be used for PATH Program improvements as well as part of the overall planning process of the AIBDHP.

Behavioral Health Disparities

The Armstrong-Indiana PATH Program will continue its focus on the Transition Age Youth (TAY) Population during fiscal year 2017-2018. The TAY population has long been identified as an underserved population in both of our counties in a number of different human service programs. It is also a population that is hard to identify early on to help prevent homelessness. For 2017-2018, we anticipate that on average between our two counties, the TAY population will

represent approximately 30% of the total individuals served in our PATH Program. The total number of unduplicated individuals expected to be 20. The amount of PATH funding expected to be used to help this population is $6,795 because of the high need for services this population often presents with. A list of all PATH funded services that will be offered to the PATH eligible TAY population is provided below:

- Outreach
- Education
- Case Management
- Peer Support
- Rental Assistance
- Security Deposit Assistance
- Transportation

When prioritizing services needs for the TAY population, the Armstrong-Indiana PATH grant then would propose to serve the following numbers of individuals with the TAY population:

Direct Services:	TOTAL	FY1	FY2	FY3	FY4
Number to be served	20	5	5	5	5
By Race/Ethnicity:					
African American	<10	<2	<3	<2	<3
American Indian/Alaska Native	<10	<2	<3	<2	<3
Asian	<10	<2	<3	<2	<3
White	<44	<11	<11	<11	<11
Hispanic or Latino	<10	<2	<3	<2	<3
Native Hawaiian/Other Pacific Islander	<10	<2	<3	<2	<3
Two or more races	<10	<2	<3	<2	<3
By Gender:					
Male	8	2	2	2	2
Female	12	3	3	3	3
By Sexual Orientation/Identity Status					
Lesbian	Unknown	Unknown	Unknown	Unknown	Unknown
Gay	Unknown	Unknown	Unknown	Unknown	Unknown
Bisexual	Unknown	Unknown	Unknown	Unknown	Unknown
Transgender	Unknown	Unknown	Unknown	Unknown	Unknown

PATH Quality Improvement Plan for the TAY Population

The TAY population presents unique challenges for PATH providers. Unlike older individuals, many TAY individuals do not know what services are available to help them, what benefits they should apply for and how to complete the application process, and how to build and preserve their credit/rental history, and what it means to be a good tenant. For these reasons, the Armstrong-Indiana PATH Program will continue implementation of the following plan to better serve the TAY population. Elements of this plan are provided below:

- PATH service education: The BHHL/PATH Case Managers will continue their educational and outreach efforts to inform people who fall in this population and those who support them, including area school district staff and behavioral health community based service staff. This will include collaboration with school teachers, guidance counselors and Student Assistance Program (SAP) workers. Staff from Blended Case Management, Family Based, Child/Adolescent Outpatient Services and Partial Hospitalization Programs will also be staff targeted to receive training about the PATH Program and what can be done to present homelessness.
- PATH technical supplies: Obtain better communication devices for the BHHL/ PATH Case Managers to increase the likelihood of continued communication with TAY clients served by PATH. This may possibly include purchasing laptops and smart phones to allow better service provision and texting capability between PATH staff and TAY clients.
- Personal documentation retrieval: The BHHL/PATH Case Managers will help the TAY population retrieve and access all pertinent personal documents such as birth certificates and photo identification that are needed to access services and housing.
- Applying for benefits: The BHHL/PATH Case Managers are to be SOAR trained so that they will be able to assist clients in applying for Social Security benefits. The BHHL/PATH Case Managers must also be knowledgeable about other resources and link clients to those.
- Support service education and referral: The BHHL/PATH Case Managers must work with community providers to locate and secure support services to help the TAY population find and maintain their housing. These services can include such things as behavioral health services, money management services, daily life skill education, and financial rental assistance.
- Early identification of PATH eligible TAY individuals: The AIBDHP Children/Adolescent Service System Program Coordinator (CASSP) works closely with AIBDHP's Quality Management and Housing Coordinator (QMHC) in identifying and assisting young adults who are transitioning from the children's behavioral health system into the adult system. Having the ability to identify housing issues/emergencies very early on will allow the AIBDHP staff to work with the Behavioral Health Housing Liaisons/PATH Case Managers located at each of our PATH providers in creating a plan to help reduce or eliminate the risk of these young adults from becoming homeless. Once a TAY individual is identified as eligible for PATH services, the housing liaisons/case managers will be invited to participate in Interagency Service Planning Team (ISPT) meetings to discuss housing options and begin working to secure housing. The AIBDHP's CASSP and Clinical Care Management Coordinator will work with our

behavioral health providers to secure all behavioral health services for the individuals as well.

The outcomes of the proposed plan will be to:

- Increase the early identification of possible homelessness among the TAY population in the behavioral health system
- Increase the overall communication and collaboration with area school districts, behavioral health providers, and CASSP staff to increase efforts to help TAY individuals who are at risk of becoming homeless.
- Decrease the overall amount of homelessness of the behavioral health TAY population.

Limited English Proficiency

For individuals with behavioral health challenges who have limited English proficiency, a number of options exist to assist them in accessing behavioral health services in Armstrong and Indiana Counties. The Armstrong-Indiana Behavioral and Developmental Health Program has working agreements with the Armstrong-Indiana Intermediate Unit 28 and the Indiana University of Pennsylvania to provide interpreter services for our consumers. These services are free to consumers, regardless of income or insurance. For those individuals with medical assistance coverage who are Health Choices eligible, the AIBDHP may also access interpreter services through the Southwest Behavioral Health Management agency and our managed care organization, Value Behavioral Health of Pennsylvania. In addition to these resources, each of our provider agencies should also have a policy and access to interpreter services for those who have a limited working knowledge of the English language. PATH staff is able to access these services through collaboration with our office on an as needed basis. It should be noted that the instances of individuals needing assistance in another language are very few, however, services are available in each county when and if the need arises.

Budget Narrative

The budget presented below is a comprehensive budget for the Armstrong-Indiana PATH Program. PATH funding for the 2017-2018 year will be divided entirely and equally between our two contracted PATH providers, Armstrong County Community Action Agency and Indiana County Community Action Program. Their projected expenses are summarized below. The AIBDHP will not use PATH funds in 2017-2018.

<u>Personnel:</u>

For the Armstrong County Community Action Agency, a total of $14,772.00 in PATH funds is devoted to PATH Program Staff salary. Of that total, $4027.00.00 helps support the Director's salary by 11%. The remaining dollars ($10,745.00) supports the Behavioral Health Housing Liaison/PATH Case Manager at 41%. Both PATH program staff members are located at the Armstrong County Community Action Agency. The director will be responsible to oversee the program and completing all reports. The Behavioral Health Housing Liaison/PATH Case

Manager will be responsible for the operation of the program through working with the PATH clients to secure housing and support services they need.

For the Indiana County Community Action Program, a total of $18,090.00 is being requested to provide for the full-time salary (68% of the time) of the Indiana County Behavioral Health Housing Liaison/PATH Case manager position. This position will be located at the Indiana County Community Action Program, Incorporated's office. The housing liaison work concentrates on increasing and creating housing resources for those who are homeless or at imminent risk of becoming homeless and have a behavioral health illness.

Fringe Benefits:

The funding amount of $8,610.00 is being requested to provide the following fringe benefits for Armstrong County PATH Program Staff which include the director and one full-time Behavioral Health Housing Liaison/PATH Case Manager position. Fringe benefits would have the following costs associated by category: Unemployment Compensation ($219.00), ACC/HLTH Insurance ($355.00), Workman's Compensation ($74.00), Social Security ($1,130.00), Pension plan ($1,182.00), Health Insurance ($5,382.00), Dental Insurance ($208.00), and Vision Insurance ($60.00).

For the Indiana County Community Action Program, the funding amount of $8,248.00 is being requested to provide for the full-time fringe benefits of ICCAP's Behavioral Health Housing Liaison/PATH Case Manager. Fringe benefits include the following costs: FICA ($1,405.55), Workers Compensation ($776.81), Pennsylvania Unemployment ($412.54), Health Insurance ($5568.51), Vision Insurance ($40.14) and Life Insurance ($48.45).

Travel:

At the Armstrong County Community Action Agency, PATH Program staff will travel to attend PATH Trainings on homeless/housing/mental health issues related to the PATH Program. Travel will be used to transport clients who have no other form of transportation to appointments, Social Security, Housing Authority, Department of Human Services, GED classes, job searches, emergency clothing supplies, medical appointments, probation/parole appointments, locating rentals, meetings with landlords, and any other agency appointments that the client accesses to help them remain stable. It is estimated that monthly travel mileage for these purposes will be 181 miles. A total amount of $1,169.00 is allotted for travel expenses on the Armstrong County Community Action Agency's PATH budget.

The Indiana County Community Action Program is requesting funding is requested to pay for meal and travel costs for the PATH Housing Liaison. Costs include monies for the Housing Liaison to be able to attend specific trainings on housing/homeless issues and mental health issues that are within the Mid-Atlantic region (sponsored by HUD, PHA, NAMI, etc.) to have the latest information that will assist in PATH program success. ICCAP is requesting $ 100 to pay for Housing Liaison's travel costs to attend specific trainings, Housing Task Force meetings, evaluation meetings and regional housing/homeless meetings, and $ 400 requested to pay for outreach travel to housing entities, drop-in-centers, community support programs, etc.

Equipment:

Neither PATH Provider is requesting PATH funding for equipment costs to operate the PATH Program.

Supplies:

Neither PATH Provider is requesting PATH funding for supply costs associated with the PATH Program.

Other:

The Armstrong County Community Action Agency intends to use PATH funding to provide one-time rental assistance to PATH clients. Assistance will be available up to $750.00 a month for a total amount of $5,621.00. Monthly rental amounts vary in the county area.

For the Indiana County Community Action Program, other costs associated with the PATH program are projected to include security deposits and one-time rental assistance payments for 8-12 individuals experiencing homelessness or at imminent risk at approximately $500.00 each, not to exceed $3,000.00; $2,000.00 would be a one-time assistance to help consumers maintain housing and $ 1,000 for security deposits. Total request for other expenses: $3,000.00.

In addition, although Indiana County Community Action Program (ICCAP) is continuing a PATH program to specifically expand existing housing and increase new housing programs for homeless/near homeless mentally ill individuals, currently ICCAP provides housing components providing over $225,740.00 in current supportive housing program costs and expenses for homeless and imminently homeless individuals which would include mental health individuals, of which, if openings existed, could possibly benefit PATH program eligible individuals in the future.

TOTAL PROGRAM BUDGET
Armstrong-Indiana PATH Program
FY 2016-2017

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
ACCAA PATH Director	$36,610.00	.11	$4,027.00	$4,027.00
ACCAA Behavioral Health Housing Liaison/PATH Case Manager	$26,208.00	.41 FTE	$10,745.00	$10,745.00
ICCAP Behavioral Health Housing Liaison/PATH Case Manager	$23,278.00	.68 FTE	$18,090.00	$18,090.00
Sub-total			**$32,862**	**$32,862**
Fringe Benefits				
ACCAA			$8,610.00	$8,610.00
ICCAP			$8,248.00	$8,248.00
Sub-total			**$16,858.00**	**$16,858.00**
Travel				
Local Travel for Outreach				
ACCAA			$1,169.00	$1,169.00
ICCAP			$400.00	$400.00
Travel to training and workshops				
ACCAA			0	0
ICCAP			$100.00	$100.00
Sub-total			**$1,669.00**	**$1,669.00**
Equipment				
ACCAA			0	0
ICCAP			0	0
Sub-total			**0**	**0**
Supplies				
ACCAA			0	0
ICCAP			$334.00	$334.00
Sub-total			**$334.00**	**$334.00**

Other				
Staff training				
ACCAA			0	0
ICCAP			0	0
One-time assistance to maintain housing				
ACCAA			$5,621.00	$5,621.00
ICCAP			$2,000.00	$2000.00
Security deposits				
ACCAA			0	0
ICCAP			$1,000.00	$1,000.00
Sub-total			**$8,621.00**	**$8,621.00**
TOTAL PATH Budget			$60,344	$60,344.00

6. Armstrong-Indiana County - Armstrong County Community Action Agency

705 Butler Road

Kittaning, PA 16201

Contact: Jeff Boarts

Contact Phone #: 7245483408

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-067

State Provider ID: 4267

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Armstrong Co Community Action Agency will receive a total of $30,172 in federal and state PATH funding.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 45

Estimated Number of Persons to be Enrolled: 30

Estimated Number of Persons to be Contacted who are Literally Homeless: 15

Number staff trained in SOAR in grant year ending in 2017: 5

Number of PATH-funded consumers assisted through SOAR: 2

Armstrong County Community Action Agency
Local Provider Intended Use Plan
FY 2017-2018

Local Provider Description

Since its inception in March of 1965, the Armstrong County Community Action Agency (ACCAA), a private non-profit corporation, has been a grassroots advocate for the disadvantaged and working poor. The agency was established under the Johnson Administration's "War on Poverty" to serve the entire County of Armstrong. ACCAA works with persons struggling with unemployment, high cost of utilities and rent, under-employment, lack of marketable skills, a declining economy, and overall lack of education in today's job market. The self-sufficiency movement has been an important component of our agency in aiding our consumers to set goals, achieving outcomes, and lessening their dependence upon others while relying on themselves. Therefore, the grassroots mission of our non-profit organization has remained the same in eliminating poverty in the lives of the disadvantaged in our county and lessening their dependence on governmental programs.

As the largest human service provider in the county, ACCAA has over forty programs that provide services to help persons become self-sufficient and productive members of society. These programs include: Employment Training, the Housing Assistance Program, three Continuum of Care Programs (Armstrong Rapid Re-housing Program, Permanent Supportive Housing, and the Armstrong/Fayette Rapid Re-housing Program), Rapid Re-housing Emergency Solutions Grant (ESG), Supportive Services for Veteran Families (SSVF), Utility Assistance Programs, Food Stamp Outreach, Medical Assistance Transportation, Head Start, Weatherization, Food Bank, Child Care Information Services, the Fatherhood Initiative program, the Child Mentoring Program, and Homeowners Emergency Mortgage Assistance Program. Our agency also provides the Summer Food Service Program and the Emergency Food and Shelter program.

ACCAA is dedicated to assisting as many clients as possible. Offering this comprehensive list of human service programs in our office complex provides ease and convenience to our consumers. This also allows for the direct one-on-one contact with all programs provided by ACCAA, ultimately lessening the consumer's travel to multiple locations for service. Due to the convenient one-stop-shop style, ACCAA has been successful in helping link consumers to the majority of the services that they immediately need. We believe that our service method is the most efficient and cost effective manner to assist consumers to increase their independence while lessening their dependence on governmental programs.

To continually assess the needs of our consumers, ACCAA has just completed compiling a Community Needs Assessment and Strategic plan ranging from 2015 to 2017. The Community Needs Assessment has been found to be an effective tool to clarify, identify, and rank the top needs according to the consumers. According to our data, our consumers identified that dealing with crime should be our county's top priority. Our consumers also identified access to transportation and access to affordable health care as the top two problems they face. ACCAA

will be beginning a new Community Needs Assessment the summer of 2017 that will span through 2020.

The ACCAA office complex is located at 705 Butler Road, Kittanning, PA 16201, the former site of the East Franklin Elementary School. The agency has approximately ninety employees, (approximately 70 full time and 20 part-time), dedicated to serving county residents. The management team of Armstrong County Community Action Agency, consisting of the Executive Director, the Deputy Director, the Director of Fiscal Operations, and Human Resource Director has approximately 100 years of combined experience in the agency and its services.

The Armstrong County Community Action Agency will be receiving PATH funds from the Armstrong Indiana Behavioral and Developmental Health Program (AIBDHP) to serve Armstrong County residents. The total amount of the state and federal allocation will be $30,172.

The Armstrong County Community Action Agency is currently a user in PDX (PATH Data Exchange) under the Provider Name: Armstrong County Community Action Agency.

Collaboration with HUD Continuum of Care (CoC) Program

The Armstrong County Community Action Agency has been involved in the HUD Continuum of Care Program (CoC) since FY 1999-2000. ACCAA applied for and was awarded a Supportive Housing Program (SHP) grant for Transitional Housing of the homeless. Since then, the agency has also received grant funding for an SHP Permanent Supportive Housing Program. In addition, the ACCAA has been a voting member of the Southwest Region Housing Advisory Board since its inception. That group has since merged with the Northwest Continuum of Care and is now known as the Western Continuum of Care. This Continuum of Care is part of the Pennsylvania Balance of State operated by the Pennsylvania Department of Community and Economic Development.

In addition to the Southwestern Pennsylvania Continuum of Care, many years ago the agency began holding quarterly housing/homelessness meetings on the local level. This group became known as the Armstrong County Homeless Advisory Board. The Armstrong County Homeless Advisory Board is our version of a Local Housing Options Team (LHOT) that is necessary to any Continuum of Care Program for the homeless. Like an LHOT, the Armstrong County Homeless Advisory Board's role is to assist in assessing needs and helping in problem resolution. This group has proven to be invaluable in interagency collaboration and information sharing. Our staff attends the monthly Western CoC meetings either in person or by a Web-Ex meeting to continue their training. ACCAA is committed to and remains actively involved in the Western Continuum of Care.

The Western Continuum of Care is currently piloting their centralized intake system to establish a coordinated entry model for all CoC programs to follow. This Coordinated Assessment System is the CoC's approach to organizing and providing services to individuals who are experiencing a housing crisis. This system will prioritize those who are in greater need for services such as those who are chronically homeless. Their ultimate goal is that persons

entering CoC programs while experiencing chronic homelessness will be given the information and support that they need to access, achieve, and maintain permanent housing.

Collaboration with Local Community Organizations

The Armstrong County Community Action Agency is committed to providing as many services as we can to consumers to help them achieve stability and independence. Due to this, the agency operates a number of programs on behalf of the County of Armstrong and the Armstrong County Board of Commissioners. Several examples of the programs we operate are: the Pennsylvania Homeless Assistance Program (HAP), three COC Programs for the homeless, the Homeowners Emergency Mortgage Assistance Program (HEMAP), the Dollar Energy fund, the Central Electric Family Fund, and we act as the clearinghouse for the Federal Emergency Management Agency's Emergency Food and Shelter Program. Known for our access to the community, Armstrong County Community Action Agency was also awarded the Supportive Services for Veteran Families (SSVF) Program a few years ago. SSVF expands our case management, employment assistance, and rapid re-housing services by specifically targeting veterans and their families. SSVF has also allowed us to expand our outreach abilities due to their heavy emphasis on outreaching to homeless veterans. The fact that all of these programs are under Armstrong County Community Action's umbrella greatly assists the referral process between the different programs. If a homeless or at-risk client needs further assistance and might have a behavioral health issue, the other programs refer the client to the Behavioral Health Housing Liaison/ PATH Case Manager to see if she might be of any assistance.

To increase collaboration and communication amongst the various other agencies in Armstrong County, ACCAA was instrumental establishing the Armstrong County Housing Advisory Board many years ago. To this day, ACCAA maintains their position as moderator of the Housing Advisory Board which meets quarterly. Many local community organizations and social service agencies continue to come together to communicate, collaborate, and solve homeless issues in Armstrong County. Due to the Housing Advisory Board, case managers from the various agencies have become familiar with each other and are better able to assist clients in need due to that association.

With many years of working together, the agencies have developed a positive professional rapport that has been advantageous to the successful delivery of human services in Armstrong County. With this rapport, case managers at different agencies are able to better assist their clients due to being able to refer them to other necessary mainstream resources. Some of the agencies represented on the advisory board are: the Armstrong-Indiana Behavioral and Developmental Health Program, Drug and Alcohol Commission, ARC Manor, United Way, Red Cross, County Board of Assistance, Area Agency on Aging, HAVIN, Head Start, Mechling-Shakely Veterans Center, Armstrong County Housing Authority, Habitat for Humanity, ARIN Intermediate Unit, Family Counseling, Myah's House of Hope, Catholic Charities, I & A Residential, Armstrong School District, Children, Youth and Family Services (CYFS), Career Track, the Aids Alliance, Laurel Legal Services, Armstrong County Memorial Hospital, the Armstrong County Jail, Adagio Health, Family Behavioral Resources, Family ACTS, Armstrong/Indiana Consumer & Family Behavioral Resources, Lutheran Senior Life,

Southwestern PA Legal Services, Career Link, the Butler VA, Salvation Army Kittanning, and Salvation Army Vandergrift.

The existence of the advisory board helped pave the way for advantageous interagency partnerships. Along with the PATH grant, the Armstrong County Community Action Agency operates a program called the Consumer Housing Contingency Fund for the Armstrong-Indiana Behavioral and Developmental Health Program (AIBDHP). AIBDHP is currently anticipating that their re-application for this funding through the Health choices reinvestment plan will be successful. Upon confirmation, AIBDHP will again award the operation of the program to ACCAA. The Consumer Housing Contingency Fund is not specifically ear-marked for PATH consumers; however, it can serve PATH consumers who are eligible. To be eligible, consumers must have active medical assistance and they must also be dealing with at least one behavioral challenge. For the purposes of this document, 'behavioral challenge' can be defined as a mental health disorder, substance abuse disorder, or any number of behavioral issues. The contingency fund is able to assist eligible individuals with essential household needs, security deposits, utility assistance, rental assistance for eviction notices, and other emergency needs as they arise. In the past partnership with AIBDHP, ACCAA has used the fund to assist various consumers with rental assistance, utility assistance, and paying for necessary housing items such as bedding and kitchen items.

Another example of successful interagency collaboration was when we partnered with our county's abused victim's shelter, HAVIN. HAVIN provided grant assistance to ACCAA in order to be awarded the Emergency Solutions Grant (ESG). The Emergency Solutions Grant was built to assist low income individuals who are at-risk of being homeless, or are literally homeless, find and maintain housing. ESG provides on-going case management, rental assistance, and can also assist with utility payments or deposits. With the existence of ESG we have increased supportive services available to homeless and at-risk individuals within Armstrong County.

In possibly the largest interagency effort, Armstrong County Community Action Agency was awarded the Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund (PHARE) Program on behalf of the County of Armstrong during the 2014-2015 fiscal year. Agencies involved, who would later become referring agencies, included Children, Youth and Family Services, Family Acts, Family Psychological, Holy Family, the Family Counseling Center of Armstrong County, and the Armstrong/Indiana/Clarion Drug and Alcohol Commission.

The goal of the PHARE Program is to temporarily house the literally homeless individuals in Armstrong County that were referred to the program for up to two months. The PHARE Program is split into two responsibilities. ACCAA's responsibility as the program holder is to supply the housing and necessary furnishing for individual who is homeless. ACCAA also supplies the apartments with emergency food products for the individual's use. ACCAA employs a PHARE Caseworker to conduct weekly inspections and to ready the housing for new tenants once the individuals leave the program. During the inspections, the PHARE Caseworker also meets with the clients inquires as to how the individuals' search for stable housing is going. The second responsibility belongs to the caseworker from the referring agency

that referred the individual. Once housed, that caseworker works with the individual to secure permanent housing and access mainstream resources. The ACCAA PHARE Caseworker stays in constant contact with the referring agency's case manager to ensure that the individual in the program is on track to achieve safe and stable housing upon completion from the program.

To further help with cooperation amongst the various provider agencies in the Armstrong County area, Armstrong County Community Action's Behavioral Health Housing Liaison/ PATH Case Manager began a new interagency outreach initiative to increase knowledge about the PATH and the Behavioral Health Housing Liaison Program and what services they are able to offer eligible clientele. In this interagency effort, the Behavioral Health Housing Liaison/ PATH Case Manager used contacts made during the Homeless Advisory Board as well as contacts made during regular street outreach to identify the major provider agencies in the area. After the agencies have been identified, the Behavioral Health Housing Liaison/ PATH Case Manager contacted the agencies and offered to do individualized trainings. To date, four agencies have participated in the PATH-sponsored training: Holy Family Social Services, HAVIN, Unity Opportunity Center, and Family Acts.

The Behavioral Health Housing Liaison/ PATH Case Manager passes around a sign-in survey at the beginning of the trainings to document the number of individuals trained. So far, thirty-nine (39) individuals have attended the training. Every individual attending the training receives a training packet which contains the following: brochures on the Behavioral Health Behavioral Health Housing Liaison Program and the PATH Outreach Program, a small resource booklet that the Behavioral Health Housing Liaison/ PATH Case Manager has prepared as a "starter" guide for resources in Armstrong County, a typed explanation about the Behavioral Health Housing Liaison position and how it works together with other housing programs, a copy of ACCAA's Housing Department's packet, a typed explanation about the PATH Outreach Program and how it can assist eligible persons, a document that explains the eligibility requirements for the PATH Outreach Program, a required documents list for the PATH Outreach Program, a blank referral in order to refer a client to either the Behavioral Health Housing Liaison or the PATH Outreach Program, and a short survey to evaluate the training. The returned surveys have been very positive, and the trainees have reported that they were glad to have been offered the training. The trainees have also reported that they believe that the services offered would be very helpful for their clients and will duly refer those clients. The Behavioral Health Housing Liaison/ PATH Case Manager hopes to host trainings to other agencies in the near future such as: Family Counseling, Family Psychological, and Children, Youth, and Family Services.

Service Provision

Armstrong County Community Action Agency will provide PATH funded housing services to eligible homeless Armstrong County residents who meet the "literally homeless or the at-risk of homelessness" definition as well as the Serious Mental Health (SMI) definition. PATH funding will be used for one-time rental assistance and security deposits as needed. Path funding will also be used to offer clients case management, referral services to mainstream resources (such as food bank, medical transportation, substance abuse treatment, mental health treatment, and clothing assistance), transportation of clients to necessary places to fulfill their

goals outlined in their intended use plans, continue street outreach efforts (to such places including parks, campsites, restaurants, laundromats, stores, and the hospital), and to continue to educate other agencies about PATH to increase agency collaboration. We plan to serve twelve (12) PATH consumers with rental assistance and/or security deposit assistance in this 2017-2018 PATH Program year. We also plan to serve at least thirty (30) enrolled PATH consumers with other PATH funded services to ultimately assist consumers locate, achieve, and maintain stable housing.

To ensure that we are supporting evidence-based practices to the full extent of our ability, our Behavioral Health Housing Liaison/ PATH Case Manager attends many webinars on the topics such as: PATH, HMIS, SOAR, homelessness, fair housing, Landlord engagement, and cultural sensitivity. To date in the 2016-2017 fiscal year the Behavioral Health Housing Liaison/ PATH Case Manager has attended over two dozen trainings in the form of calls, webinars, and in-person trainings. The Armstrong Community Action Agency's PATH Program is fully integrated into HMIS. The Behavioral Health Housing Liaison/ PATH Case Manager pays special attention to webinars hosted by HMIS as well as PATH HMIS Learning Communities to be positive that our PATH Program is operating with the most updated guidelines as possible. Our goal is to continue to maintain HMIS according to all guidelines and to enter data into the database in a timely and comprehensive manner to improve data quality.

In the course of collecting and inputting data into HMIS, we maintain high standards of client confidentiality. Although we do not have to follow standards such as 42 CFE Part 2, our Case Managers and staff members are well-informed about the significance of the confidentiality and security of client data. Every client signs a release of information that is then stored in their case management folders. Our Behavioral Health Housing Liaison/ PATH Case Manager also continually updates a PA-HMIS/ Client Track Reference binder that can answer many questions that might come up about HMIS. If any other questions should arise, we also have support through David Weathington, who is a PA-HMIS Administrator, and Brian Miller who also works closely with PA-HMIS and Client Track.

To further serve PATH consumers, we continuously collaborate with other housing resources in our agency that assist homeless or at-risk clients. Some examples of these programs are the Emergency Solutions Grant, Housing Assistance Program, Continuum of Care Programs, Supportive Services for Veteran Families, and the PHARE Program. The advantage of having multiple housing assistance programs under one agency umbrella is that a client will have more opportunities for assistance; therefore, the likelihood that they will receive assistance increases. The Behavioral Health Housing Liaison/ PATH Case Manager is able to refer PATH clients to the different housing programs ensuring that they get as much assistance as possible. The Behavioral Health Housing Liaison/ PATH Case Manager joins the client in the interviews with the other programs to assist the clients with document gathering and any other tasks that may be posed to them. Having the capability for inner agency referrals allows the PATH funding stream to be truly a last resort funding. For those otherwise eligible individuals who are not applicable for funding in the other housing programs, PATH funding will be able to assist. ACCAA is also anticipating the operation of the Contingency Program to further assist those PATH clients who are eligible.

Although gaps are present within most services systems, the rural nature of Armstrong County seems to compound these difficulties. Among the major gaps identified within Armstrong are: the lack of affordable housing, the lack of an emergency shelter, the lack of transportation resources, the continuation of the stigma surrounding mental health and addiction disorders, and having a criminal justice history. The lack of affordable housing is a daunting task for consumers who are on a fixed income. Most consumers are unable to find housing that they can afford to pay. Although Fair Market values have been set for properties within the county, landlords are very hesitant to offer their rentals at those values. This problem began a number of years ago when the Marcellus Shell Drillers and Gas Well Drilling companies began offering landlords premium rent prices in order to ensure that their workers have housing. In some instances, payment up to six months in advance is made by these companies for the available rentals. In comparison to the deep-pocketed companies, our consumers on fixed or low to moderate incomes do not appear as favorable. Currently, our Behavioral Health Housing Liaison/ PATH Case Manager assists clients to try to find more affordable rentals. Often, the Behavioral Health Housing Liaison/ PATH Case Manager will call the landlords to attempt to convince the landlords to lower the rental price to house consumers.

Most individuals who are unable to find housing in Armstrong County stay with family members or friends, creating more doubled-up (at-risk) situations than literally homeless situations. For those individuals who are unable to stay with anyone in the area, the lack of an emergency shelter poses an almost insurmountable difficulty. Armstrong County does have programs that offer some low-income housing assistance such as: the Housing Authority which has a number of low income rentals, The Section 8 program that offers vouchers, the Family Unification Program that offers vouchers, and a HUD-VASH program that also offers vouchers. The difficulty is that these programs are so inundated with applications that there are extreme waitlists for each program. For example, the local waitlist to get into an income-based rental in the Housing Authority is anywhere from one to three years. Also, the waitlist for our local Section 8 program is so long that they do not even open the program every year to accept new applications for the waitlist.

Armstrong County Community Action Agency's housing department is able to assist with a brief emergency shelter stay of five (5) to ten (10) days in a local motel. These emergency stays are, unfortunately, subject to motel room availability. Often we find that seasonal construction workers, that in the area for a project, often rent out a number of the motel rooms motel room availability to deplete. The PHARE Program that is held at ACCAA is able to help homeless individuals; however, due to funding cuts the PHARE Program only has the capability to hold four rentals at a time. ACCAA is working diligently to try to find alternate funding sources to try to expand and continue this indispensable program. As a last resort, individuals who are homeless are referred to out-of-county shelters such as the Just for Jesus Shelter in Brockway, PA and the Pathway homeless shelter of Blacklick, PA.

Due to the rural nature of Armstrong County, our public transportation system is minimal. Other than the Town and County Transit Authority, there is no other means of public transportation in the area. The services provided by the Town and Country Transit Authority are limited to only servicing the mid-county region of Armstrong County; therefore, only encompassing a six (6) to eight (8) mile radius of the towns of Kittanning and Ford City.

Although this selected area does include two of the more densely populated areas in Armstrong, there is a considerable amount of the population that is outside of the selected area.

Those individuals who receive medical assistance are able to receive transportation to medical appointments through ACCAA's Medical Assistance Transportation Program; however, there are still a number of places that those individuals may need to get to. To try to address this need, we have incorporated transportation services into our PATH Program. The main goal of PATH's transportation service is to assist the client to places necessary to completing goals set in place in their Individual Service Plan (ISP). The Behavioral Health Housing Liaison/ PATH Case Manager cannot serve as a taxi service for clients; however, she can transport clients to places such as the Housing Authority, The Human Services Department, the Social Security Office, the consumer's probation or parole meeting, local banks, St. Vincent de Paul for personal items, and to the Salvation Army.

In order to be eligible for PATH, individuals must have a Serious Mental Illness (SMI) diagnosis. Like many other areas in the United States, Armstrong County is experiencing an increasing number of PATH eligible individuals with a co-occurring addiction disorder. With every day passes it becomes more evident that Armstrong County has not been spared from the nationwide drug crisis. Armstrong County has programs in which someone can obtain Narcan to save those individuals who are experiencing an overdose as well as Drug and Alcohol programs to assist those who have an addiction. Unfortunately, negative sentiments which compound stigma are steadily increasing. Even with all of the education about mental health disorders that has been dispersed in the past several years, we still see a lot of stigma associated with individuals having a mental health diagnosis. One possible explanation that mental health stigma is so pervasive in our community is that we are a very rural county. It is crucial to mention that as negative and pervasive as the stigma associated with mental health is, the stigma associated with addiction, especially drug addiction, is far worse.

Our community has a few initiatives that are attempting to increase information and outreach to individuals who are suffering with mental health diagnoses and /or addiction as well as other members of the community. A Suicide Taskforce has newly begun in Armstrong County to try to increase education around mental health disorders such as depression and how to identify suicide risks. To address the drug crisis, there are a number of neighborhood groups have arisen to try to increase the education around drug usage and decrease the overall drug usage. These neighborhood groups also attend Armstrong County Drug Free Communities Coalition which is lead in part by the Armstrong/Indiana/Clarion Drug and Alcohol Administration. During these meetings the community and the agencies in the area are invited to create a dialogue about addiction and try to come up with solutions to problems posed to the community.

Laurel Legal and the Fair Housing Law Center are also increasing their presence in the community to assist consumers with mental health, addiction, and other disabilities by informing them about their rights as tenants. The Behavioral Health Housing Liaison/ PATH Case Manager attends the coalition meetings, the Suicide taskforce meetings, and has attended a Fair housing training provided by the Fair Housing Law Center. The Behavioral Health Housing Liaison/ PATH Case Manager is also assisting the Fair Housing Law Center by informing other provider

agencies that Fair Housing trainings can be hosted by the Fair Housing Law Center. In addition, the Behavioral Health Housing Liaison/ PATH Case Manager stays in contact with the Armstrong/Indiana/Clarion Drug and Alcohol commission to make sure that those at-risk or homeless consumers participating in Drug and Alcohol programs have access to PATH and Behavioral Health Housing Liaison services. If the Behavioral Health Housing Liaison/ PATH Case Manager comes into contact with an individual who has a mental health or a substance abuse disorder and isn't receiving treatment, the Behavioral Health Housing Liaison/ PATH Case Manager will refer the individual to those services.

Many people who fit the eligibility for PATH also experience difficulties trying to assimilate into the community due to their criminal justice history. Armstrong County has an active Justice Related Services (JRS) Program that helps many individuals re-entering society gain their footing and get into necessary services. The JRS case workers know about the PATH and Behavioral Health Housing Liaison Programs and do not hesitate to reach out if they need assistance with helping their individuals with housing issues. The Behavioral Health Housing Liaison/ PATH Case Manager is also in contact with the local jail's re-entry program enabling them to refer at-risk or homeless clients to the PATH or Behavioral Health Housing Liaison Programs. Whether individuals are referred from other service agencies or from the jail, each individual is interviewed to verifying their eligibility and assess the situation.

After that initial interview (and program entry if the individual wishes to become a PATH client) the Behavioral Health Housing Liaison/ PATH Case Manager completes an Individual Service Plan to address the client's goals. Among those goals, the Behavioral Health Housing Liaison/ PATH Case Manager assesses the need for housing, medical care, drug and alcohol addiction treatment, mental health treatment, and the need for other referrals (such as clothing assistance, food assistance, etc.). The Behavioral Health Housing Liaison/ PATH Case Manager will make sure that the individual has access to housing before other goals are addressed. Many landlords in Armstrong County refuse to rent to individuals who cannot pass a background check. The Behavioral Health Housing Liaison/ PATH Case Manager tries to act as an advocate for the client and will remind the landlords about fair housing practices if needed. The Behavioral Health Housing Liaison/ PATH Case Manager also acts as an advocate for employment and can assist the client with gaining positive interviewing skills.

Data

Armstrong County Community Action Agency's PATH Program Behavioral Health Housing Liaison staff fully utilizes the Homeless Management Information System (HMIS) to back-up, store, and organize consumer information. The Behavioral Health Housing Liaison/ PATH Case Manager is trained and authorized to use the PA HMIS/ Client Track system. She will continue to attend all webinars offered through PA HMIS/ Client Track as well as the PATH HMIS Learning communities to stay continuously updated on guidelines and regulations within the database and the program. All case management, contacts, and other allowable services are entered into the database in a timely and comprehensive manner to ensure data quality. The Behavioral Health Housing Liaison/ PATH Case Manager maintains a PA HMIS/ Client Track reference binder to refer to if any questions should arise. Should any questions arise that cannot be addressed by the reference binder, we are able to refer to David Weathington, who is a PA-

HMIS Administrator, and Brian Miller who also works closely with PA HMIS and Client Track. Any new staff members to the PATH Program will be trained to use the database using peer-to-peer support, the PA HMIS reference binder, and recordings of past PA HMIS/ Client Track webinars available on the PA HMIS/ Client Track system.

Alignment with PATH goals

The PATH Program at Armstrong County Community Action (ACCAA) continually endeavors to serve the most vulnerable adults combatting impediments associated with serious mental illness and homelessness by offering outreach, engagement, education, case management, and referral services. Our PATH Program has two outreach initiatives to increase access to PATH services. The first initiative is to go on street outreach to parks, local businesses, and other places not meant for human habitation in order to see if there are any individuals in need of services staying in those locations. Traditionally, this is how most PATH Programs find individuals for their program; however, the homeless individuals in Armstrong County are not often found in these places. Even when there doesn't seem to be any human habitation in the area, we distribute brochures and flyers to these locations. The second initiative is to go on service provider outreach in the form of educational trainings about the PATH Program. Educating other providers on what PATH can do to help individuals increases the likelihood that they will share information about PATH to their consumers who may not have considered housing assistance at our agency before.

Once an individual that needs services is found, the Behavioral Health Housing Liaison/ PATH Case Manager engages them to see if they would like to join the program to receive help. If the client agrees, the first focus becomes getting the client in some form of housing and see to other immediate needs such as food and clothing. The majority of the time the clients that we find are safely doubled up with friends and family but it is not a permanent living situation. After we verify that the client has shelter we start looking for other long-term options such as rentals and work on goals set up in their individual service plans (ISP). While working through the items set up on the consumer's ISP, we ensure that the consumer has an active role in the completion of every item. We believe that this active role goes a long way in improving the consumer's mental health and improving their sense of independence. Ultimately, upon completion of the goals set in the ISPs, clients should be able to graduate from the PATH Program with the assurance that they can independently maintain their stable housing.

Alignment with State Comprehensive Mental Health Services Plan

The PATH Program was created under the McKinney Act to assist individuals with serious mental health conditions, or co-occurring mental health and substance use disorders, experiencing homeless find and maintain stable housing. Our PATH Program mimics the state's plan to end homelessness for those with mental illness by assisting our clients to recover from homelessness and maintain resiliency by managing their mental health and co-occurring conditions. We outreach to these individuals through our community using street outreach and interagency outreach. Once individuals are identified and engaged in the PATH Program, we follow the Housing First initiative by making sure that the consumer is in a stable living environment before we refer them to mainstream resources (i.e. mental health or substance abuse

treatment). After housing has been found, we encourage stability and independence by involving them into treatment services (mental health and substance abuse treatment as needed) and offering case management which might include budgeting and life skills. With the collaboration of the Behavioral Health Behavioral Health Behavioral Health Housing Liaison/PATH Case Manager, the consumer, and the mental health professionals, the PATH consumer's ability to maintain their stable housing status greatly increases. In comparison to the outcomes of individuals with similar backgrounds and boundaries who are not involved in services, individuals graduating from PATH are more successful and more independent.

Alignment with State Plan to End Homelessness

In November of 2005, the Pennsylvania Interagency Council on Homelessness proposed the "Agenda for Ending for Ending Homelessness in Pennsylvania" that focused on establishing supportive services for homeless persons in order to obtain permanent housing. An additional report released by Pennsylvania's Joint State Government Commission on April 5, 2016 entitled "Homelessness in Pennsylvania: Causes, Impacts, and Solutions- A Task Force and Advisory Committee Report" further focuses the state's efforts towards permanently reducing and eliminating homelessness. In this report, the state moves its focus specifically to the following subpopulations at-risk: victims of domestic violence, individuals with a criminal justice history, individuals with mental health and/or substance abuse disorders, individuals experiencing homelessness in rural areas, veterans, and children and youth populations. The PATH Program at Armstrong County Community Action Agency (ACCAA) addresses the state's homeless plan by targeting many of these subpopulations through outreach (both street outreach and outreach to other service agencies), engagement, education, case management, and referral services to mainstream resources such as mental health and/or substance abuse treatment. Specifically, our PATH Program focuses on those individuals who have a serious mental health disorder and/or co-occurring substance abuse disorder who are also at-risk or literally homeless.

In our experience, it is not unusual for the subpopulations outlined in the state's homeless population to blend together. For instance, there are a great number victims of domestic violence, individuals with criminal justice histories, veterans, individuals experiencing homelessness in rural areas, and youth exiting aging out of child services that have been diagnosed with a serious mental health disorder and/or co-occurring substance abuse disorder. With this in mind, our PATH Program not only completes street outreach to parks, businesses, and places not meant for habitation, but it also focuses outreach into other service provider agencies to increase collaboration. We have found that by offering focused training on how the PATH Program can help each specific agency's target populations, those agencies are more likely to refer their clients to the program. To date, we have offered trainings to HAVIN, the local domestic violence shelter, and multiple mental health and social service agencies in the county. ACCAA also has the contract to run the local Supportive Services for Veterans Families (SSVF) enabling the Behavioral Health Housing Liaison/ PATH Case Manager collaborate closely with the SSVF Case Manager should a veteran experiencing homelessness need extra services.

Once an individual in need has been identified, the Behavioral Health Housing Liaison/ PATH Case Manager begins the process to engage those individuals to build trust and increase the likelihood of a successful professional relationship. At times, engagement with an individual

is as simple as offering possible services; however, there are other instances where engagement may need multiple contacts to build enough trust between the individual in need and the Behavioral Health Housing Liaison/ PATH Case Manager. After the individual has been engaged and entered into the PATH Program, our primary focus becomes obtaining safe housing for the individual in accordance with the "housing first" initiative. We also assist the individual obtain immediate needs such as food and clothing. After the individual's situation is no longer an emergency situation, an individual service plan (ISP) is written to establish all of the goals that the client is working toward.

Once the ISP has been established, the Behavioral Health Housing Liaison/ PATH Case Manager provides individualized case management to the individual to realize their goals. Case management often includes introducing the individual to other housing programs (such as Continuum of Care Programs) to ensure that they have access to the best housing options possible, helping the client increase their income through employment advocacy, and establishing a working budget. During the case management process, the individual can be referred to other mainstream resources to further assist the realization of their goals. If the individual is not currently in treatment for their mental health and/or co-occurring substance abuse disorder, the Behavioral Health Housing Liaison/ PATH Case Manager will refer them to local treatment facilities. Over time we see that the individual's independence is positively correlated with the removal of barriers in their lives. Overall, this process is made easier through the collaboration and cooperation of all those involved in the individual's life including family, other case managers, and peer support persons. Ultimately once all barriers are removed, the individual is able to graduate the program with a heightened sense of independence and stable housing.

Armstrong County Community Action Agency was directly involved with planning and developing the Armstrong County Hazard Mitigation Plan. The agency was designated by the Armstrong County Board of County Commissioners several decades ago as the first response team to be the first point of contact with county residents experiencing an emergency situation or county disaster. Our case managers completed the intake applications and assessed the disaster situations. Our agency also located resources for the families to utilize to assist them when possible. This information was then relayed to the Armstrong County Emergency Management Agency for documentation. ACCAA played an integral part in responding immediately upon notification of any disaster situation. For future disasters, the HUD Office of Housing Counseling has established a new Disaster Recovery Website to utilize. It features new toolkits for housing counseling agencies and other resources for housing counselors in the event a disaster strikes the community.

Other Designated Funds

At this time, the Armstrong County Community Action Agency does not receive any other funds specifically designated for individuals who are experiencing homelessness and have a serious mental illness. We do, however, operate a program call the Contingency Program, which was granted to us by the Armstrong Indiana Behavioral and Developmental Health Program (AIBDHP). The Contingency Program was built to assist clients who have medical assistance and are at-risk of or experiencing a serious behavioral challenge. The Contingency

Program can potentially assist with rental assistance, security deposit assistance, procuring adequate necessary furniture (i.e. a bed), and limited utility assistance. At this time AIBDHP is anticipating the renewal of the Contingency Program through the Health Choices reinvestment plan. This funding will not only continue the Contingency Program but it will also assist with salary costs associated with the PATH Program (i.e. the salary of the Behavioral Health Housing Liaison/ PATH Case Manager). The Behavioral Health Housing Liaison/ PATH Case Manager will be the operator of the Contingency Program; therefore, clients in the PATH Program or in the Behavioral Health Housing Liaison Program will be immediately evaluated to see if the Contingency Program can assist them.

Programmatic and Financial Oversight

The Armstrong County Community Action Agency (ACCAA) is operating the PATH Program through the Armstrong Indiana Behavioral Health and Development Program (AIBDHP). With the PATH Program, AIBDHP also supplies funding for the Behavioral Health Housing Liaison Program which supplements the salaries of the staff operating the PATH Program. Since the contract was written to allow ACAA to operate the PATH Program, Joni Putt, the Behavioral Health Quality Management coordinator, has monitored the activities of the program. Fiscally, ACCAA operates the PATH and Behavioral Health Housing Liaison Programs in house and then sends monthly invoices to AIBDHP to be reimbursed.

SSI/SSDI Outreach, Access, Recovery (SOAR)

The Armstrong County Community Action Agency currently has a total of five (5) SOAR trained Case Managers, including: the Behavioral Health Housing Liaison/ PATH Case Manager, the Emergency Solutions Grant (ESG) Case Manager, the Permanent Supportive Housing Case Manager, the Rapid Rehousing Case Manager, and the Housing Assistance Program (HAP) Case Manager. ACCAA also plans to train any other staff members who are hired for the PATH or the Behavioral Health Housing Liaison Programs. As an agency we plan to assist as many eligible consumers with SOAR as possible, however, a situation where SOAR could assist a consumer has not yet arisen. In the past we have assisted two individuals with the regular Social Security Disability process. Of those two individuals ACCAA was notified that one individual was approved for SSDI. Although Armstrong County is notably a rural county, the majority of individuals we see that would qualify for SSI or SSDI already receive benefits. Due to this, our staff does not dedicate a significant portion of their time to the SOAR program. Should a SOAR eligible consumer be found, the SOAR trained staff member will use resources on the SAMHSA SOAR TA Center and track their progress on the Online Application Tracking (OAT) System.

Housing

Armstrong County Community Action Agency is committed to assisting all individuals who are in need of shelter, including those who are eligible for the PATH Program. Upon being interviewed by The Behavioral Health Housing Liaison/ PATH Case Manager and the housing department staff, there is a collaborative effort by all the parties involved to find the best solution available for the individual. As an agency we operate by the "Housing First" model, where the

Case Manager immediately locates housing and then proceeds to work on any other obstacles. The Armstrong County Community Action Agency Housing Department is able to assist with emergency housing as funding and availability exists. ACCAA's PHARE Program is also able to house individuals who are literally homeless for up to two months as availability exists. The resources outside of our agency that we utilize to find rentals are as follows:

- Armstrong County Landlords: Rental units are made available to the consumers needing housing, including PATH consumers. Armstrong County Community Action Agency has a very good, long-standing, working relationship with the landlords in our county, and they work in collaboration with the Armstrong County Community Action Agency in placing consumers into appropriate housing.
- Armstrong County Housing Authority: Armstrong County Community Action Agency has a working relationship with the Housing Authority for Section 8 Voucher Program and the Low-Income Housing and Family Unification Program (FUP).
- Department of Human Services (formerly known as the Department of Public Welfare) assists with their many programs to help our consumers with a multitude of needs including emergency housing and rental assistance as funding allows.
- Private housing for low-income rental units such as Rayburn Manor Apartments and Lindenwood (privately owned for single and multi-family units for low-income).
- Mechling-Shakely Veteran's Center: housing for homeless veterans in Armstrong County such as the HUD-VASH program.
- HAVIN: Helping All Victims in Need-Abuse Shelter in Armstrong County.
- The Salvation Army: main offices in Kittanning and Vandergrift, and satellite offices in Dayton, Leechburg, Rural Valley and Freeport that uses private money to house people that need a place to stay temporarily.
- American Red Cross: Will provide three days of motel stay for displacement from a home due to fire and victims are helped regardless of income.
- Real Estate Agencies – a network of real estate agencies that have available rentals assist us in housing consumers having a hard time finding an affordable rental.
- Local Ministeriums: cluster of churches that assist persons who need housing, on an emergency basis only.
- High-rise units managed by the Public Housing Authority – Housing provided for single people with no children or an adult household who have disabilities.
- Allegheny Kiski Hope Center – Provides housing services to homeless consumers in our area.
- Just for Jesus: a homeless shelter located in Brockway, PA that accepts our referrals and provides transportation for consumers to get to their shelter.

Coordinated Entry

Due to having three programs through the Continuum of Care (CoC), Armstrong County Community Action Agency is an active member of the Western Continuum of Care. The coordinated entry initiative that the CoC has been working on is in the final stages of implementation. Currently ACCAA is training diligently through the Western CoC to ensure that they will properly follow the rules and guidelines that are set up for the coordinated entry system. The coordinated entry system hosted on PA HMIS will be used to increase collaboration

in all of the CoC programs within each CoC region. Each CoC program will look to the coordinated entry lists within HMIS to make sure that the most vulnerable and in need individuals are receiving timely access to services.

Individuals who are into the system to get services are rated by need; however, the need-based list is not separated geographically. This means that if a CoC program here in Armstrong has an opening for a new client, they would have to offer the slot to the first person on the coordinated entry system list even if that client is from a different county in the Western CoC. There have been two main questions voiced in this issue locally. The first question is: how would a client without transportation get to the CoC program outside of their immediate geographical area? Most of these programs do not have a large enough budget to include transporting clients over long distances. The second question is: what happens to those clients who are in immediate need in the counties that the Coc programs are in? The selection of a client to go into a program could be a drawn-out process considering programs have to offer the available slot to the individuals outside of the county. Increasing the time span between the first contact with the "at-risk" or "homeless" client to when the client would be housed in a program does not bode well. The majority of individuals seek out assistance when they have no other options; therefore, the extra time it will take to get them into a program will have a detrimental effect upon them.

Justice Involved

In Armstrong County, Crisis Intervention Team training has been provided to law enforcement and court personnel to increase education and insight into the effects of mental illness. The training has been very well received and attended. So far, about 25% of applicable attendees have attended trainings that have been completed. Members from the district magistrate office, the district attorney's office, local police departments, local sheriff's departments, local jails, and the Pennsylvania State Police have been in attendance. Our local HAVIN (Helping All Victims In Need) Shelter has also hosted Mental Health First Aid USA for adults as well as Youth Mental Health First Aid USA. Both First Aid trainings have seen great attendance and participation from law enforcement and court personnel as well as our local service providing agencies. AIBDHP also provides detailed training on the Mental Health Procedures Act to law enforcement and court personnel. All trainings mentioned will continue to offer more training sessions and education as funding continues.

Staff Information

Armstrong County Community Action Agency's PATH Program staff members are currently all Caucasian females. Staff members were specifically hired for PATH due to their knowledge and history assisting those with mental disorders and illnesses. ACCAA is committed to serving clients regardless of age, gender, race, ethnicity, sexual orientation, or creed. All staff members are required to have cultural competency in their backgrounds and they are also required to periodically attend cultural competency and health disparities trainings. The Behavioral Health Housing Liaison/ PATH Case Manager is currently attending a monthly webinar series on cultural understanding spanning from April 2017 to August 2017 called the "Culturally Responsive Service Spotlight Series" provided by SAMHSA. PATH staff members

have also attended a live training on Fair housing laws. In the future PATH staff will continue taking advantage of available training opportunities to increase cultural and social competency.

Client Information

Armstrong County is fairly homogeneous with the majority of the residents identifying as being Caucasian and English speaking. Of that population, Armstrong County Community Action Agency's PATH Program is built to serve adults or emancipated minors that have been diagnosed with a Serious Mental Illness (SMI) and who are also experiencing homelessness. Experiencing homelessness is defined as the client being "at-risk of homelessness" or be "literally homeless" at the time of the first contact. Individuals who are "at-risk of homelessness" are those who are doubled up with family or friends and are unable to continue to stay, those who are in a temporary living situation such as transitional housing that carries time limits, those whose housing was recently condemned requiring them to move, and those who have received an eviction notice. Individuals who are considered "literally homeless" are persons who are sleeping in areas not meant for human habitation (streets, underpasses, parks, and buildings not fit for habitation), persons who are staying in supervised public or private facilities that provide temporary or emergency living accommodations, and persons being released from prison or other institutional environments without a place to stay.

Our program expects around forty-five (45) individuals to be contacted about the program. Of those, we expect thirty (30) of those individuals will wish to enroll into the PATH Program. Of the thirty (30) enrolled individuals, we expect that 50% will be considered "literally homeless."

Consumer Involvement

The Armstrong Indiana Behavioral and Developmental Health Program (AIBDHP) supports the monthly CSP (Community Support Program) Meetings in which service providers and consumers can get together and create a dialogue about the services available in the area. The Behavioral Health Housing Liaison/ PATH Case Manager attends the meetings and participates in the dialogue. AIBDHP also supports the local Consumer/Family Satisfaction Team that reaches out to get feedback from individuals getting mental health or addiction services. The team is very helpful to the different providers within the counties to make sure they are doing the best the possibly can to address the needs of their clients. Currently there are no questions on the surveys to assess the PATH Program; however, AIBDHP is currently working to see if it would be possible to include prompts about the program in the survey. At the program level, ACCAA's PATH Program Staff disperses a survey to PATH consumers at upon exiting from the program. The survey attempts to identify any areas where improvements can be made, gauge the client's experience in the program, and highlight suggestions the consumers have regarding the effectiveness of the PATH Program.

At the service provider level, The Armstrong County Community Action Agency sponsors a formal Housing Advisory Board meeting quarterly in our county where over forty organizations and agencies are registered and their members participate in a collaborative way to help solve the problems of the homeless consumers in our area. When the Homeless Advisory

Board members meet, they share important updates on new or innovative program services as well as updates or changes to existing programs. They also make recommendations to the Armstrong County Community Action Agency based upon their experiences collaborating with ACCAA staff while assisting a client. At this time, neither clients nor their families attend the Advisory Board meetings; however, service providers in attendance gladly share if their client has had a positive or negative experience.

Health Disparities Impact Statement

In the United States, the Transition Age Youth (TAY) Disparity population has seen many difficulties receiving the help that they need to succeed in gaining independence. The PATH eligible TAY disparity population has been defined as individuals whose ages fall within 18-30 years of age that have a serious mental illness (SMI) and/or co-occurring substance abuse disorders. Applicable individuals must also be homeless or at imminent risk of becoming homeless. Armstrong County's TAY population is primarily made up of Caucasian, English-speaking individuals; however, they have increased difficulty accessing necessary due to the rural nature of the county and its limited resources. Due to their age, the location, and a number of other factors that exist in their lives, the behavioral health outcomes for the TAY group are significantly worse than the other populations served by the grant.

ACCAA has increased their efforts to spread the information about the services that the agency can offer all individuals, including the TAY population. ACCAA shares information about all of our housing programs at the Armstrong County Housing Advisory Board to encourage referrals of at-risk or homeless individuals to our programs. Our agency also distributes brochures throughout the community through street outreach in order educate the local population about services. Due to the ever-increasing technological preference of the current TAY population, ACCAA has also increased their online presence with a Facebook page where potential consumers can seek assistance and message any questions they may have. We are also looking into adding the ability to text clientele from work devices to increase the chances of TAY population involvement. Finally, ACCAA is in the process of building an interactive web page to increase instant information availability about programs and services in the agency. Our Behavioral Health Housing Liaison/ PATH Case Manager also might have more luck reaching out to this population due to the fact that she also fits into the TAY age range. With all of these aspects combined, it is our hope that the Behavioral Health Housing Liaison/ PATH Case Manager will be able to draw more TAY individuals into services by building a rapport with them.

Once a TAY consumer has been contacted and evaluated by the Behavioral Health Housing Liaison/ PATH Case Manager, they are able to obtain any of services that PATH offers as long as they meet the eligibility requirements. PATH expects to serve at least 4 TAY individuals with PATH funds which is roughly 30% of the total individuals that we plan on serving. To prioritize assistance to the TAY population, the total amount of PATH funds expected to be expended on rental assistance is $1,794.72, which is utilizing roughly 30% of our rental assistance services budget.

If the consumer does not have an income, the consumer is still eligible for case management services (creating a budget, goal completion, smart shopping habits etc.), referral services within the Armstrong County Community Action Agency (Medical Transportation, SNAP, Emergency Housing, Emergency Food Pantry, etc.), and outside of the agency resources (mental health services, job search, GED classes, drug counseling, emergency clothing, etc.). Unlike the non-TAY population, most TAY individuals do not have access to transportation to get to necessary services. The PATH Program at Armstrong County Community Action Agency is able to offer transportation assistance to necessary service centers such as, the Housing Authority, the Department of Human Services, Probation and Parole Office, the DMV, and the Social Security Office. This is very important because many TAY individuals may not have access necessary items such as their Birth Certificate, Social security card, or photo identification. The Behavioral Health Housing Liaison will be available assist TAY individuals with signing up for and/or understanding programs as needed.

With more access to the TAY population, ACCAA will design and implement services and activities in accordance to the population's needs. Even though we do not expect individuals to be ethnically and culturally unfamiliar to our PATH staff members, our staff will continuously attend trainings to ensure their cultural and social competency. It is our goal that once we get the TAY consumers involved into services, they will have positive experiences and successful outcomes. All contacts, program services, and referrals are collected, organized, and timely entered into the PA HMIS/ Client Track system. With the updates to the system, such as the TAY report, we are able to track services and expenditures directly related to TAY individuals. With reports like these, we plan to monitor the effects of inserting more technological usage on overall service usage and expenditures.

Limited English Proficiency

In pursuant to Executive Order 13166, the Armstrong County Community Action Agency (ACCAA) has contacts within the Armstrong County School District who can be called upon for translation services. Also, Armstrong Indiana Behavioral and Developmental Health Program (AIBDHP) has contacts within ARIN IU 28 as well as the Indiana University of Pennsylvania (IUP) if further translation services are needed. To date, the PATH Program at ACCAA has not needed to call upon translation services at all. The only instance where someone had called for assistance in a language other than English was two years ago, and the language was Spanish. Due to being proficient in Spanish, the Behavioral Health Housing Liaison/ PATH Case Manager was able to assist the client by giving her information she requested. The PATH staff is very intuitive in picking up cues to assess situations for the potential need for language assistance. To further ensure language accessibility, ACCAA PATH staff hangs a language chart in the office so that if a client is unfamiliar with English they can chose their preferred language. The chart was obtained off of the Limited English Proficiency website, http://www.lep.gov, where it was posted by the Health Research and Educational Trust of New Jersey (HRET). A picture of the chart can also be found at the end of this section.

I Speak ...

ARABIC	أنا أتحدث اللغة العربية
ARMENIAN	Ես խոսում եմ հայերեն
BENGALI	আমি বাংলা কথা বলতে পারি
BOSNIAN	Ja govorim bosanski
BULGARIAN	Аз говоря български
BURMESE	ကျွန်ုပ်/ကျွန်မ မြန်မာ ဘို့ ပြောတတ် ပဲတယ်
CAMBODIAN	ខ្ញុំនិយាយភាសាខ្មែរ
CANTONESE (CHINESE)	我講廣東話 我讲广东话
CROATIAN	Govorim hrvatski
CZECH	Mluvím česky
DUTCH	Ik spreek het Nederlands
FARSI (PERSIAN)	من فارسی صحبت می کنم
FRENCH	Je parle français
FRENCH CREOLE (HAITIAN CREOLE)	M pale kreyòl ayisyen
GERMAN	Ich spreche Deutsch
GREEK	Μιλώ τα ελληνικά
GUJARATI	હું ગુજરાતી બોલું છું
HEBREW	אני מדבר עברית
HINDI	मैं हिंदी बोलता हूँ।
HMONG	Kuv has lug Moob
HUNGARIAN	Beszélek magyarul
ITALIAN	Parlo italiano
JAPANESE	私は日本語を話す
KOREAN	한국어 합니다
LAOTIAN	ຂ້ອຍປາກພາສາລາວ
LITHUANIAN	Aš kalbu lietuviškai
MANDARIN (CHINESE)	我講國語 我讲国语/普通话
NORWEGIAN	Jeg snakker norsk
POLISH	Mówi˙ po polsku
PORTUGUESE	Eu falo português do Brasil (Brasil) Eu falo português de Portugal (Portugal)
PUNJABI	ਮੈਂ ਪੰਜਾਬੀ ਬੋਲਦਾ/ਬੋਲਦੀ ਹਾਂ।
ROMANIAN	Vorbesc românește
RUSSIAN	Я говорю по-русски
SERBIAN	Ја говорим српски
SLOVAK	Hovorím po slovensky
SPANISH	Yo hablo español
SWAHILI	Ninaongea Kiswahili
SWEDISH	Jag talar svenska
TAGALOG	Marunong akong mag-Tagalog
THAI	พูดภาษาไทย
TURKISH	Türkçe konuşurum
UKRAINIAN	Я розмовляю українською мовою
URDU	میں اردو بولتا ہوں
VIETNAMESE	Tôi nói tiếng Việt
YORUBA	Mo nso Yooba

* **Registrars should use this tool to guide patients in identifying their spoken language when they do not speak English at all.**

Source: Adapted from the State of Ohio's Office of Criminal Justice Services and recommended by the US Department of Health and Human Services - Office of Civil Rights for use by healthcare facilities.

Budget Narrative

Armstrong County Community Action Agency received PATH funding from both the State and Federal branches. From the State branch, ACCAA received $7,543.00. From the Federal branch, ACCAA received $22,629.00. The total amount of PATH funding ACCAA received, in the amount of **$30,172.00,** will be used for providing rental assistance housing services, transporting consumers, transportation for outreach, assistance for procuring birth certificates and personal identification, and for augmenting the salaries of the director, Kimberly Pivetta, and then the Behavioral Health Housing Liaison/ PATH Case Manager, Kaila Mulvey. A breakdown of the costs associated with the Armstrong PATH Program is provided below:

Personnel:

Of the **$14,772.00** of PATH funds devoted to salary costs, $4,027.00 helps support the Director's salary by 11%. The Behavioral Health Housing Liaison/ PATH Case Manager position is supported 41% by $10,745.00. All PATH program staff members are located at the Armstrong County Community Action Agency. The director will responsible to oversee the program and completing all reports. The Behavioral Health Housing Liaison/PATH Case Manager will be responsible for the operation of the program through working with the PATH clients to secure housing and support services they need.

Fringe Benefits:

The funding amount of **$8,610.00** is being requested to provide the following fringe benefits for Armstrong County PATH Program Staff. Fringe benefits include unemployment compensation, health insurance (health, eye and dental), worker's compensation, social security, pension/retirement.

Unemployment Compensation:	Director	($46.00)
	PATH/BHHL #1	($173.00)
	Total: $219.00	
ACC/HLTH Insurance:	Director	($97.00)
	PATH/BHHL #1	($258.00)
	Total: $355.00	
Worker's Compensation:	Director	($20.00)
	PATH/BHHL #1	($54.00)
	Total: $74.00	
Social Security:	Director	($308.00)
	PATH/BHHL #1	($822.00)
	Total: $1,130.00	
Pension Plan:	Director	($322.00)

	PATH/BHHL #1	($860.00)
	Total: $1,182.00	
Health Insurance:	Director	($2,423.00)
	PATH/BHHL #1	($2,959.00)
	Total: $5,382.00	
Dental Insurance:	Director	($44.00)
	PATH/BHHL #1	($164.00)
	Total: $208.00	
Vision Insurance:	Director	($26.00)
	PATH/BHHL #1	($34.00)
	Total: $60.00	

Travel:

Staff will travel to attend PATH Trainings on homeless/housing/mental health issues related to the PATH Program. Travel will be used to transport clients who have no other form of transportation to appointments, Social Security, Housing Authority, Department of Human Services, GED classes, job searches, emergency clothing supplies, medical appointments, probation/parole appointments, locating rentals, meetings with landlords, and any other agency appointments that the client accesses to help them remain stable. We estimate that monthly travel mileage for these purposes will be 181 miles. To reach the total about budgeted for travel we use the following formula:
12 months x 182 total miles x .0535 = **Total: $1,169.00**

Rental Assistance:

There is one-time rental assistance that is available up to $750.00 a household for a total amount of $5,621.00. Monthly rental amounts vary in the county area.

Total: $5,621.00

Armstrong County Community Action Agency
FY 2017-2018 PATH Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
PATH Director	$36,610.00	.11	$4,027.00	$4,027.00
Behavioral Health Housing Liaison Case Manager	$26,208.00	.41FTE	$10,745.00	$10,745.00
sub-total			$14,772.00	**$14,772.00**
Fringe Benefits				
FICA Tax			$1,130.00	$1,130.00
Unemployment			$219.00	$219.00
Retirement			$1,182.00	$1,182.00
Life Insurance			$355.00	$355.00
Health/ Dental/ Eye Ins			$5,650.00	$5,650.00
Workman's Comp			$74.00	$74.00
sub-total			$8,610.00	**$8,610.00**
Travel				
Local Travel for Outreach			$1,169.00	$1,169.00
Travel to training and workshops				$0.00
sub-total			$1,169.00	**$1,169.00**
Supplies/Equipment				
Consumer-related items				
sub-total				**$0.00**
Other				
Staff training				$0.00
One-time rental assistance			$5,621.00	$5,621.00
Security deposits				
sub-total			$5,621.00	**$5,621.00**
Total PATH Budget				**$30,172.00**

7. Armstrong-Indiana County - Indiana County Community Action Agency

300 Indian Springs Road

Indiana, PA 15701

Contact: Sandra Harber

Contact Phone #: 7244652657

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-068

State Provider ID: 4268

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Indiana County Community Action Program will receive a total of $30,172 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 100

Estimated Number of Persons to be Enrolled: 25

Estimated Number of Persons to be Contacted who are Literally Homeless: 10

Number staff trained in SOAR in grant year ending in 2017: 2

Number of PATH-funded consumers assisted through SOAR: 0

Indiana County Community Action Program, Inc.
Local Provider Intended Use Plan
FY 2017-2018

Local Provider Description

Incorporated in March 1965, Indiana County Community Action Program, Inc. (ICCAP) is a private non-profit agency which provides a variety of human services to low-income citizens of Indiana County. ICCAP's mission is "to serve as the community agency to mobilize services and resources to empower families and individuals to progress towards self-sufficiency." For the past fifty-two years, the Indiana County Community Action Program has been the lead emergency assistance provider to Indiana County income-eligible residents.

Over the years, ICCAP has offered numerous programs aimed at helping low-income families and individuals obtain self-sufficiency. Programs have been developed to teach clients new ways to solve household problems and manage emergencies. With a staff of 26 full and part-time employees, ICCAP provides a variety of services to thousands of individuals every year.

ICCAP's address: 827 Water St., Indiana, PA 15701
Amount of Grant for Indiana County: $ 30,172
Our PATH PDX provider name is: Indiana County Community Action Program

Collaboration with HUD Continuum of Care Program

The Indiana County Community Action Program, Inc. (ICCAP) has a long history of collaboration with the HUD Continuum of Care. Since 1999 ICCAP has received funding through McKinney-Vento CoC programs to provide housing services to homeless and chronically homeless persons and households; it is now transitioning to programs funded under the HEARTH Act. Currently the agency receives funds for two supported housing programs for the homeless, Project LIGHT, a transitional housing program for the employable and Project PHD for the disabled. ICCAP has just been awarded grant funds for another supported housing program for the chronically homeless and disabled; PHD 2, which will begin in October of 2017. In addition, the agency operates the Pathway Homeless Shelter with funding through H-ESG and also provides Rapid Re-Housing.

ICCAP is Indiana County's Local lead Agency/811 contact, and the Continuum of Care contact for the county. ICCAP's Executive Director, is active on the PA Western Region CoC Governing Board, and the Vice Chair of the local Housing Consortium (LHOT). The Shelter Director is a voting member for Indiana County on the Southwest Regional Homeless Advisory Board, and a member of our local Housing Consortium. ICCAP enters the data of all homeless or near homeless individuals into the Housing Management Information System (HMIS). ICCAP staff has been active in developing the Coordinated Assessment and Coordinated Entry tool that must be utilized by all homeless providers by January 1, 2018. Other than those in a Domestic Violence shelter, ICCAP will be using the Coordinated Assessment and entering all homeless individuals into the Coordinated Entry as the local lead agency in the county.

Collaboration with Local Community Organizations

Primary Health Providers
The importance of information and referral is woven into the fabric of every community action agency. In this spirit, the many county residents Indiana County Community Action provides services to annually are offered information about and assistance in applying for medical benefits. In addition, the agency enjoys a close working relationship with our primary health provider, Indiana Regional Medical Center. The Executive Director is a member of the County Health Advisory Committee.

Mental Health Providers
As a provider of representative payee services for mental health consumers since 1996, ICCAP has a long history of working with mental health providers. Contracted for services by the Armstrong-Indiana Base Service Unit, the payee program provides services to over 200 consumers a year and in this capacity interacts with case management, the sheltered workshops, Indiana and Armstrong (I&A) Residential services, the Community Guidance Center and the Family Counseling Center. Our Representative Payee Coordinator also sits on I & A's board of directors. Other ICCAP programs including the Pathway Shelter, Homeless Case Management, and our utility programs work closely with mental health providers to provide the best outcomes for consumers; conversely, our familiarity with mental health services allows us to make informed referrals for services, particularly Peer Support services. The Behavioral Health Housing Liaison/PATH Case Manager regularly attends meetings of the Community Support Program (CSP).

Substance Abuse Providers
As a provider of services to the homeless, ICCAP often encounters barriers to housing related to drug and/or alcohol issues. We have a history of working closely with the Open Door and case management from the Armstrong-Indiana Drug and Alcohol Commission. We have also assisted consumers exiting from Spirit Life, a residential rehabilitation unit for those suffering with addiction. Many have exited their program and entered Pathway, our emergency homeless shelter. From there, they were able to get assistance either through our Rapid Re-housing program or with security deposits and/or rent through our Housing Assistance Program.

Employment Providers
The Department of Human Services funds the agency Work Ready program. This intensely individual employment program provides job readiness, resume preparation, job interview skills, and job development for the most difficult to employ clients. Work Ready staff assists clients in removing significant barriers to employment.

Service Provision

The Behavioral Health Housing Liaison/PATH Case Manager provides outreach at the local drop-in center and the Pathway Homeless Shelter. She travels to any place reporting a homeless consumer; such as a park, store, or church. She works closely with the Representative Payee Program staff and our Food Bank Warehouse which provides a box of food monthly to all PATH enrolled clients. In addition, many eligible clients simply walk in to the agency's main office seeking assistance. The Behavioral Health Housing Liaison/PATH Case Manager completes an

assessment on each referral to determine eligibility which will include meeting the criteria for homeless or imminently homeless; self- declaration of mental illness; and residency in Indiana County. The Liaison will utilize PATH funds to assist homeless or imminently homeless individuals with security and/or utility deposits to move them out of homelessness or authorize the payment of past due rent to resolve an eviction.

Indiana County Community Action Program serves as the county's primary point of contact/service provider for the homeless. State and local police, township supervisors and other human service agencies are aware that ICCAP's housing staff is available through the Pathway shelter 24/7. This position in the county continuum of care allows us a unique outreach to the homeless and imminently homeless. The housing staff works with residents of Pathway. Homeless clients are assessed, entered into HMIS Coordinated Entry, and then referred to appropriate housing programs such as Pathway, Alice Paul House (domestic violence shelter), Rapid Re-Housing, Rental Assistance, and Permanent Housing for the Disabled (PHD). Additional outreach is provided through written resources such as flyers, brochures and staff at ICCAP's 17 food pantries. Consumers can contact ICCAP by phone, by referral from other agencies, and/or simply walk into one of our buildings and ask for help. The Behavioral Health Housing Liaison/PATH Case Manager is part of this team and will also take referrals from other mental health service providers particularly the Family Psychological Associates Peer Specialists. Coordination of services among the housing staff (consisting of the Community Services/Resource Director, the Shelter Director, three homeless Case Managers, our Homeless Advocacy Liaison, and the Housing Counselor) occurs as needed. Formal meetings and discussion of specific client issues take place at a more formal bi-weekly housing staff meeting. In addition to the available services listed above, PATH clients with both a serious mental health illness and a substance abuse disorder are referred to the Open Door where they can receive an assessment, counseling, intensive outpatient services, or attend a co-occurring disorder's group, and/or the relapse prevention group. The Open Door also provides a 24 hour crisis line and evaluation for inpatient services.

Despite having an array of treatment and housing options available within the county, gaps in service systems do exist. PATH clients often face the challenge of finding housing that fits into their budget, as many would be considered to be low income. While having funds available to access housing is a major concern for PATH clients, many also have criminal histories that limit landlords are very reluctant to consider or overlook. Those charged with sexual related offenses have an even bigger challenges securing housing. Another gap identified by PATH clients is the lack of reliable transportation. Being a rural county, public transportation is limited. Often clients have to wait long periods of time in between treatment appointments for a bus to pick them up to return home. Others could not find housing near a bus route. This gap creates distinct challenges to encouraging clients to stay involved in their mental health and/or substance abuse treatment. Finally, in-home supportive living services are limited within the county. While these services do exist, there are often waiting lists to access them because of the need. ICCAP will continue working with the AIBDHP and other human service agencies to address these gaps identified.

The Behavioral Health Housing Liaison/PATH Case Manager attends local CSP meetings; and is trained as a SOAR advocate, as is the Community Services/Resource Development Director. PATH funding will also be used to provide training to PATH staff on PATH related topics and evidence-based practices.

ICCAP is not required to follow 42 CFR Part 2 Regulation since our program does not operate any substance abuse programs.

Of the PATH consumers served by Indiana County 49% have a criminal history. Because of this relatively high percentage, the Behavioral Health Housing Liaison/PATH Case Manager has spent a good deal of time developing working relationships with local correctional staff, mental health providers, and local landlords/housing providers. Through these relationships, the liaison/case manager is able to help consumers with criminal histories access benefits, support services, and housing in a timely manner. In working with landlords specifically, the liaison/case manager is able to reassure landlords that someone supporting the consumers, giving them a person to call in times of concern. These relationships have the potential of positively impacting the way landlords see behavioral health consumers who also have involvement in the Criminal Justice System. The overall goal is to use these relationships to develop more safe and affordable housing for the justice involved populations. In addition to this work, the Behavioral Health Housing Liaison/PATH Case Manager will be called upon to work with the AIBDHP in the development of any future Justice Related Service's program in Indiana County.
ICCAP maximizes use of PATH funds by leveraging our Rental Assistance, Food Bank Warehouse, Representative Payee and Utility Assistance programs.

Data

Client demographic data will be collected in ICCAP ORS (Outcome Results System) an in-house data collection database and the Pennsylvania HMIS (Homeless Management Information System). Both the Supervisor and the Behavioral Health Housing Liaison/PATH Case Manager are trained in both data bases. Currently 100% of PATH client information is entered into the HMIS system.

Our Behavioral Health Housing Liaison/PATH Case Manager and Community Services/Resource Development Director attended the Coordinated Entry training given by the CoC of Western PA. They will also attend the training in State College, PA from June 13 through June 15, 2017, and will continue to be trained on HMIS as training is available. The Behavioral Health Housing Liaison/PATH Case Manager will be responsible for entering client data in the HMIS system and the Community Services/Resource Director will be responsible for supervision of the Behavioral Health Housing Liaison/PATH Case Manager, pulling information for reports, etc.

Alignment with PATH Goals

ICCAP will continue to make outreach and case management a top priority to those who are homeless or at risk of becoming homeless in Indiana County. The Behavioral Health Housing

Liaison/PATH Case Manager will work closely with the Peer Specialists to identify individuals in need and begin working on a plan to stabilize their housing and living situation. ICCAP will continue to provide rental assistance as funding permits, limited transportation, referrals and other services needed to help our residents. The Behavioral Health Housing Liaison/PATH Case Manager outreach includes attending local CSP meetings, Suicide Task Force meetings, Children's Advisory Commission meetings, Senior Care Task Force meetings, going to the Drop in Center and Pathway Homeless Shelter. ICCAP fully supports the overall PATH Goals of the Armstrong-Indiana Behavioral and Developmental Health Program.

Alignment with State Comprehensive Mental Health Services Plan

ICCAP, working under Armstrong/Indiana Behavioral and Development Health Program (AIBDHP) will continue to comply with and perform all duties and functions that are outlined and executed in the State Mental Health Services Plan. Also, as a primary point of contact for the homeless in Indiana County, ICCAP will continue to provide services to the homeless. ICCAP's Behavioral Health Housing Liaison/PATH Case Manager, works very closely with our shelter staff and spends one day per week at the shelter to assist eligible consumers. As ICCAP moves forward into the PA Western CoC's Coordinated Entry Plan and Assessment application process, the Liaison will continue to help consumers access and apply for needed services; coordinate the delivery of services; provide follow-up and monitor progress of goals. One of the goals to eliminate homelessness is "housing first"; to eliminate a waiting list and for agencies across Western PA to work together to provide "Housing First". Currently, all agencies/organizations having a vacancy in one of their housing programs sends out an email across the state posting their housing opening. Once the Coordinated Entry is up and running across Western PA, all homeless individuals will be entered into HMIS Coordinated Entry data base. The goal is that those most vulnerable will be housed first. Once implemented, ICCAP and the Behavioral Health Housing Liaison/PATH Case Manager will be implementing the Coordinated Plan and using the Application/Assessment tool for all individuals that are homeless or imminently homeless.

Alignment with State Plan to End Homelessness

ICCAP is currently working with the Western Regional Housing Advisory Board on the State's Plan to implement "Housing First". ICCAP has also sat on the committee to develop the Coordinated Assessment Tool which, once completed will be used all throughout the Western Region of PA. The Assessment Tool will be used with HMIS to house individuals more quickly and to eliminate the days that someone remains homeless. ICCAP, being the lead agency in the county will be the agency implementing the Coordinated Assessment Tool to house the most vulnerable first.

In addition to the activities described above, ICCAP works in conjunction with the local 911/Emergency Management System and other agencies to assist Indiana County residents in the event of a disaster. PATH staff is available to assist those who may become homeless when a disaster strikes the area. Staff is strongly encouraged to participate in meetings and trainings offered that relate to disaster planning and response to ensure the needs of PATH clients are included in all discussions. Staff members are also expected, if asked, to participate in any rapid response/preparedness drills that may be held in the county to further strengthen their knowledge

of disaster/response protocol in order to serve the needs of PATH clients fully.

Other Designated Funds

ICCAP receives funds from the following to help with individuals that are homeless; HUD, ESG, HSDF, HAP, CSBG and we anticipate receiving funds from AIBDHP through a long range Health Choices Reinvestment housing plan once approved by the Office of Mental Health and Substance Abuse Services which will be designated to our PATH program. The Health Choices Reinvestment housing plan is specifically for homeless and nearly homeless with serious mental illness and will be earmarked for PATH.

Programmatic and Financial Oversight

ICCAP receives PATH funding through Armstrong-Indiana Behavioral and Developmental Health Program (AIBDHP). We invoice services to them on a monthly basis. All of our reporting; the quarterly TAY report and PATH Annual report are coordinated with AIBDHP. AIBDHP sends quarterly financial confirmation letters to ICCAP's fiscal dept. and executive director for review to insure all financial totals match. AIBDHP also monitors the program.

SSI/SSDI Outreach, Access, and Recovery (SOAR)

Our Community Services/Resource Development Director and the Behavioral Health Housing Liaison/PATH Case Manager are SOAR trained. ICCAP has another case manager working with homeless individuals also trained as a SOAR advocate. ICCAP had two PATH funded staff trained in SOAR during the grant year ending in 2016, but had no clients who qualified to be assisted with SOAR.

Housing

Locating safe affordable housing in Indiana County has always been difficult due to a number of factors including the rural nature of the county and inadequate public transportation. While this situation is not new to the county, recent factors have exacerbated the situation: Marcellus shale extraction has been started at over 200 sites in Indiana County; more than 200 temporary workers are needed to bring in each well. This has caused an increase in the demand for housing. According to a study completed by the Center for the Study of Community and the Economy at Lycoming College entitled "Marcellus Natural Gas Development's Effect on Housing in Pennsylvania" the increased demand for housing caused by the influx of Marcellus Shale workers is "broad-based, but the negative effects are felt heaviest by those living on the economic margins…the impact of the housing shortage are falling heaviest on those whose housing situation was most at risk prior to the growth of the Marcellus Shale industry, namely the non-working poor, seniors, the disabled and, newly, the working poor." The Pennsylvania Department of Community and Economic Development has indicated in their Marcellus Shale Fact Sheets that the experience of other states suggests that a gas boom will drive up prices for housing and lessen the availability of housing for middle-income as well as lower-income families. ICCAP's response to this situation takes many forms. First, the agency maintains a current database of safe, affordable rental properties in the county for distribution to clients. Rental assistance in the form of security deposits and/or rents is available through the Housing

Assistance Program. Housing programs include the Pathway Homeless Shelter, Bridge Transitional Housing, Project LIGHT transitional housing program, Project PHD; supportive permanent housing for the disabled, a phase 2 of PHD which is PHD 2 which will begin in October of 2017 and Homeless Case Management. The Behavioral Health Housing Liaison/PATH Case Manager position has become an added position member of the ICCAP Housing team in April 2013.

The Behavioral Health Housing Liaison/PATH Case Manager uses a housing assessment to identify barriers to housing and then works with the consumer to develop an achievable goal plan which results in stable housing. The Liaison helps the consumer access and apply for needed services; coordinates the delivery of services; provides follow-up and monitors progress towards goals.

In addition to the programs mentioned above, the Indiana County Community Action Program partnered with the Armstrong-Indiana Behavioral and Developmental Health Program and other agencies in early 2017 to assess the housing needs of the behavioral health population in Indiana County. The group developed a long-range plan called the Indiana County Housing Opportunities Plan that was submitted by the AIBDHP to pull down Health Choices Reinvestment Funding. The plan focuses on creating additional bridge subsidies, a Master Leasing Program, and building better relationships with local landlords and potential landlords in the community. The plan also calls for using funding to further support the Behavioral Health Housing Liaison/PATH Case Manager position, as well as expanding the Supported Living Program in Indiana County.

Coordinated Entry

In 1997, PA initiated the Regional Homeless Assistance Process to address homelessness in Pennsylvania's rural counties known as the "balance of the state". To cover the participating counties, this process began with the formulation of four separate Regional Continuum of Care: Central-Harrisburg, Northeast, Northwest and Southwest. Each region established a Regional Homeless Advisory Board (RHAB). Over the last two years a Governance Charter was formed; the Northwest RHAB and Southwest RHAB merged to create one Continuum of Care (CoC). ICCAP has been at the table serving on the CoC's Governance Board as well as the Southwest RHAB. The State Plan is implementing under the CoC's "Housing First". Both the Western and the Eastern CoC's are in the process of working on a Coordinated Assessment Tool and Coordinated Entry tool that must be utilized by all homeless providers by January 1, 2018. The application/tool would be completed by the lead agency in the County, which, ICCAP would be providing that service for Indiana County. At the end of the Coordinated Assessment Tool there is a point system as per most vulnerable; chronically homeless, those receiving treatment for mental health issues, homeless veterans, etc. Once the Assessment Tool is completed, the information is then put into the HMIS system and those agencies with housing openings will offer their housing to those with the most points. The purpose is to eliminate waiting lists and get everyone in to housing. The Assessment Tool and procedures are still being developed and will be followed up by our LHOT.

Justice Involved

ICCAP's Behavioral Health Housing Liaison/PATH Case Manager attends Consumer Service Provider (CSP) meetings on a monthly basis along with other Providers such as the Indiana Borough Police Dept., The Open Door, The Drug & Alcohol Commission, and Value Behavioral Health, just to name a few. We also work closely with the local Magistrate who resides in our building. Approximately 25% in law enforcement and court-related personnel have been trained under the Crisis Intervention Team training.

Staff Information

The program is staffed by a full-time Behavioral Health Housing Liaison/PATH Case Manager, housed in the main office at 827 Water Street, Indiana. PATH program staff is currently 100% Caucasian females. The Behavioral Health Housing Liaison/PATH Case Manager is supervised by the Community Services/Resource Development Director and will be part of the agency housing team. The Behavioral Health Housing Liaison/PATH Case Manager has a Bachelor's degree and experience in mental health. This experience will be supplemented through supervision. The liaison/case manager is SOAR trained. She also attends Community Support Program Meetings, and appropriate available trainings. As our county consists overwhelmingly of English speaking persons of Western European descent, we have little need for expertise in cultural competency; however, we rely on the nearby Indiana University of Pennsylvania and ARIN IU 28 to assist us with language and cultural issues.

ICCAP does not discriminate on the basis of race, ethnicity, religious creed, disability, ancestry, national origin, sex, sexual orientation, age, political beliefs, familial status, military service, genetic information, or citizenship. All clients are treated equally. Client characteristics (with the exception of sexuality) are maintained in a data system; real time results can be reviewed at any point in time.

Client Information

The Behavioral Health Housing Liaison/PATH Case Manager will facilitate housing assistance to mentally disabled homeless or nearly homeless individuals (nearly homeless is defined by the Department of Housing and Urban Development) during the term of this grant. A minimum of 100 clients will be contacted via outreach services; 25 will be enrolled; and 10 literally homeless clients will be assisted. The percentage of PATH clients served who fit the "literally homeless" definition will be approximately 47%.

Consumer Involvement

We had two formally homeless board members representing the low-income sector on our board. However, one of them resigned in August of 2016 and one finished there term in September of 2016. We had hired a homeless individual as staff of Pathway, ICCAP's homeless shelter, but he resigned in March of 2017. We currently have a formally homeless person who in the past was PATH-eligible has volunteered on a regular basis for ICCAP and now works for PathStone, an employment training program here at ICCAP. She plays an active role regarding our housing programs: She reviews Policies and Procedures for all of our housing programs, gives input on

housing programs as well as sits as a member of our Housing Committee who hears the appeal of those who may have been terminated from a program. She attends case management meetings twice per month on Tuesday mornings after our regular staff meetings. They discuss clients and services; the best approach to assist someone who is currently homeless or has just moved into housing. She has met all of ICCAP's board members by attending board functions and has provided input when asked. She is also a member of the Agency's Strategic Planning Committee. She has also designed the agency newsletters, annual report and assists wherever needed with various programs. However our PATH-eligible volunteer is involved at all levels in the planning, implementation and evaluation of PATH-funded services. We currently have no family members that are involved at an organizational level in the planning, implementation and evaluation of PATH – funded services. We ask each PATH client to submit a satisfaction survey of how we can improve services to them on a yearly basis.

Health Disparities Impact Statement

It is projected that 25% of clients served through PATH funds will be TAY ages 18-30. These consumers are eligible for assistance in applying for social security, emergency housing, assistance with housing applications, funding for housing related barriers, case management and other services generally available to all clients of the agency. Some of the housing related barriers for TAY consumers are due to their lack of income, and rental history. Also compared to older consumers who have had a mental health diagnosis, TAY consumers don't know what services are available. ICCAP's Behavioral Health Housing Liaison/PATH Case Manager will continue to educate this population about resources and services available as well as coordinating services.

- The unduplicated number TAY individuals who are expected to be served using PATH funds: 16.
- The total amount of PATH funds expected to be expended on services for the TAY population: $ 5,000.
- The types of services funded by PATH that are available for TAY individuals: housing support, case management, outreach, transportation, information and referral.
- A plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population: Most of our TAY clients are referred from our emergency homeless shelter. Income has definitely been a barrier; with Social Security difficult to obtain due to their age. Employment can also be difficult to obtain or maintain due to their mental health.

	Total	FY1	FY2	FY3	FY4
Direct Services: Number to be served	16	4	4	4	4
By Race/ Ethnicity					
African American	<8	<2	<2	<2	<2

American Indian/Alaska Native	<8	<2	<2	<2	<2
Asian	<8	<2	<2	<2	<2
White	<40	<10	<10	<10	<10
Hispanic or Latino	<8	<2	<2	<2	<2
Native Hawaiian/Other Pacific Islander	<8	<2	<2	<2	<2
Two or more Races	<8	<2	<2	<2	<2
By Gender					
Female	8	2	2	2	2
Male	8	2	2	2	2
By Sexual Orientation/Identity Status					
Lesbian	unknown	unknown	unknown	unknown	unknown
Gay	unknown	unknown	unknown	unknown	unknown
Bisexual	unknown	unknown	unknown	unknown	unknown
Transgender	unknown	unknown	unknown	unknown	unknown

Limited English Proficiency
As our county consists overwhelmingly of English speaking persons of Western European descent, we have little need for expertise in cultural competency. We rely on the nearby Indiana University of Pennsylvania to assist us with language and cultural issues.

Budget Narrative
PATH funds are used to support the Housing Liaison's time used in doing outreach, assessing PATH consumer referrals, enrolling clients, and entering data into the HMIS, as well as providing assistance to help clients maintain their housing. A further breakdown of the costs associated with the PATH program is provided below:

Personnel:
The funding amount of $18,090 is being requested to provide from the full-time salary (68% of the time) of the Indiana County PATH/Behavioral Health Housing Liaison position. This position will be located at the Indiana County Community Action Program, Incorporated's office located at 827 Water Street, Indiana, PA. The housing liaison work concentrates on increasing and creating housing resources for those who are homeless or at imminent risk of becoming homeless and have a behavioral health illness.

Fringe Benefits:
The funding amount of $8,248 is being requested to provide for the full-time fringe benefits of ICCAP's Behavioral Health Housing Liaison/PATH Case Manager. Fringe benefits include the following costs: FICA ($1,405.55), Workers Compensation ($776.81), Pennsylvania Unemployment ($412.54), Health Insurance ($5568.51), Vision Insurance ($40.14) and Life Insurance ($48.45).

Travel:
ICCAP is requesting funding is requested to pay for meal and travel costs for the PATH Housing Liaison. Costs include monies for the Housing Liaison to be able to attend specific trainings on housing/homeless issues and mental health issues that are within the Mid-Atlantic region (sponsored by HUD, PHA, NAMI, etc.) to have the latest information that will assist in PATH program success. ICCAP is requesting $ 100 to pay for Housing Liaison's travel costs to attend specific trainings, Housing Task Force meetings, evaluation meetings and regional housing/homeless meetings, and $ 400 requested to pay for outreach travel to housing entities, drop-in-centers, community support programs, etc.

Other:
Other costs include the delivery of case management and support services for consumers in the PATH program; security deposits and one-time rental assistance payments for 8-12 individuals experiencing homelessness or at imminent risk at approximately $500 each, not to exceed $3000; $ 2,000 would be a one-time assistance to help consumers maintain housing and $ 1,000 for security deposits. Total request for other expenses: $3,000.00.

In addition, although Indiana County Community Action Program, Inc. (ICCAP) is continuing a PATH program to specifically expand existing housing and increase new housing programs for homeless/near homeless mentally ill individuals, currently ICCAP provides housing components providing over $ 225,740 in current supportive housing program costs and expenses for homeless and imminently homeless individuals which would include mental health individuals, of which, if openings existed, could possibly benefit PATH program eligible individuals in the future.

Indiana County Community Action Program, Inc.
FY 2017-2018 PATH Budget

	Annual	PATH-	PATH-	TOTAL

	Salary	funded FTE	funded salary	
Position				
Housing Case Manager/ Admin costs	23,278	.68 FTE	18,090.00	18,090.00
sub-total			**18,090.00**	**18,090.00**
Fringe Benefits				
FICA Tax			1,401.55	1,401.55
Unemployment			412.54	412.54
Workman's Compensation			776.81	776.81
Health Insurance			5,568.51	5,568.51
Vision Insurance			40.14	40.14
Life Insurance			48.45	48.45
sub-total			**8,248**	**8,248.00**
Travel				
Local Travel for Outreach			400.00	400.00
Travel to training and workshops			100.00	100.00
sub-total			**500.00**	**500.00**
Equipment				
(list individually)				
sub-total				
Supplies				
Office Supplies			334.00	334.00
Consumer-related items				
sub-total			**334.00**	**334.00**
Other				
Staff training				
One-time assistance to maintain housing			2,000.00	2,000.00
Security deposits			1,000.00	1,000.00
Postage				
sub-total			**3,000.00**	**3,000.00**
Total PATH budget				**$30,172**

8. Blair County - Home Nursing Agency

500 E Chestnut Avenue

Altoona, PA 16601

Contact: Kelly Williams

Contact Phone #: 8149430414

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID: PA-029

State Provider ID: 4229

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 47,087	$ 15,696	$ 62,783	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 47,087	$ 15,696	$ 62,783	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 47,087	$ 15,696	$ 62,783	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 47,087	$ 15,696	$ 62,783	

Source(s) of Match Dollars for State Funds:

Blair Co will receive a total of $62,783 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 100

Estimated Number of Persons to be Enrolled: 80

Estimated Number of Persons to be Contacted who are Literally Homeless: 15

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Blair County Human Services Office
PATH Intended Use Plan
FY 2017-2018

Home Nursing Agency
201 Chestnut Ave.,
Altoona, PA 16601
PDX: Home Nursing Agency

Local Provider Description

The Home Nursing Agency (HNA), was established in 1968 as a home health care organization. In 1975 mental health services were initiated with a Blair County contract to provide housing support and case management to residents discharged from the local state mental health institution. HNA offers a full outpatient continuum of services for adults and well as children and adolescents. In addition to behavioral health services, the agency provides home care, hospice, private duty, maternal and child services, day and community services for individuals with intellectual disabilities, WIC and Adult Day services. In 2014 HNA was acquired by the University of Pittsburgh Medical Center (UPMC) and is now a part of the UPMC system.

Quality is important to HNA in relation to providing effective and efficient services to empower individuals and families to lead a happy and healthy life. The behavioral health services that HNA provides includes Outpatient Therapy, Acute Partial Hospitalization, Blended Case Management, Resource Coordination, Certified Peer Support Services, Permanent Supportive and Transitional Housing, Mobile Psychiatric Rehabilitation, and Family Support Services. Our philosophy is co-occurring capable with a "no wrong door policy" that is person centered, recovery oriented and practices a housing first philosophy.

It is currently estimated that the PATH program will receive $62,783 during 2017-2018 via contract with the Blair County Department of Human Services. A budget table is attached and budget justification information is in this IUP. PATH funds will supplement the salary of a full-time housing case management position to ensure a housing first model is followed to prevent homelessness or shorten the length of any homeless episode. This case management position will be a full time case manager working within the PATH program. Case Management is an effective model to work within our existing housing structures to assess, screen, locate appropriate housing and assist with other needs the individual may have. We realize that ensuring a steady income and locating housing is not the end to homelessness. Individuals have many factors that play a significant role in homelessness and we work to give the individual the tools they need to be self-sustaining and successful. Funds will also supplement the salary of a Housing Manager who will provide for an increased level of customer contact, customer satisfaction and community integration of our services

Collaboration of HUD Continuum of Care Program

HNA participates in monthly RHAB meetings and PA Eastern Continuum of Care Collaborative meetings. We also work closely with and consult Diana T. Myers and Assoc. on a regular basis.

Our Continuum of Care works frequently with Department of Community and Economic Development and participate in any trainings they have to offer regarding HMIS utilization.

The PA Eastern CoC is currently working on developing and implementing our Coordinated Entry Project. Home Nursing Agency is hosting the RHAB meeting in June that will focus on the Coordinated Entry Process. Jason Alexander, CoC consultant for Coordinated Entry, will be presenting at this meeting and will be walking us through the process. As a CoC we are planning to roll out with Coordinated Entry by January of 2018.

We are an active participant of the Blair County LHOT committee and communicate regularly with other LHOT members such as SKILLS of Central PA, Blair County Community Action, Family Services of Blair County, James E. Van Zandt Medical Center and the Blair County Department of Human Services. We also work closely with the County of Blair Redevelopment and Housing Authority in conjunction with our Housing Assistance Rental Program (HARP) which is our HUD awarded program.

Collaboration with Local Community Organizations

There are no other agencies in Blair County that provide street outreach to our homeless population, we work closely with the agencies listed below to make referrals, complete assessments, and provides housing.

HNA has letters of agreement with the following community resources:

Primary Physical Health Network: There are several major physician practices within the county, including Blair Medical Associates and Mainline Medical both of which accept Medical Assistance reimbursement. Individuals without health coverage may use the free clinic operated by UPMC Altoona. PATH staff will assess the need for individuals to be linked to the physicians and nurses in these practices, based on individual choice.

Mental Health: Blair County Department of Human Services contracts with UPMC Altoona and Home Nursing Agency to provide a full continuum of care to persons with serious and persistent mental illness. In addition, the county contracts with The Skills Group for vocational and housing services and with Contact Altoona for the Consumer Satisfaction Team. Listed below are the key mental health services available to PATH participants as part of the Blair County continuum.

Community Psychiatric Inpatient	UPMC Altoona
Blended Case Management	Home Nursing Agency
	Alternative Community Resource Progam
	Nulton Diagnostic Inc.
	Cen Clear
Resource Coordination	Home Nursing Agency
Children's Blended Case Management	Home Nursing Agency
Outpatient Mental Health Psychiatric Clinics	Home Nursing Agency

	Nulton Diagnositic Inc.
	Primary Health Network
Crisis Center	UPMC Altoona
Community Employment	The Skills Group, Office of Vocational Rehabilitation & Home Nursing Agency
Certified Peer Support	Home Nursing Agency,
	PeerStar Inc.
	Cen Clear
	Alternative Community Resource Program

Individuals open with the PATH program utilize mental health case management services when appropriate and agreed upon. Operating out of the same office fosters development of well-defined working relationships and shared goals. Assurance is given to the funding source that PATH will supplement, and not supplant, the role of case management in the provision of services.

Substance Abuse: A full continuum of substance abuse services is available within Blair County. The following services and providers are available to meet the needs of individuals in the PATH program:

Residential Non-hospital Treatment	Cove Forge
	Pyramid Healthcare
	White Deer Run
Medical Detoxification	UPMC Altoona
Non-Hospital Detox	Pyramid Healthcare and White Deer Run
Non-Medical Detoxification	Pyramid Health Care
Intensive Outpatient	Home Nursing Agency
	Pyramid Healthcare
Outpatient	Meadows, Home
	Nursing Agency
	Pyramid Healthcare
Shelter/Half Way House	Pyramid Healthcare
	White Deer Run

Housing: A number of housing facilities and services exist for the purpose of providing housing for individuals receiving mental health services. Below is a listing of housing projects potentially available to PATH individuals.

Juniata House – permanent SRO	Home Nursing Agency
Blair House – transitional & permanent	Home Nursing Agency
Tyler Hall-a long term transitional SRO	The Skills Group
Tartaglio Personal Care Home	Home Nursing Agency
Twin Mountains-permanent housing	The Skills Group
Union Avenue Apartments-permanent	Improved Dwellings-Altoona
Scattered Site Apartments – HUD permanent	Home Nursing Agency

County Housing Emergency Fund	Blair Senior Services
Mental Health Housing Fund	The Skills Group
PATH Project	Home Nursing Agency

General public housing services are also provided that will be available to PATH clients:

Section 8 Program	Altoona Housing Authority and Blair County Housing Authority
Public Housing Projects	AHA and Improved Dwellings of Altoona
HUD Scattered Site Housing	Blair County Community Action
HUD Supportive Services Project	Blair County Community Action
Family Shelter	Family Services Incorporated
Domestic Abuse Shelter	Family Services Incorporated
Teen Shelter	Family Services Incorporated
Precious Life Shelter (for pregnant women)	

Employment: Several agencies offer services to Mental Health clients to promote sheltered employment, transitional employment and competitive job training and placement.

Sheltered employment	The Skills Group
Transitional employment	Home Nursing Agency
	The Skills Group
Competitive training and employment	The Skills Group
	Office of Vocational Rehabilitation
	Goodwill Industries

Service Provision

Our Housing First philosophy strongly focuses on those individuals who are literally homeless and individuals and families who are at-risk of homelessness. Most of Blair County is rural and much of our homeless population is not visible from the streets. It is our experience that more people meet the definition of imminent risk of homelessness. Staff identify and market PATH to key professionals in agencies with regular contact with the homeless, such as the Community Crisis Center at UPMC Altoona, the Blair Senior Services Housing Program, housing programs at Blair County Community Action, Blair County prison, James E. Van Zandt Medical Center and local emergency shelters. We also canvas the local Wal-Mart and other businesses that are open 24/7 for people who are homeless. We provide information for employees of these businesses to have on hand to share with individuals if they suspect that someone is homeless. Many local agencies and private organizations i.e. churches, contact our PATH program by phone regarding PATH services for their clients. PATH staff is visible in the community and services are easily accessible by all potential consumers.

HNA'S PATH program is located in the same building as our mental health and drug and alcohol programs. We are able to leverage our PATH program by referring and utilizing programs in-house, such as partial hospitalization, intensive outpatient, outpatient, adult blended case

management, adult resource coordination, certified peer specialist and mobile psychiatric rehabilitation. Individuals in our PATH program are easily referred to the necessary programs within our own organization and are even able to see the psych doctor on site. PATH staff is knowledgeable in the programs we have available and are able to refer out to other community organizations if the need cannot be met by our agency. Almost all of the individuals in our PATH program are receiving at least one if not most of the programs mentioned, so we are able to focus on housing while treating the whole individual.

The PATH Case Manager meets with individuals at emergency and transitional sites or anywhere in the community in order to engage people in service. HNA receives many telephone calls from people looking for housing and we conduct initial telephone assessments. These assessments provide enough information to determine whether the person meets criteria to become enrolled with services if they are agreeable. Once that is determined, PATH staff will schedule a face to face meeting with that person to conduct a more intense assessment and complete necessary paperwork to get the individual enrolled in services.

Blair County has kept pace with development of innovative services for individuals receiving mental health services. However, there remain some gaps in services and areas in which resources are very tight or non-existent. One significant gap is that we do not have an adequate amount of emergency shelters or transitional housing for families who are on the waiting list for subsidized housing. Shelters function at full capacity most of the time. There is only one local shelter that can take families and single males and/or females. Beds are limited and individuals are often turned away. PATH staff does attend the LHOT meetings and sit on Housing Steering Committees to look further at housing gaps in Blair County and how to adequately solve them. Another obstacle we have is the number of homeless people with no income who do not qualify for programs such as SOAR. It is difficult, if not impossible, to find housing with zero income. Although we work closely with the criminal justice system for reentry, it is very difficult to find housing for individuals with felony charges, and offenders that are registered under Megan's Law.

HNA has a "no wrong door" policy, which simply means that if someone comes through our door, via any HNA program, we will not send them away without pairing them up with the service(s) needed. We have an open access treatment center at our facility. Anyone can walk in during these hours for an intake and can be enrolled into treatment that day or the very next day. During the intake, individuals are screened for homelessness, physical and mental illness as well as drug and/or alcohol dependency. This has tremendously helped to identify homelessness or people imminently at risk of becoming homeless. Referrals may be made to multiple services, depending on the need such as PATH, a primary care physician, outpatient therapy, case management and drug and alcohol counseling, etc. Once stabilized, additional referrals are made for supportive services as needed such as peer support, mobile psychiatric rehabilitation, to assist in forward movement toward recovery for the individual.

HNA's PATH program is housed in the same building as our mental health and drug and alcohol services to ensure access to various levels of treatment. For individuals experiencing both a serious mental illness and a substance use disorder we offer: partial hospitalization, intensive

outpatient, outpatient, center for counseling, one-one sessions, and we have a psychiatrist on site for individuals to meet with.

The PATH staff is knowledgeable of co-occurring treatment and services and attended several co-occurring trainings on assessment, motivational interviewing, ethics and building on the individuals' strengths. Blair County's chapter of the National Alliance of Mental Illness (NAMI) has an office within the same building as our PATH program; our facility also hosts various NAMI programs such as Peer to Peer, Family to Family and NAMI Connections. HNA celebrates May is Mental Health Month by participating in an annual evening workshop for individuals receiving mental health services and their families. HNA also hosts an Art in Healing arts exhibit displaying artwork of individuals in services during the month of May.

Using a Housing First model, we focus on those individuals who are literally homeless or at risk of becoming homeless. Because Blair County is mostly rural, much of our homeless population meets the definition of imminent risk of homelessness. Agencies with regular contact with the homeless, such as the Community Crisis Center at UPMC Altoona, the Blair Senior Services Housing Program, housing programs at Blair County Community Action, Blair County prison and local emergency shelters are familiar with our PATH program make regular referrals to PATH. We also canvas the local businesses that are open 24/7 for people who are homeless. We provide information for employees of these businesses to have on hand to share with individuals if they suspect that someone is homeless. Many local agencies contact our PATH program by phone regarding PATH services for their clients. PATH staff is visible in the community and services are easily accessible by all potential consumers. The PATH Manager will be tasked with ensuring that all applicable local agencies are aware of the program, understand how to contact us and building bridges in the community for a continuous collaboration of service provision that maximizes the potential of the individuals in the PATH program.

HNA is currently working with our Department of Human Services to develop new evidence based practices for supportive employment and supportive housing. We are also collaborating with the Department of Human Services to access evidence based practices training and offer that to our PATH staff.

We are a UPMC company and receive technical assistance from Western Psychiatric Institute and Clinic and Mon Yough Community Services on evidence based practices, such as: Motivational Interviewing, Supportive Employment, Supportive Housing and other models of behavioral health services.

HNA is required to follow 42 CFR Part 2 regulations for our Drug and Alcohol programming. We have access to the Compliance Officer through Western Psychiatric Institute and Clinic, and we also have our own in-house compliance officer to seek guidance from.

The PATH manager is active with the Blair County Criminal Justice/Mental Health Diversionary Team that meets on a bi-weekly basis with a goal of discharging planning for clients preparing to leave the criminal justice system or those that have recently been released. There are multiple

local providers involved including representatives from the Blair County Prison and Blair County Adult Probation and Parole.

Data

HNA has been utilizing HMIS for at least 8 years for our HUD programs. We are now entering data into HMIS for the PATH program and have been since July 2013. Staff does participate in the webinars offered by DCED to remain up to date with changes to the system.

HNA has been utilizing HMIS for the last 8years. In 2016 PATH staff and manager attended an on-site training for HMIS technical assistance and are educated on new definitions and reporting measures. We also learned how to utilize the HMIS system to our benefit for more than just annual reporting, and plan to begin using the system for collecting all PATH data and information to keep a working client file in that system. All PATH staff will be knowledgeable in HMIS and have the ability to enter data and run reports. Staff will participate in all available trainings, ensuring that we stay up to date on new definitions and reporting measures.

HNA is in the discovery phase of Psych Consult which will be our Electronic Medical Records system. We have had brief conversations with our own technology department and our HMIS state contact, and it was decided that it is too costly to interphase an EMR with the HMIS system. As a result, we would have PATH complete double entry into our EMR once it is available and also into PA HMIS system.

Alignment with PATH Goals

HNA's PATH program serves our most vulnerable populations. Our goal is to reduce or eliminate homelessness for individuals in the Blair County Mental Health system who are experiencing severe and persistent mental illness and or substance use disorders. Our PATH staff strive to meet individuals where they are, not only in terms of physical local but where someone is on their path to recovery. HNA's PATH staff are located in the same building as our mental health and drug and alcohol services allowing us quick and efficient access to treatment for our individuals experiencing homelessness or who are at-risk of homelessness. We are able to work collectively with Blended Case Managers and Resource Coordinators to help homeless individuals' secure safe and stable housing while assisting to improve their health and live a self -directed and purposeful life.

HNA believes in treating the whole person and not just a mental health issue, which is why we implemented our Behavioral Health Home Plus Expansion (BHHPE) in 2014. This is a program that is designed to assist individuals in eight dimensions of wellness. We have case managers, peer specialists, counselors and housing staff trained in wellness coaching. The BHHPE has a wellness nurse/health navigator that provides support and resources for the wellness coaches. Our HUD Housing Case Manager is also trained as a wellness coach and can provide assistance when necessary to the PATH Housing Coordinator.

HNA'S PATH program goal is to increase access to permanent housing. We have a HUD funded permanent housing program within our own agency's continuum of care that we can refer

PATH individuals to that meet the HUD definition of homeless and who are Chronically Homeless. Our PATH case manager works closely with individuals to first meet their housing and basic needs. Once housing is attained, we assist individuals with employment. We can refer to various employment programs in the Blair County system such as the Skills Group, the Office of Vocational Rehabilitation, Goodwill Industries and Career Link. Staff also assist with obtaining, completing and submitting applications to employers. We are in contact with our local DPW office who regularly provide us with a list of businesses that are hiring. Staff also work closely with our Criminal Justice system, who also can provide a list of employers that will hire individuals who have a criminal record that are a difficult population to find employment for.

PATH staff regularly refer individuals to our Certified Peer Support program who will assist with setting and achieving goals surrounding social supports. We can offer referrals to our Lexington Clubhouse, a psychiatric rehabilitation program that focuses on skill teaching, education and employment. HNA has a small social rehabilitation program offered once a week.

Alignment with State Mental Health Services Plan

HNA collaborates with the Blair County Department of Human Services when developing the County Mental Health Service Plan. Blair County DHS includes all of our housing services, including PATH into the Mental Health Plan. The PATH Housing Supervisor also attends public hearings when they are offered regarding the County Plan.

Alignment with State Plan to End Homelessness

HNA PATH program is aligned with the State Plan to End Homelessness. We participate in the Eastern PA Continuum of Care whose primary goal is to end homelessness throughout the CoC. We are working to reduce the number of people experiencing homeless through engagement and enrollment in our PATH program. PATH staff are also working to decrease the length of time homeless, reduce the returns to homelessness, reduce the number of first time homeless, and increase exits to permanent housing.

PATH Housing Supervisor is a member of our local Disaster Crisis Outreach and Referral Team (DCORT). We also hand out the Pennsylvania Emergency Preparedness Guide to all individuals coming in for services, including anyone we come into contact with through our PATH program. The PATH Housing Supervisor and HUD Housing Coordinator have recently been trained in Blair County's Smart 911 program and are working with individuals in the PATH and HUD programs to get enrolled with a profile in the event of an emergency or disaster.

Our CoC is striving to increase participation in the HMIS system and by doing so, increasing the successful placement in or retention of permanent housing. PATH staff are educated on these goals and are monitoring them year round to ensure quality outcomes.

Other Designated Funds

At this time, HNA is not aware of any other designated funds specifically for serving people experiencing homelessness and have a serious mental illness. We do not currently have any Mental Health Block Grant or Substance Abuse Block Grant that HNA utilizes.

Programmatic and Financial Oversight

HNA sends monthly invoices to Blair County Human Services Offices for review. HNA and the County hold regular monitoring meetings with the finance departments.

SSI/SSDI Outreach, Access and Recovery (SOAR)

HNA plans to have the PATH Housing Coordinator complete the online SOAR training in 2017-2018 along with HNA's HUD Housing Coordinator. Once trained, our PATH Housing Coordinator will be primarily responsible for the screening of individuals to determine eligibility for SOAR and then to assist in the development of an application.

Housing

Providing a Housing First Model of case management services is the main objective of the HNA's PATH project. HNA's Blair House and Skills Inc.'s Tyler Hall are both SRO facilities that have the capacity to welcome a homeless individual and provide for personal care items and emergency food if needed. The priority at each facility is to first provide shelter and second to arrange for supports such as case management and treatment services. From there, the PATH case manager will assist individuals with locating, securing and maintaining permanent housing. HNA's HARP (Housing and Rental Assistance Program) is a great resource for PATH staff. The HARP program provides permanent apartments on a scattered site basis with subsidies from HUD.

Permanent Housing is available for homeless mentally ill persons at the Skills Group Twin Mountains Apartments (2 facilities, totaling 16 beds) and Union Avenue Apartments (11 beds). The Home Nursing Agency provides apartments at Blair House (8 units). These buildings are designated for individuals receiving mental health services and offer single bedroom apartments. Single room occupancy permanent housing is offered at Juniata House by Home Nursing Agency (7 beds). This is a facility for homeless individuals in the mental health system that are literally or chronically homeless. Another HUD funded program, HARP, currently is providing rental subsidies to 23 individuals and families in scattered site apartments.

PATH staff access permanent housing when available and appropriate. The PATH project staff work with individuals during the time they are homeless, through any of the various levels of housing, and into the period of permanent housing occupancy. Once in permanent housing, PATH staff can work with people on the necessary skills to maintain that permanent housing. The PATH coordinator is trained in the Prepared Renters Education Program (PREP) offered through our Regional Housing Coordinator. This program educates individuals on becoming

good, long term tenants. The PATH staff is in a position to facilitate this permanent "housing first" approach.

Blair County PATH operates with the philosophy that housing should be separate from treatment. The project will advocate with housing providers to offer housing without requirements for treatment as a contingency to access housing. We believe that safe, secure and affordable housing can be the first step toward recovery for people experiencing mental illness.

The public mental health system can sometimes be fragmented and PATH services can serve to assist individuals in accessing case management services and needed treatment in the Blair County Mental Health system. The PATH program can connect individuals into the behavioral health system where they would otherwise not access needed services.

Housing projects within the system, like private landlords, are wrestling with the issues of drug abuse, intoxication, drug induced acting out, illegal behavior and disturbances of the peace. HNA staff continues to seek ways to help individual's access treatment and avoid the harmful physical, emotional, social and legal consequences of abuse and addiction. PATH staff is working with our Local Housing Options Team (LHOT), which should lead to more housing options for individuals with co-occurring disorders.

PATH staff also sit on the Housing Roundtable of Operation Our Town, this gives us access to private landlords that we otherwise may not have an opportunity to interact with. We have made positive connections with potential landlords are able to educate them on the benefits of renting to someone in services who may have a mental health diagnosis.

PATH staff works with individuals to assist them in becoming good tenants and understanding an appropriate landlord/tenant relationship. We review leases with individuals to ensure that they understand what they are signing and what they are agreeing to with this document.

Coordinated Entry

Blair County does not currently have a coordinated entry program. HNA currently participates in monthly CoC meetings that are primarily focusing on developing and implementing a coordinated entry system. The official planning meeting for our RHAB is in June 2017 and will be hosted at HNA. Our CoC is on track to roll out with a Coordinate Entry Program in January 2018.

Justice Involved

HNA's PATH staff participate in the Blair County Criminal Justice/Mental Health Diversionary Team Meeting. This group meets bi-weekly and is comprised of various community service providers: Adult Probation and Parole, Blair County Department of Human Services, Blair County Prison, Home Nursing Agency Case Management and Primary Health Network. This is a great opportunity for our PATH staff to collaborate with other treatment providers and the criminal justice system to find ways to best serve our justice involved individuals. Through this meeting we have been able to communicate with Probation and Parole and be able to prevent

someone from going back to jail just for the sole purpose of not having an address. Currently about 85-90% of the people we serve in PATH have a criminal history and benefit from the relationships we have developed through these meetings. PATH staff also participate in the Criminal Justice Advisory Board's Housing workgroup, where our main focus is re-entry and diversion for this vulnerable population.

Staff Information

The PATH staff is comprised of one Caucasian male Housing Coordinator and one Caucasian female Housing Supervisor. All PATH staff participated in cultural competency training, limited English proficient training and person centered training. PATH staff understand the importance of considering one's cultural or personal preferences when providing services and locating housing. HNA continues to look for another training to build upon what we have learned. We are working with our Management Information Systems (MIS) staff to ensure that we have the ability to change languages on our documentation forms when needed through our software programs.

Client Information

HNA has served the mental health population of Blair County for the past 49 years. Blair County has a population of about 124,650, primarily Caucasian (95%) and Black or African American (2%), Two or more races (1.3%). The mental health population mirrors the racial breakdown of the county. Rarely do we encounter a person in need of mental health services who does not communicate in English; local professionals are available should a translator be needed. Additionally our staff is reflective of the demographics of the area. The primary cultural diversity of the area is a large rural population surrounding the City of Altoona.

About 10% of PATH individuals we worked with this past fiscal year met the definition of literally homeless. Blair County is an extremely rural area, and we do not have the visible "street" homeless that a bigger city may have; our homeless population is primarily people living doubled up with family or friends. HNA does anticipate an increase from the 10% of literally homeless, because we are now staffed at full capacity and will be able to identify and contact more people.

HNA expects an increase in the number of adult individuals to be served due to the PATH Housing Coordinator being fully trained in PATH and homeless definitions and being mor equipped to assess and identify individuals that are homeless or at-risk of homelessness. HNA projects to contact 100 individuals and enroll 80 into our PATH program based on the economic situation of our area.

Consumer Involvement

HNA has a long history in behavioral health of providing opportunities for individuals receiving services to be involved in planning, implementation and evaluation of services. In July of 2008, HNA implemented a Certified Peer Support Program. The Peer Specialists use their personal

experience to provide support and guidance to individuals who are going through the recovery process. One of our Certified Peer Specialists was promoted to a housing management position.

PATH staff has received training in consumer and family involvement with services and PATH activities. PATH staff is involved with the local CSP committee and attend their meetings regularly. This committee is essential in determining the direction for current and new services in our continuum of care.

Blair County and Home Nursing Agency continues to enlist consumers and family members to participate as members of the LHOT. As LHOT members work with individuals who are receiving services or their family members, staff will approach them concerning participation. Satisfaction surveys will be completed twice yearly by all active PATH clients. Surveys are reviewed carefully to contact PATH consumers regarding any input that they would like to provide for the program.

Individuals receiving services and family members are represented on the Home Nursing Agency Behavioral Health Advisory Committee. This committee welcomes the involvement of PATH individuals and families as opportunities are presented. Many individuals have benefits for behavioral health services through Blair County's MCO, Community Care Behavioral Health Organization. This organization leads quarterly stakeholder meetings and we encourage individuals to attend these meetings to have their voice be heard.

Health Disparities Impact Statement

PATH services are provided in a rural area that is not very culturally diverse. PATH staff do complete a thorough assessment on each individual. We have not yet encountered anyone who would require language services, but we do have the ability to access translators or sign language interrupters. Staff coordinates with the Fair Housing Coordinator for the City of Altoona to make sure that individuals are not discriminated against based on race, ethnicity, gender, LGBTQ, and age. We have received training on Fair Housing and are aware of what to look for to ensure housing is available for all who need it. HMIS will be utilized to measure, track and respond to these disparities.

HNA PATH program expects to assist at least 5 unduplicated Transitional Age Youth based on our last fiscal year reporting. Our PATH program is available for any adult 18 years of age and older, capturing the TAY. HNA offers an entire continuum of care for children and adolescents, and we receive many referrals from Children's case managers for the TAY age group. PATH staff are in contact with the Homeless Coordinator for all of the school districts in the Blair County service area, and their staff have our contact information should they come across a homeless Transition Age Youth. We work closely with Family Service Inc., who runs our local Teen Shelter and meet and assess with referrals from there on a regular basis.

At this time, HNA does not have a particular dollar amount set aside specifically for Transitional Age Youth, however it is in our Policy and Procedures that we cannot serve anyone under the age of 18 in our PATH program at HNA. PATH staff has a close working relationship with

Family Services of Blair County, who operates our local Teen Shelter, who can identify homeless individuals, over the age of 18 that still fit into the TAY category.

The HNA PATH program does not currently provide services that are funded specifically for TAY individuals. We plan to collect and monitor data over the next fiscal year on the TAY that we come in contact with through our PATH program, to determine what strategies we need to implement to decrease the disparities in access, service use and outcomes for this population.

Limited English Proficiency

PATH services are provided in a rural area that is not very culturally diverse. PATH staff do complete a thorough assessment on each individual. We have not yet encountered anyone who would require language services, but we do have the ability to access translators or sign language interrupters.

Budget Narrative

Personnel:

The Case Manager is a FT position integral to the success of PATH. This will increase the ability of our PATH program to do more with a higher number of individuals. The Housing Manager will supervise the Case Manager and provide for an increased level of PATH services that we have not been able to provide in the past. This manager position can assess and screen individuals for services and provide any initial service needs. The Manager will be able to coordinate effectively with county stakeholders in housing connected to PATH and ensure that our services are utilized and are effective and efficient.

Fringe Benefits:

Total for benefits is budgeted at $10,532 of the personnel expenses.

Travel:

Staff are reimbursed at .54 per mile, which we anticipate spending $900 for travel in the fiscal year.

Supplies:

Our office supply cost is minimal and we approximate rent of $1320 for the year for office space for the PATH program.

Equipment:

PATH will provide for 2 smart phones for the PATH staff at $50 per month each. Record retention is the cost of preserving records per HIPAA regulations for the PATH program. Laptop expense for new staff for employer requirements and HMIS data entry.

Other:

We anticipate receiving much training through Western Psychiatric Institute and Clinic and paying some registration fees for these trainings. Rental Assistance and Security Deposit payment will be made within applicable PATH allowances to assist individuals in a quick turnaround time period from near homeless or homeless to having permanent housing. Often, the initial payment for rental is too high for many individuals to afford.

Total Federal PATH Allocation $67,783.

Blair County
Home Nursing Agency
PATH Program
FY 2017-2018 Budget

*Please add additional rows as necessary

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**PATH TOTAL**
Position				
Housing Coordinator	27,885	1	27,885	27,885
Housing Supervisor	39,975	.31	12,392	12,392
sub-total	67,860	1.31	40,277	40,277
Fringe Benefits				
FICA Tax	5191		3081	3081
Health Insurance	12,554		7451	7451
Retirement				
Life Insurance				
sub-total	17,745		10,532	10,532
Travel				
Local Travel for Outreach			900	900
Travel to training and workshops				
sub-total				
Equipment				
Cell phone			1200	1200
Record Retention				
Books, dues				
sub-total				
Supplies				
Office Supplies				
Rent for Office Space			1320	1320
Consumer-related items				
sub-total				
Other				
Administrative Expenses			8,544	8,544

Staff training				
One-time rental assistance				
Security deposits				
sub-total				
TOTAL				
Total PATH Budget				62,783

9. Bucks County - Penndel Mental Health Center

1517 Durham Rd

Penndel, PA 19047

Contact: Keith Smothers

Contact Phone #: 2157509643

Has Sub-IUPs: No

Provider Type: Other mental health agency

PDX ID: PA-003

State Provider ID: 4203

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 51,680	$ 17,227	$ 68,907	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 51,680	$ 17,227	$ 68,907	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 51,680	$ 17,227	$ 68,907	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 51,680	$ 17,227	$ 68,907	

Source(s) of Match Dollars for State Funds:

Bucks County will receive a total of $68,907 in total federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 175

Estimated Number of Persons to be Enrolled: 130

Estimated Number of Persons to be Contacted who are Literally Homeless: 70

Number staff trained in SOAR in grant year ending in 2017: 2

Number of PATH-funded consumers assisted through SOAR: 2

Penndel Mental Health Center
PATH Intended Use Plan
FY 2017-2018

Local Provider Description

Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

The contracted agency for the Bucks County PATH program is Penndel Mental Health Center (PMHC), which is located at 2005 Cabot Blvd West, Suite 100, Langhorne PA 19047. PMHC is a non-profit agency that provides a continuum of mental health clinical and support services to individuals who reside in the southern region of Bucks County.

The address as listed in the PATH PDX:

Penndel Mental Health Center
2005 Cabot Blvd West
Suite 100
Langhorne PA 19047.

PATH will receive 68,907.00 in federal and state funds for fiscal year 2017-2018.

Collaboration with HUD Continuum of Care (COC) Program

Describe the organization's participation with local HUD Continuum of Care (COC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care Briefly explain the approaches to be taken by the agency to collaborate with the COC(s) in the areas where PATH operates.

The PATH program is a member of the Housing Continuum of Care of Bucks County (HCoC-BC) and as is represented on a number of subcommittees including the Local Housing Option Team, Data Management, SSI/SSDI Outreach Access and Recovery (SOAR), and the yearly Point-in Time homeless count. PATH is also a participant with the county coordinated entry and assessment for those in housing crisis, known as the Bucks County Housing Link.

Collaboration with Local Community Organizations

Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH eligible individuals, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

The community organizations that provide key services to eligible PATH individuals are as follows:

Mental Health Services

- Penndel Mental Health Center- Housing, supported residential, outpatient, partial hospital, case management services, Community Treatment Team and peer support services
- Northwestern Human Services of Bucks County- MH CRR and SLP residential programs and case management
- Lenape Valley Foundation- supported residential housing, outpatient, partial hospital, case management, crisis intervention
- Family Services Association of Bucks County- outpatient, case management, emergency shelter, and housing for individuals who have HIV
- Penn Foundation- Village of Hope (MH/D&A transitional housing)
- Brooke Glen Hospital- Inpatient psychiatric services
- Horsham Clinic- Inpatient psychiatric services
- Lower Bucks Hospital- Inpatient psychiatric services
- Mental Health Association of Southeastern PA. – Peer support

Housing and Shelter

- Bucks County Emergency Homeless Shelter
- Bucks County Housing Group
- Advocates for the Homeless and Those in Need- Code Blue Shelter
- A Women's Place- Domestic violence shelter
- Sunday Breakfast Mission- Men's homeless shelter in Philadelphia
- America's Best Value Inn – Motel that is used for emergency shelter, 1-3 nights
- Bucks County Opportunity Council- Rapid rehousing, Tenant Based Rental Assistance, Contingency funding and Housing /Clearinghouse
- Framar Rooming House- SRO housing
- Recovery House Association

- Synergy Project – Focus on homeless youth

Substance Abuse Treatment

- Aldie Counseling Center
- Livengrin
- Gaudenzia House
- Pro-Act/Southern Bucks Recovery Community Center
- Bucks County Drug and Alcohol Commission
- Penn Foundation Village of Hope

Other Community Agencies and Programs

- Hope for Veterans
- VA Homeless Outreach Team
- Bucks County AAA- Works with elderly individuals
- Bucks County Assistance Office- Health insurance, food stamps
- Bucks County Children and Youth- Child protection and advocacy
- Salvation Army-Community action agency
- Catholic Social Services- Community action agency
- Reach Out Foundation of Bucks County- Peer run recovery support and drop-in center
- Social Security Administration

The PATH program works in close collaboration with the above providers and agencies. The vast majority of agencies that we work with also members of the Housing Continuum of Care-Bucks County, which is a stakeholder group working towards the prevention and elimination of homelessness throughout Bucks County. The ultimate goal is for all residents to live in adequate housing and achieve economic self-sufficiency. PMHC maintains service linkage agreement letters with all of these agencies regarding service coordination and collaboration.

On example of strong collaboration between agencies is the work that PATH has done with the Bucks County Opportunity Council (BCOC), local law enforcement, and the Bucks County Department of Mental Health/Development Programs to assist the residents of several homeless encampments to move into either permanent housing or supported housing in addition to connecting these individuals to benefits. The PATH program was able to provide outreach and gather the information necessary for these individuals to determine what BCOC was able to offer in terms of housing and supports. One goal for the upcoming year is to develop a protocol working with the Bucks County Opportunity Council and local law enforcement to address other encampments.

The PATH program has also worked very closely with Advocates for the Homeless and Those in Need in providing case management support for their code blue shelter program. On nights when code blue is called and shelter is open PATH has provided a case manager to work with the individuals that are at the shelter for the evening. Often this is an opportunity to assist shelter guests with gathering and completing paperwork for entitlement programs, health insurance, food stamps, and Social Security benefits.

Service Provision

Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless.

As stated in the PATH FOA, the goal of PATH is as follows:

"The goal of the PATH program is to reduce or eliminate homelessness with individuals with serious mental illness or co-occurring serious mental illness and substance abuse disorders who in imminent risk of becoming homeless"

The Bucks County PATH program is in alignment with the above in that the program is focused on reaching out to those in the community who have severe and persistent mental illnesses who are homeless or in imminent danger of becoming homeless. The PATH program meets the individuals where ever they are, be it an encampment in the woods, an abandoned building, their car, etc. PATH utilizes motivational interviewing skills which meets the person where they are regarding their readiness to change behaviors or situations that might prevent their success in being housed. Often this approach creates trust and tends to minimize the resistance that might be encountered. Once individual is identified as meeting PATH eligibility criteria, the PATH team can provide linkage to emergency housing, assistance in acquiring benefits, debt counseling, legal counselling, mental health and substance abuse treatment, and health care and employment supports. The primary goal of PATH is to assist the client in obtaining the resources required to live in the housing of their choice and reduce barriers to housing by assisting with the acquisition of income, benefits and advocating for the client.

Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services.

For the past 10 years the PATH program has been able to obtain funding through United

Way's Emergency Food and Shelter Program, and generally received grants for between $2,000.00 to $15,000.00 dollars to provide funding for emergency housing, security deposits, and one-time funding to prevent eviction. In the fall of 2016 MH/DP released MH Reinvestment Plan that provides TBRA and contingency funding. PATH has also been able to support individuals to access these resources under the BCOC MH Housing Program.

Gaps that exist in the current service systems.

One of the primary gaps in the system is the continued lack of affordable housing. Most individuals present with minimal income and even when PATH is able to secure an income through the use of SOAR, the resulting award isn't enough to sustain an apartment in Bucks County. The frustration is that PATH may be able to assist an individual through Rapid Re-Housing funding to get them housed with rental assistance in place, but this is time limited and at times only lasts 6 months. The need for strong service collaboration between housing and behavioral house supports with an intensive focus on self-sufficiency is needed. Unfortunately without this at the end of those 6 months if the client cannot pay the rent on his/her own they may end up returning to homelessness. Section 8 Housing Choice Vouchers are a potential long-term resource, but it can be several years before an applicant receives a voucher. Currently the Section 8 waiting list is closed in Bucks County and this creates a significant gap between the need and the available resource.

Another gap is the limited capacity of our current shelter. Regardless of season PATH workers anticipate a 6-8 week wait before a bed becomes available. This does not meet the truly crisis nature of emergency shelter for many in Bucks County. Again, a single male only shelter is a reported need in Bucks County.

Serving TAY has been a challenge. TAY typically do not want to stay in a shelter and they often lack any income or benefits at onset of engagement.

> Brief description of the current services available to clients who have both a serious mental illness and a substance abuse disorder.

In terms of housing there is the Village of Hope run by Penn Foundation which is a residential program for dually-diagnosed individuals. The program has a total of sixteen beds, 8 male, 8 female. There are also a number of substance abuse treatment agencies within Bucks County, but coordination with mental health and housing supports remains an area to strengthen. Access to the MH Residential programs remains an option for eligible persons, but coordination of MH and separate D&A services can be difficult.

How the local provider agency pays for providers or otherwise supports evidenced based practices, trainings for local PATH funded staff, and trainings and activities to support collection of PATH data in HMIS.

PATH case workers are required to have 20 hours of training annually. Some examples include evidenced-based training in areas of cultural competence, trauma informed care, co-occurring disorders and supported employment. The county contract with PMHC PATH program includes an allocation for these trainings. In terms of HMIS, the County has a HMIS lead who will conduct trainings and provide support as needed.

Please provide information on whether or not your agency is required to follow CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

At present PMHC does not follow CFR Part 2 regulations.

Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities, and other supports (e.g., jail diversion, active involvement in re-entry, OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g., jail diversion, active involvement in reentry)

At present PATH works with Bucks County MH/DP and the State Department of Corrections and local prisons in helping inmates transition back to the community. Once a client is identified for release and as having a mental health diagnosis, PATH is contacted and a plan is put in place to transition the individual back to the community. The case manager will assist the individual in reinstating benefits, locating housing, and coordinating treatment services. Significant barriers encountered with supporting this population is that not only is there the challenge of a criminal history to overcome, but many of these individuals also have poor credit histories. PATH hopes to collaborate with the Legal Aid of Southeast PA for assistance and guidance regarding criminal record expungements.

Data

Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For providers who are fully utilizing HMIS describe plans for continued training and how providers will support new staff.

The PATH program at Penndel Mental Health Center is putting all data into HMIS. Most training has been provided by the DCED and Bucks County has an HMIS lead as well who provides support and training as needed.

Alignment with PATH goals

Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximized serving the most vulnerable adults who are literally and chronically homeless

The Bucks County PATH program is in alignment with PATH goals in that the program's focus is outreach to those who have a severe and persistent mental illness or co-occurring substance abuse disorder and are homeless or in imminent danger of becoming homeless. The Bucks County PATH program continues to cultivate and expand their network of providers and provides services designed to help overcome the barriers to homelessness by linkage to emergency housing, assistance in the acquisition of health insurance and Social Security benefits, as well as linking individuals to substance abuse, physical health and mental health treatment. Additionally, more generic community resources are utilized to assist individuals to obtain and maintain affordable housing by utilizing resources such as local churches, furniture and food banks.

Alignment with State Comprehensive Mental Health Services Plan

Describe how to services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans

The PATH program, in serving an extremely vulnerable population is designed to be easily accessible. There are few barriers to program participation, with the only requirements being that the individual be homeless or in imminent danger of becoming homeless and have a mental illness or co-occurring substance abuse. The PATH program provides services such as, case management, outreach, benefits acquisition, and emergency housing. The program emphasizes outreach to individuals, meeting them in the community PATH works as an advocate for the homeless individual by assisting in the acquisition of benefits such as Social Security and utilizing the SOAR program to accomplish this goal. PATH also does "in reach" to organizations that may be in contact with homeless individuals and can serve as sources of referral for individuals who might not otherwise come into contact with PATH outreach workers.

Alignment with State Plan to End Homelessness

Describe how the services to be provided using PATH funds are consistent with the state plan to end homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster

preparedness and emergency planning and to the continuity of care planning, and a process for updating and testing emergency response plans.

PATH is in alignment with the State Plan to End Homeless in that again PATH emphasizes outreach and case management to individuals who have a mental illness, co-occurring substance abuse and who are homeless or in imminent danger of becoming homeless. PATH helps the client by assisting them with overcoming the barriers to obtaining housing such as lack of income, poor credit, criminal background, lack of mental health and substance abuse treatment. PATH advocates for individuals who are homeless and collaborates with a network of community agencies to assist the client in finding housing of his/her choice.

With regard to emergency disaster and emergency planning and preparation, during an emergency PATH would follow the lead of the County Emergency Management Team and comply with the protocols established by the County. The County has established a series of trainings with regard to Disaster and Emergency Planning and PATH personnel will attend these trainings as they come available.

The Bucks County Department of MH/DP continues to have an identified staff who participates in both the Pennsylvania Department of Human Services Emergency Behavioral Health Program (DHS EBH) and the Southeast Pennsylvania Health and Human Services Recovery Task Force (SEPA HHS RTF). Bucks County has announced an upcoming training, Skills for Psychological Recovery to the PATH program staff. The date if this free training is June 21-22 in the Southeast Region of PA. As additional trainings in this area will be promoted with the PATH program.

Other Designated Funds

Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, and general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

PMHC PATH program does receive additional State and county funding. This is further outlined under the budget section of this plan.

Programmatic and Financial Oversight

In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds

The MH/DP Department fiscal oversight includes reviews of annual budgets for contract development and the annual intended use plan, claims submission for payment, quarterly

expenditure reports, and audited financial reports. MH program staff meet bi-monthly with the PATH program to review caseloads and discuss challenges and needs.

SSI/SSDI Outreach, Access, Recovery (SOAR)

Describe your (providers's) plan to ensure the PATH staff have completed the SOAR Online Course and which staff plan to assist individuals with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR on Online Application Tracking (OAT) system. For the grant year 2016 – 2017, include all of the following data:

The number of staff trained in SOAR
The number of staff and provided assistance with SSI/SSDI applications using the SOAR model.
The number of individuals assisted through SOAR
Application eligibility results (i.e., approval rate on initial application, average time to approve the application)
The number of staff dedicated to implementing SOAR, part and full-time.

At present all three PATH staff are trained in SOAR. Two staff have provided assistance with SOAR applications in this current fiscal year. Two individuals have been assisted with SOAR and both their applications were approved. The average time to approval was 38 days. When the one FTE vacancy is filled this staff will be required to take the on-line SOAR training.

Housing

Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided in the name of the agency).

Once a PATH case manager has engaged with an individual, the PATH worker will do an assessment of the individual's situation to ascertain what residential or housing options might be most suitable. PATH will typically request the individual calls the Bucks County Housing Link, which is the county's centralized intake and referral for those experiencing a housing crisis. The PATH case manager will then work with the individual and Housing Link partner agencies to locate housing, which may be emergency housing at a shelter, application for Rapid Re-Housing, subsidized housing through HUD, or rental assistance through other county programs. If the individual is in need of and agrees to a MH residential or supported living program, a referral will be made to a Community Residential Rehabilitation or Supported Living program. In some cases PATH has assisted individuals with placement into Personal Care Boarding Homes. PATH also uses short term placements, such as a motel as a bridge to a more permanent housing situation, which is typically no more than three days. Below are several agencies and providers of housing are as follows:

- The Bucks County Emergency Homeless Shelter

- The Lenape Valley Foundation Acute Respite Care Program
- The Penn Foundation Village of Hope
- Recovery Houses
- MH/DP CRR and SLP programs
- Americas Best Value Inn
- Bucks County Opportunity Council
- Bucks County Housing Group
- Private Landlords

Coordinated Entry
Indicate if/how the organization is engaged with the local coordinated entry processes of your CoC. Please also describe the roles of key partners in the CoC

The PATH program works very closely with Bucks County's coordinated entry program, The Bucks County Housing Link. Residents experiencing homelessness or a housing crisis may contact the Housing Link via a 1-800 number. The Housing Link staff screen all callers with a brief interview to determine the households general eligibility for housing assistance. The results are then entered into the Housing Link centralized referral database and an in person assessment will be scheduled at the nearest regional assessment center. During the in person appointment, the level of housing assistance needed to resolve the crisis is determined and referral will be made to available resources and housing options. Agencies involved in the Housing Link include the Family Services Association, the Bucks County Housing Group, the Bucks County Opportunity Council, and Keystone Opportunity Council.

Additionally, PATH also supports the Housing Link assessment process by completing the required vulnerability assessments in the field and forwarding this information to the assessment center. This is often needed as a homeless individual may not have transportation or even a reliable telephone where they can be contacted. One recent change to the assessment process has been for the availability of open access hours for individuals who have difficulty with planning and keeping appointments. Overtime the Housing Link partners anticipate seeing a decrease in the drop off rate of engagement following the initial assessment.

Justice Involved
Please indicate if Crisis Intervention Team training is being used in your County/joinder. If so, please provide approximate percentage of law enforcement that has been CIT trained and any feedback on effectiveness.

The Bucks County CIT Task Force has trained nearly 50% of all law enforcement throughout the county. Bucks County was chosen to participate in study completed by University of Pittsburgh on the effectiveness of Crisis Intervention Team (CIT). The results of the study showed that

Bucks County CIT officers are less like to have a criminal justice disposition and CIT officers are less likely to use force in calls that involve individuals with a mental illness. This training initiative began in 2009.

Staff Information

Describe the demographics of staff serving the clients.
Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients.
Discuss the extent to which staff are receptive to differences of clients. Identify the extent to which staff receive periodic training in cultural competence and health disparities.

The PATH staffing is consistent with client demographics and consists of a 44-year-old Caucasian male, a 47-year-old Caucasian female, and a 58-year-old African-American male. Both of the PATH case managers are certified peer specialists who have experienced homelessness. In keeping with PMHC policy, all individuals are to be treated with dignity and respect and all Penndel Mental Health Center employees have been given training in trauma informed care. PATH case managers are required to have 20 hours of training annually which will include training in cultural competence and health disparities. A number of recovery focused trainings are available in Bucks County throughout the year and are free of charge. In June 2017 the county is hosting a one day training focused on serving the LGBTQI community, which is also available to all PATH staff.

Client Information

Describe the demographics of the client population.
Projected number of adult clients to be contacted.
Identify the expected number of clients to be enrolled.
Give estimated percentage of adult clients served using path funds to be literally homeless.

In terms of demographics the vast majority of PATH participants are Caucasian, with the percentage being 84%, African-Americans make up 18%, with 12% being Latino. Women make up 63% of participants, men 37%. In terms of age, 31-40 33%, 41-50 44%, 51-61 28%, those under 30 12%, and those over 62 6%. We anticipate contacting over 175 individuals in the upcoming fiscal year, we hope to enroll between 120-140 individuals with 30-50 presenting as literally homeless.

Consumer Involvement

Describe how individuals who experience homelessness have serious mental illnesses, and family members will be meaningfully involved organizational level in the planning, implementation, and evaluation of PATH funded services. For example, indicate whether

individuals who are PATH eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix 1 "Guidelines for Consumer and Family Participation".

Penndel Mental Health Center has a Board of Directors that includes a member with mental illness and also includes family members of individuals who are receiving behavioral health services. The Board is regularly apprised of the activities of the PATH program. Two of the PATH case managers are certified peer specialists and use their lived experiences to better serve PATH clients. PATH is also a member of the Bucks County Community Support Program and chairs a subcommittee on homelessness. The goal of this subcommittee is to improve coordination and communication between agencies providing outreach and referral of homeless individuals to the Housing Link. Sub-committee members, by providing feedback on the HL process have been able to improve and streamline the process of moving homeless individuals from the street into safe stable housing. These changes have resulted in improved communication to the applicant and the referring agency. One of the goals for this upcoming year is to have a landlord forum, where behavioral health organizations and currently supportive landlords can engage and educate prospective landlords. This is being done in an effort to broaden our landlord base and increase those willing to provide rental opportunities to individuals supported by PATH and other behavioral health providers.

Health Disparities Impact Statement

Please identify efforts to support the Transition Age Youth disparity population by providing the following:

The unduplicated number of Tay individuals who are expected to be served using PATH funds.

The total amount of PATH funds expected to be expended on services for the Tay population.

The types of services funded by PATH that are available for Tay individuals

A data driven quality improvement plan that implements strategies to decrease disparities and access, service use, and outcomes both facilitate population and in comparison to the general population.

At present in the current fiscal year PATH has served 8 TAY individuals, or about 8.5% of the total. It is expected that PATH will spend 8 to 9% of its funds on TAY individuals. The types of services and programs available to TAY who access the PATH program are the same as any service provided adults. Currently PATH does not specifically seek out the TAY population and serves them alongside the adult population. As it is with the adult homeless population, the most difficult aspect of serving them is often finding them. PATH has developed relationships with community organizations and law enforcement to help in identifying the locations where the homeless youth might be. This strategy of "in reach" has allowed PATH to serve those whom we

might not otherwise know about. In the future PATH hopes to work more closely with organizations that serve youth such as the Synergy Project that works with homeless youth in the county and the Valley Youth House which offers a dedicated shelter for homeless youth and runaways.

In the past few years Bucks County has focused on the TAY population and developed several programs focused on serving the needs of the TAY population. One is a TAY shared living program developed in collaboration with the Bucks County Housing Group. There is The TIP (Transition to Independence Program) which provides services to youth between the ages of 16 and 26, and helps them build upon their strengths. In addition the county CRR program has set aside 9 beds specifically for TAY individuals.

Limited English Proficiency

Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please access the extent to which language assistance services are necessary in your grant program by utilizing the HHS guidance to federal financial assistance recipients regarding title VI prohibition against national origin discrimination affecting limited English proficient persons, available at Https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-I/index.html/language=es.

Penndel Mental Health Center keeps a list of employees who speak various languages to assist in case there is a client who does not speak English, in addition Penndel Mental Health Center has access to translation services in the event we need to serve a non- English speaking client.

The Bucks County Department of MH/DP contracts with Magellan Health Services, Inc. for our HealthChoices medical assistance population. Magellan has in-network provider linguistic competencies, which reflect the county's minority populations. Additionally Bucks County MH/DP contracts with three translation services to support intake and monitoring needs across the Department. MH/DP contracted providers are also required to have translation services available to meet the needs of linguistic minorities.

Budget Narrative -

Personnel:
This component of the budget is **$97,541**. The personnel costs that are supported by PATH dollars represent 15% of the Director's salary, 20% of the Coordinator's salary, two FTE Case Manager salaries, 50% of a Certified Peer Specialist.
Federal Share - $32,184 State PATH Share - $7,970 County Share - $57,387

Fringe Benefits:
Fringe benefits are calculated at 24.96%@ of total salaries (equal **$24,346**) and include FICA, unemployment compensation, health and dental benefits, accidental death & disability/life insurance as well as short term/long term disability.
Federal Share - $8,033 State PATH Share - $1,989 County Share - $14,324

Travel:
The costs for travel are at $**5,971**. The costs for staff travel include local travel for outreach and travel to training and workshops. Client travel includes the cost of vehicle fuel, insurance, maintenance and repairs.
Federal Share - $1,419 State PATH Share - $1,144 County Share - $3,408

Supplies:
The total budget for supplies for 2017-2018 is **$2,031.** This includes $733 for office supplies necessary to run the program. Client-related supplies ($1,298) include those supplies necessary for clients to be able to occupy housing on a successful basis.
Federal Share - $1,553 State PATH Share - $0 County Share - $478

Other:
The total budget figure includes office expense(rent, utilities, repairs/maintenance/housekeeping and property insurance), emergency housing assistance, one time rental assistance, security deposits, travel, assistance in obtaining housing, and staff training. The cost for other expenses for 2017-2018 is **$59,231**.
Federal Share - $6,503 State PATH Share - $3,622 County Share - $44,471
EFSP Funding through United Way - $4,635

Indirect Cost:
Administrative cost at 4% of total direct costs for Federal PATH Allocation but 16.99% Agency overall administrative cost. Indirect cost is **$32,131.**
Federal Share - $1,988 State PATH Share - $2,502 County Share - $27,641

Total PATH Funding……$221,251

Federal Share - $51,680 State PATH Share - $17,227 County Share - $147,709

EFSP Funding -$4,635

Bucks County Department of Mental Health/ Developmental Programs
Penndel Mental Health Center, Inc.
PATH Program –State and Federal PATH MATCH Funding
FY 2017-2018 Budget

	Annual Salary	PATH-State & Federal funded FTE	PATH-State & Federal funded salary	Total
Position				
Dir-Path Program	$ 83,646	.05	$ 4,182	
Co-ordinator	51,061	.18	9,191	
Case Manager	32,160	.36	11,578	
Case Manager	28,561	.36	10,282	
Certified Peer Spec.	28,122	.175	4,921	
Subtotal				$ 40,154
Fringe Benefits (@ 24.96%)			$ 10,022	
Subtotal				10,022
Travel				
Staff travel: local travel for case mgrs.			$ 325	
Client travel-motor vehicle/repairs/maint/ins.			2,238	
Subtotal				2,563
Supplies				
Office supplies			$ 553	
Client-related supplies			1,000	
Subtotal				1,553
Other				
Office expense, including rent, utilities, bldg. insurance, housekeeping, repair and maintenance, depreciation.			$ 0	
Emergency housing assistance			5,025	
One-time housing rental assistance			1,500	
Security deposits			1,500	
Assistance in obtaining housing-client travel exp.			1,100	
Staff training			1,000	
Subtotal				$ 10,125
Total Direct Charges				$ 64,417

Indirect Costs: Administrative Cost @ 4% for Federal share;16.99% for State PATH share - overall Agency administrative rate				4,490
Total				$ 68,907

10. Butler County

124 West Diamond Street

Butler, PA 16003

Contact: Amanda Feltenberger

Contact Phone #: 7248245114

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-026

State Provider ID: 4226

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 81,903	$ 27,301	$ 109,204	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 81,903	$ 27,301	$ 109,204	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 81,903	$ 27,301	$ 109,204	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 81,903	$ 27,301	$ 109,204	

Source(s) of Match Dollars for State Funds:

Butler Co will receive a total of $109,204 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

Estimated Number of Persons to be Contacted who are Literally Homeless: 0

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

BUTLER COUNTY HUMAN SERVICES
2017-2018 COMPREHENSIVE PATH INTENDED USE PLAN

124 West Diamond Street
Butler, PA 16001
PDX Name: Butler County Mental Health/Mental Retardation

Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.

Butler County Human Services is the recipient of the PATH funds which are utilized to serve homeless individuals with serious mental illness in Butler County. Butler County Human Services is a department of the local government that is charged with the development, implementation, and oversight of the human service system for our County residents and includes the following programs: Mental Health, Intellectual Disabilities, Early Intervention, Drug and Alcohol, Children and Youth, Community Action, and Area Agency on Aging. The department does not provide direct services with the PATH funds received and will contract with two local organizations, Catholic Charities and the Grapevine Center, Inc. to provide specified services to PATH eligible Butler County residents.

Catholic Charities is a private, non-profit organization with the goal of serving human need and affirming human dignity by offering important services and programs to individuals and families. Catholic Charities of Butler County serves all residents of Butler County regardless of race, religion, age, or gender. This organization focuses on providing assistance in basic needs to Butler County residents. Their services include pregnancy and parenting programs, housing assistance, homeless outreach and case management, emergency shelter, permanent supportive housing, life skills training, vocational educational guidance, individual and family counseling, and emergency services. This organization also began functioning as Butler County's Central Intake for housing and homeless services in October 2014 and PATH funds will be used to provide outreach and case management services to those who are at risk of homeless or homeless seen through this department.

The Grapevine Center, Inc. is an independent, non-profit organization serving Butler County residents. It is consumer operated to benefit persons with mental illnesses. Like most support groups, it offers a chance to share problems, advice and ideas with others who have similar concerns, in an atmosphere of understanding, empathy, confidentiality, and companionship. The Grapevine Center will utilize PATH funds to provide outreach and case management services primarily to support Housing Engagement Specialist. The role of the Housing Engagement Specialist is to connect with hard to reach individuals and assist them in navigating the system. The Specialist is also responsible for providing these individuals with extended support until which time they can be linked to services and/or locate appropriate housing.

Butler County Human Services' total PATH allocation for 2017-2018 is $109,204 with $81,903 in federal funds and $27,301 in state funds. Catholic Charities will receive $96,568 and the Grapevine Center, Inc. will receive $12,636.

Describe the organization's participation in the HUD Continuum of Care program and any other local planning, coordinating or assessment activities.

Butler County is one of twenty counties to make up the new Western Region Continuum of Care (PA-601) and one of seven counties that make up Pennsylvania's Southwest Regional Homeless Advisory Board (SW RHAB). This advisory board functions as the HUD Continuum of Care for the region and is charged with coordination and oversight of the region's homeless services system.

Butler County Human Services and Catholic Charities were represented on the Coordinated Entry Committee, a subcommittee of the Western Region CoC to develop a coordinated assessment for the Western Region. This committee met diligently for almost a year to develop an assessment and the policies and procedures to begin utilizing across the Western CoC. Butler County Catholic Charities was also identified as one of the pilot counties to begin testing the assessment. The pilot is still occurring, with a plan for full implementation of Coordination among the 20 county CoC by January 2018. Butler County Human Services and Catholic Charities also attend quarterly Western Region CoC meetings, which are a requirement for providers receiving Continuum of Care funding.

Butler County Human Services, Catholic Charities, and the Grapevine Center are active participants in the Butler County LHOT. The Butler County LHOT currently has 27 member organizations, as well as additional community members, who work on a community level to implement the regional, state and Continuum of Care goals and objectives in our county. This advisory committee's role is to address program, funding, and networking problems within the homeless and housing service system. The LHOT also assesses housing and homeless service needs within the community, coordinates state and federal grant applications, and serves as an essential information and feedback source for the regional board on homeless programming, services and outcome data. The LHOT participates in many annual needs assessments within our community, focusing on such things as drug prevention, child care needs, and housing and other basic needs. This information is used on a county-wide level to drive planning and programming.

PATH providers also participate in coordination activities with other service providers on a daily basis. These organizations include Butler County Human Services, Center for Community Resources, Child Care Information Services, Career Link, Office of Vocational Rehabilitation (OVR), Mental Health Association, The Care Center, Glade Run Lutheran Services, Butler Memorial Hospital, the Butler County Assistance Office, the United Way, St. Vincent de Paul, and the Butler County Housing Authority.

Provide a brief description of partnerships with local community organizations that provide key services to PATH eligible clients and describe coordination activities and policies with those organizations.

Both Catholic Charities and the Grapevine Center have been in business for many years and over that time have built positive relationships with various community organizations that have come to partner with them in effectively serving homeless individuals and families. When one of the PATH case managers works with a PATH eligible person, the person is immediately referred to go through Central Intake at Catholic Charities who will conduct a comprehensive assessment and place them on the prioritization list for services according to the person most in need.

Connection to mainstream services is a critical aspect when a major goal of the program is to help homeless individuals and families overcome barriers to self-sufficiency. The following list is comprised of the community organizations that Catholic Charities and the Grapevine Center partner with in serving PATH-eligible clients:

- PATH -eligible clients who are unable to secure employment due to their disability are referred to apply for Social Security benefits. A new resource to the community that Catholic Charities works closely with is the SOAR program through Center for Community Resources. Staff at Center for Community Resources are newly trained in completing SOAR applications and the agencies goal is to complete 9 applications this year. PATH eligible clients scoring with the most severe needs on the Coordinated Assessment will be referred to Center for Community Resources for the SOAR program as openings become available.

- PATH-eligible clients in applying for all mainstream resources for which they might be eligible. The County Assistance Office provides many of these resources, including cash assistance (in very limited circumstances as the State of PA has eliminated general assistance), SNAP, and Medicaid to eligible individuals and families. PATH service providers then work with the program participants to access medical care through a network of primary care physicians throughout Butler County. Mental health treatment services are available to PATH-eligible clients through a number of providers, including The Care Center, Glade Run Lutheran Services and Family Services of Butler Hospital. The services available include residential, assertive community treatment, outpatient, psychiatric rehabilitation, blended case management, and mobile medication services.

- A variety of drug and alcohol treatment services are also available, both in and out of the county, to give clients an opportunity for recovery. Program

participants are referred to the Butler County Drug and Alcohol Program for assessment and referral to the appropriate level of treatment.

- Services for victims of violence are provided by the Victim Outreach Intervention Center (VOICe). VOICe provides free and confidential services to individuals and families who are survivors of various crimes. VOICe works within our community to bring about social change and provide survivors with the ability to take control of their lives.

- PATH eligible clients that are not able to secure medical coverage are connected with the Community Health Clinic of Butler County. The clinic serves county residents with no health insurance and provides them with free outpatient primary medical care, preventive medical services, referrals for specialized services, and free medications when possible.

- Salvation Army, the Lighthouse Foundation, and five local churches offer free community meals for both lunch and dinner during the week, as well as non-prepared food available through a network of over twenty-six different food cupboards across the county.

- Beyond immediate needs, PATH eligible clients are offered numerous ancillary services ranging from peer support and leisure groups, to assistance with furniture, transportation and clothing.

- PATH eligible clients are provided with assistance in accessing other housing in the community, which might involve assisting a client in applying for housing services through another provider within the homeless continuum of care, including the Housing Authority of Butler County, Center for Community Resources, the Lighthouse Foundation, and Victim Outreach Intervention Center.

- Examples of other service programs that meet the needs of PATH eligible clients and assist them in becoming self-sufficient and remaining in permanent housing include, but are not limited to:

    - Representative Payee Program: The Representative Payee program offers community support service through providing a volunteer to handle participants' Social Security benefits on their behalf. This program assists individuals with disabilities to maintain financial stability in the community.

    - Support Groups/Social/Recreational Opportunities: Many homeless individuals, especially the transition-age population, have no

experience with, or knowledge of how to access positive and healthy socialization and recreation programs in the community. There are numerous support groups (AA, NA, etc.), as well as socialization and leisure activity programs, in the community available and willing to support PATH-eligible clients.

- S.H.O.P Program: The Supportive Housing Opportunities Program (S.H.O.P) helps participants ready to enter the housing market with all the necessary skills and knowledge to become a successful renter.

Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

Describe how the services to be provided using PATH funds will align with to target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Butler County Human Services enters into a contractual arrangement with Catholic Charities and the Grapevine Center to provide these specific services to ensure that PATH funds are targeted for street outreach and case management services. Contracted providers are only permitted to provide the services dictated under the terms of their contract. A majority of the PATH funds are used to pay for the salary and benefits of the housing and homeless case managers, who, in addition to providing the various supports that fall under the definition of case management are also responsible for conducting street outreach on a weekly basis.

Provide specific examples of how the agency maximizes use of PATH Funds by leveraging use of other available funds for PATH client services

In Butler County, individuals and families who are homeless or at significant risk of becoming homeless are one of the major target populations. As such, significant resources, including funds from PATH, MH Base, HAP, CSBG, PHARE, Act 137, and HUD, are combined to ensure a comprehensive array of services are available. Our strategy is to utilize PATH funding primarily to support the services within our continuum that focus on engaging homeless people and connecting them with the housing, treatment, and resources they need to reach a greater level of stability. At Catholic Charities, PATH funds are utilized to partially support the Central Intake Department. Case Managers in this department complete the Coordinated Assessment and provide case management services until the person or family is connected with a housing program. At that time, case management responsibilities are then shifted to the program with which they are participating.

Describe any gaps that exist in the current service systems.

The primary gap in Butler County's homeless system still remains safe, affordable housing. In Butler County, the units of housing that are available in the private market that are affordable and accessible to the people we serve are often not safe and/or are not conducive to support their continued journey with recovery. Units that are desirable quite simply are often unaffordable to the PATH-eligible clients.

Provide a brief description of the current services available for clients who have both a serious mental illness and substance use disorder.

Butler County recognizes the high percentage of individuals who struggle with dual diagnoses. Statistics from Catholic Charities intake data show that 43% of individuals presenting for housing and or homeless assistance reported to have both mental health and drug or alcohol concerns. Catholic Charities and the Grapevine Center utilizes PATH funding primarily to target homeless individuals and families with mental illness and substance abuse issues while working to provide or connect them with services such as outreach and engagement, housing, information and referral, case management, healthcare related services, and substance abuse and mental health treatment. These services are often necessary in order to overcome symptoms of their disorders that have likely contributed to their unstable housing situation. In addition, other supportive services are provided that help the target population to build the skills necessary to access and retain permanent housing and also to become productive members of the community. These services include life skills training, personal supports, advocacy, educational/vocational services, socialization, and peer support.

Describe how the local provider agency pays for providers or otherwise supports evidenced-based practices, training for local PATH-funded staff, and trainings and activities to support migration of PATH data into HMIS.

Catholic Charities has a policy and procedure to support internal training done by senior staff for new staff, register for both free and paid trainings onsite and through webinars and travel to trainings such as the State PATH technical assistance conference and annual trainings. PATH staff will complete the online PATH training that is posted in the support section of PA HMIS. In addition, HMIS data manuals are printed and easily accessible to staff for reference. Senior staff and Butler County Human Services collaborate on needs and concerns and provide technical assistance as needed. All PATH required HMIS data is placed on a worksheet and included in intake packets to ensure staff gather this information and each agency maintains policies on entry practices. Butler County Human Services, Housing Coordinator is trained on PATH data entry and HMIS and enters all contacts and enrollments for the Grapevine Center, per agreement. Butler County Human Services also annually monitors Catholic Charities and the

Grapevine Center for attendance at required trainings including health disparities and cultural competency.

In addition, Butler County Human Services, Catholic Charities and the Grapevine Center are members of the Butler Collaborative for Families, which is a collaborative committee that aims to break down barriers to services for children and families in our community. This group focuses heavily on supporting the provision of trainings, including those focusing on the delivery of evidence-based programs, locally so that our providers have easier access. Examples of trainings that have been offered recently are Trauma-Informed Care, Motivational Interviewing, and Family Development Credentialing.

Provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If so, please explain your system.

Catholic Charities and the Grapevine Center are not required to follow 42 CFR Part 2 regulations.

Please provide specific examples on how your agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports, or specific efforts to minimize the challenges and foster support for PATH clients with a criminal history.

Butler County was awarded a grant to begin a Reentry Coalition whose mission is to address issues related to incarceration, recidivism and barriers to successful reintegration into the community for individuals with a criminal history. Twelve subcommittees were formed in identified areas including family, mentoring, housing, transportation, education, employment, criminal justice, mental health and drug and alcohol. A five year strategic plan was developed with the goals of making an impact on the criminal justice population, many of whom are PATH eligible. Butler County Human Services chairs the Housing Subcommittee group whose focus is to identify gaps related to housing barriers. Catholic Charities is an active member of the Housing Subcommittee and provides valuable input in regards to gaps in housing services and areas that need addressed in order to reduce the percentages of at risk and homeless individuals in Butler County.

PATH staff has also went through training to have permission to complete assessments within the prison and begin working on housing, employment and healthcare concerns pre-release which helps to reduce unseen barriers and allows the opportunity for the inmate to begin building some formal supports and trust that for when they are released from prison. Catholic Charities has also worked to identify and form collaboration with landlords who do not immediately refuse a tenant if they have a criminal background. Often times, criminal backgrounds can be a reason to refuse tenancy and is a barrier to obtaining safe and stable housing. In addition, Catholic Charities encourages individuals to attend SHOP, a financial education course offered through the Butler County Housing Authority, in which individuals

take classes on being a better renting, budgeting, reducing past debts, financial literacy and others. Completion of this course offers two powerful end results, a more educated individual who has been skills to be successful and proof of that in a portfolio which can be shared with potential landlords.

The Housing Engagement Specialist with the Grapevine Center has played a vital role in helping individuals obtain the documents necessary to enter the work force and apply for mainstream benefits. Often, the literally homeless, especially those with a criminal background, present with limited or no identification. No identification creates barriers to accessing most services and the Housing Engagement Specialist has developed contacts with the Social Security office, Department of Transportation, Vital Records and others to be able to apply for and receive these documents as quickly as possible. The Housing Engagement Specialist has also found financial resources from other community partners to assist with the cost of obtaining these when necessary. In addition, the Housing Engagement Specialist has worked to form excellent connections with landlords and employers who are open to considering individuals with a criminal history. Often times, all the situation calls for is a call from the Housing Engagement Specialist and the person is given an opportunity.

Describe the provider's status on the transition to collect PATH data in HMIS. If providers are fully utilizing HMIS for PATH services, please describe plans for continued training and how providers will support new staff.

Catholic Charities staff is trained and entering all PATH required data into the HMIS system. They have been doing so since the implementation of the new PA HMIS system in December 2014. The Grapevine Center will receive technical assistance from Butler County Human Services and utilize the training webinars and documentation available through PA HMIS prior to July 1, 2016. County administrators of PATH funded staff are educated in running required reports and pulling APR data for reporting purposes. Catholic Charities and the Grapevine Center, with technical assistance from Butler County Human Services as needed, are responsible for implementing agency policy on HMIS required entries and data is monitored monthly for accuracy by Butler County Human Services. Butler County is part of the Western Region CoC which utilizes PA HMIS, operated through the Department of Community Economics and Development (DCED).

Describe how the services to be provides using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Catholic Charities utilizes the PATH funds primarily to support the staff within their Central Intake Department as well as fund a portion of the emergency shelter coordinator. These program serves individuals are risk of homeless, literally homeless and chronically homeless. As previously mentioned, Catholic Charities is currently one of the five counties piloting the Coordinated Entry process for the Western

Region CoC and has been utilizing the Coordinated Assessment for all referrals for over 18 months. As such, all individuals presenting for housing and homeless services are prioritized based on need.

The Grapevine Center uses PATH to fund the Housing Engagement Specialist, who provides case management to individuals who are at risk of homeless, literally homeless and chronically homeless. The Housing Engagement Specialist completes outreach and provides case management services to the hardest to serve in our community in an attempt to engage them so that they will agree to assistance with housing. The Grapevine Center, located very centrally in Butler City, is also close to the outdoor location where homeless individuals choose to sleep in tents, that is commonly referred to as the "PIT". Individuals from the PIT often come to the Grapevine, the communities' drop-in center, to shower and get a meal or hot cup of coffee. The location creates perfect opportunities for "in reach" for the literally homeless as well.

Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how your agencies PATH program supports the efforts to reduce/eliminate chronically homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning in continuity of care planning and the process of updating and testing emergency response plans.

Services provided using PATH funds by Catholic Charities and the Grapevine Center, Inc. are consistent with the State Plan to End Homelessness. Catholic Charities functions as the central intake provider for housing and homeless in Butler County. They are responsible for assessing individuals based on need, prioritizing them for housing services and providing case management to until the individuals are successfully housed and connected to other necessary community supports. The Housing Engagement Specialist with the Grapevine Center is responsible for identifying, engaging and supporting individuals experiencing a housing crisis or who are homeless and are considered the hardest to serve, providing more intensive case management to a smaller number of individuals who will benefit from this service. Both agencies work closely with our LHOT, RHAB and Continuum of C0are to focus on priority populations identified through Opening Doors and HUD.

Butler County Human Services, which functions as the administrator of Butler County's PATH program, has a Continuity of Operations Plan (COOP) which addresses the continued delivery of services in case of a disaster or other emergency. This plan is reviewed annually and updated as needed. In addition, table top exercises related to the plan are conducted periodically as a way to test the plan and identify necessary changes. Butler County Human Services as includes requirements in its legally binding contract with providers of service, including PATH service

providers, that they develop and actively maintain a preparedness plan specifically focusing on continued operations of the organization in the event of an emergency.

Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Indicate if any of these are earmarked for PATH services specifically.

Butler County participates in the Human Services Block Grant, which includes Mental Health Base Funds and also funds from the Drug and Alcohol system. The Block Grant represents 30% of Butler County Human Services' base funding. Other than the PATH funds that are administered by our office, we do designate additional funding from the Block Grant specifically for serving people who experience homelessness and have serious mental illness in the community. These funds are contracted to provider organizations to serve the target population. These funds are used to support the provision of rental assistance, case management and permanent supportive housing.

In Butler County, we do not view PATH services as a stand-alone program, but a part of larger, integrated service system. Many additional resources are directed toward serving the homeless population in our community; however, many of the programs are designed to be able to serve anybody who is homeless, not limiting the service just to individuals who have serious mental illness.

In cases where the state provides funds through intermediary organizations describe how these organizations monitor the use of PATH funds.

Butler County Human Services is the recipient of PATH funds and monitors Catholic Charities and the Grapevine Centers PATH funded programs on an annual basis. PATH HMIS data quality is reviewed at least quarterly and technical assistance is provided as needed.

Describe the provider's plan to ensure PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with applications using the SOAR model and track the applications in the OAT system.

Currently, Catholic Charities and the Grapevine Center have no staff members trained in SOAR. One of the providers in Butler County, a previously funded PATH provider, has had four staff trained in SOAR this past year. The goal of the SOAR team is to meet with the individuals who are prioritized with the highest needs through coordinated assessment and work with those individuals to obtain income. Butler County Human Services, recipient of the PATH grant, is responsible for tracking the outcomes of those applications in the OAT system.

Indicate what strategies are used for making suitable housing available for PATH clients.

Butler County is participating in the piloting of the Coordinated Entry system for the Western CoC that will be fully implemented by January 2018. Therefore, all PATH eligible clients will be assessed based on need in accordance with the Department of Housing and Urban Developments definition of homeless and with the goals identified in Open Doors, the Federal Strategic Plan to Prevent and End Homelessness. PATH eligible clients are also connected to mainstream resources and referred to such programs as the Housing Choice Voucher through the Housing Authority. The ability to obtain and maintain income is identified and plans to find employment or a referral to SOAR is started shortly after enrollment. In addition, a factor identified as a priority in the Human Services Block Grant plan is housing. As such, initiatives such as landlord engagement, incentive plans and pursuit and obtainment of funding to increase safe, affordable housing options are in progress.

Butler County and its housing and homeless providers, adheres to the Housing First model, understanding that it is critical for homeless individuals to have a safe place to live before they will be able to focus on fulfilling other needs in their lives, such as treatment, employment, life skills training, medical care, etc., that will help lead them to self-sufficiency. Case Managers work intensively with PATH-eligible clients to identify natural supports whenever possible, such as family or friends, that will welcome them into their home while they work on goals to move themselves toward self-sufficiency, including obtaining and remaining in a permanent housing situation. Many times, however, the individuals served do not have supports available to them. In these instances, PATH-eligible clients are primarily referred to programs within the local homeless continuum of care. Regardless of the housing that PATH-enrolled clients are referred to, they are still offered the various PATH-funded supports available including outreach and case management.

Indicate if your organization is engaged with the local coordinated entry process of your CoC. Please also describe roles of key partners in the CoC.

The Western Region Continuum of Care, which Butler County Catholic Charities is a part of, began the process of developing Coordinated Entry in April 2015. The Coordinated Entry Committee, designated by the CoC, which Catholic Charities is also a member of, met tirelessly to develop an assessment, policies and procedures and best practices that include the 20 county region that the CoC encompasses. Currently, coordinated entry is in the pilot process, where 4 counties, one of which is Butler County Catholic Charities, are testing the assessment and scoring, adding to the policies and procedures and providing feedback for adjustments and improvements both on the scoring tool and the layout in the PA HMIS system.

The Grapevine center is engaged with the coordinated entry process. Once the Housing Engagement Specialist engages the individual and they are open to PATH services, they are accompanied to Catholic Charities, a key partner in the CoC and the identified site for Coordinated Entry in Butler County. Catholic Charities then completes the

coordinated assessment and makes referrals for housing based on the individuals need. The Housing Engagement Specialist then assesses the individual's best interest and either then gives a warm hand off to the PATH staff at Catholic Charities who officially enroll the client into PATH services or the Housing Engagement Specialist will continue with the PATH enrollment and provide case management until the individual becomes stably housed.

Key partners in the CoC include in Lawrence County Community Action Partnership (LCCAP) who applied for and received the Coordinated Entry Grant to move the CoC further along in the process. LLCAP has effectively taken over the responsibilities from the Coordinated Entry Committee and is working with the Department of Community and Economic Development to implement and improve the Coordinated Entry tool in PAHMIS as well as train both the General and Domestic Violence sites identified for each county. LLCAP will also be responsible for reporting Coordinated Entry outcomes and performance to HUD.

Please indicate of Crisis Intervention Team Training is being used in your county/joinder. If so, please provide an approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

Butler County began participating in Crisis Intervention Team training in 2011. The Crisis Supervisors help organize and implement the week long training that is held twice a year, in the spring and fall. Being that there are over 10 different police departments serving Butler County, including the State Police which covers a large portion of our rural county, we don't have an accurate count of the total number of officers, or in turn, the % trained in CIT so far. However, Butler County has trained approximately 20 law enforcement personnel along with numerous other first responders and individuals from both prison and probation. In 2016, the crisis team completed a mobile with a first responder approximately 75 times and we have received excellent feedback from them regarding the effectiveness of the training in guiding them to interact differently with people exhibiting mental health symptoms.

Describe the demographics of staff serving the clients, how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients; and the extent to which staff receive periodic training in cultural competence and health disparities.

Butler County is a primarily rural county located in the southwestern section of the state of Pennsylvania with a population of approximately 183,000 residents. Although there is only a very small percentage of racial mix within our borders, the PATH staff of Catholic Charities and The Grapevine Center are well aware of the importance of cultural competence and the need to recognize and value differences in clients, even beyond race, including age, gender, disability, sexual orientation, and health disparities. These organizations pride themselves in reaching out to people of all different cultures and backgrounds and have much hands-on experience working with

these populations. In addition, PATH staff attend annual trainings that focus on cultural competence and health disparities. All programs implemented through Catholic Charities and the Grapevine Center adhere to a non-discrimination policy, which demonstrates their commitment to provide necessary and effective services to all residents of Butler County regardless of age, gender, religion, sexual orientation, race/ethnicity, health disparities and other differences.

Cultural competency within Butler County's PATH funded services is further ensured through the participation of consumers and family members in the planning, implementation, and evaluation of the program. These populations have constant input regarding the operation of PATH services and represent a valuable source of information regarding cultural competency, particularly relating to the target population.

Catholic Charities and the Grapevine Center serve PATH-eligible clients of all ages, ethnicities, religions, abilities, sexual orientations, etc. The staff serving PATH clients include Catholic Charities three Housing and Homeless Case Managers; two Caucasian female between the ages of 50 and 60 and one Caucasian male between the age of 50 and 55 and the Grapevine Center's Housing Engagement Specialist who is a Caucasian male over the age of 60.

Describe the demographics of the client population, the projected number of adult clients to be contacted, enrolled, and the percentage of adult clients served using PATH funds to be literally homeless.

Catholic Charities and The Grapevine Center serve PATH-eligible clients of all ages, ethnicities, religions, etc. A majority of program participants are Caucasian (about 90%), which is expected because Butler County as a whole is comprised of approximately 97% Caucasian, though all races and ethnicities are accepted into this program. About 10% of people served are Black/African American. Approximately 49% of program participants are female and 51% are male. .

It is projected that Butler County will use PATH funds to contact 218 adult clients and 183 will become enrolled. It is projected that approximately 68% of the adults served with PATH funds will be "literally" homeless. The remaining 32% will be at imminent risk of homelessness.

Describe how individuals who are homeless and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.

Catholic Charities involves program participants in the evaluation and planning process by inviting to participate in questionnaires developed by the Consumer Family Satisfaction Team (C/FST). In addition, participants are encouraged to share any issues they might have or suggestions to improve the program during this time or during their one on one contact with C/FST. These face to face opportunities to

assess client satisfaction and receive feedback have proven very effective. Any feedback provided, through surveys or directly from the program participants, is considered for possible improvements to the program. Potential program changes for the purpose of improvement are always discussed with participants.

The Grapevine Center's mission is: with respect and dignity for all, the Grapevine Center will empower peers to mentor, inspire and support individuals and families in recovery. Grapevine Center will advocate for social justice on behalf of all people. The Grapevine Center proudly boasts a full time Drop-In Center, Consumer/ Family Support Teams, the Certified Peer Specialist Program and the Warmline Program. With limited paid staff, many who identify as having a mental illness and others who volunteer their time, all of these services are ran by consumers and families members who have a very active role in the provision of services.

Perhaps even more important than their involvement on the organizational level is the involvement of PATH eligible clients at the system level. Butler County Human Services' Mental Health Program serves as the administrative and oversight body for all state and federal mental health funded programs in the county. Although this office does not offer direct services to consumers, it works closely with consumers, advocates and family members to ensure that their opinions and input are acknowledged and evident in all aspects of the system, from program development, to quality assurance and outcome evaluation. Butler County Human services works with consumers, family members, provider agencies, and community organizations to produce the annual Human Services Block Grant Plan that outlines the goals, objectives, and plans for the human service system, including the mental health system for the upcoming year. Community-wide planning meetings are held each year and are attended by consumers, family members, county administrators, and representatives of various human service systems. Also, Butler County Human Services has been working collaboratively with other organizations in the community to develop strategies to involve more individuals with mental health disorders, include those who are or were PATH-eligible, on governing or advisory boards.

The local Community Support Program (CSP) is another primary vehicle for consumer, family, provider, agency and advocate input into the design, development and quality of services in the mental health system, including PATH funded services. CSP is a coalition of mental health consumers, family members, County MH representatives and professionals who work together to ensure that individuals with serious mental illnesses are receiving necessary supports from a recovery-oriented service system in order to live successfully in the community. Butler County's Local Housing Options Team (LHOT) is also an avenue for consumer and family participation in the planning, development, and evaluation of the homeless service system and the PATH programs within our community. This is an open committee and homeless service providers are encouraged to support program participants in attending.

PATH eligible clients are also critical in helping us to make our annual Point-In-Time Counts a success. We work with them to identify locations within the County where we might find homeless individuals or families. We also encourage their participation on the outreach teams for the Point-In-Time count and provide with a gift card to a local retailer as a small token of thank you for their assistance.

Please identify efforts to support the Transition Age Youth (TAY) Disparity population by providing the following:

The unduplicated Number of TAY individuals who are expected to be served using PATH funds.

It is anticipated that Catholic Charities and the Grapevine Center will serve approximately 79 TAY individuals this year who are PATH eligible.

The total amount of PATH funds expected to be expended on services for the TAY population

The total amount of PATH funds expected to be expended on the transition age youth population between Catholic Charities and the Grapevine Center is approximately 47% of the grant total or $47,842.24.

The types of services funded by PATH that are available for TAY individuals

PATH funds distributed to Catholic Charities and the Grapevine Center are used specifically for street outreach and case management services. Transition age youth who are at risk or literally homeless will be outreached to and ideally engaged to enroll in case management services.

A plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population.

Based on the general population who will receive services from this grant, the transition age youth population being served by PATH funds through Catholic Charities and the Grapevine Center will focus on outreach activities by talking with the transition age youth already being served through case management to identify known outreach locations and areas frequently visited by the transition age population. Path funded outreach staff will attempt to engage the TAY population they are working with to assist in their biweekly outreach activities as well. In addition, outreach flyers and information will be targeting to assist in reaching this population, paying special attention to appearance and wording to make information more appealing.

In our geographic region, disparities within the TAY population are can be identified as those:

- exiting the foster system
- identifying as LGBTQ
- diagnosed with behavioral health and/or intellectual disabilities

Strategies Catholic Charities and the Grapevine Center will take to reduce disparities in this special population in comparison to the general population will be to increase education and training opportunities for the community and service system and as a whole. Butler County recognizes there is great significance to increase overall collaboration amongst its Human Service System and to incorporate a cross systems approach when it comes to service planning. In addition, it is important for service providers to begin developing relationships with foster care providers and other supervised settings before TAY leave these living situations and potentially fall through the system.

Please describe your organizations ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient persons in their programs and activities. Please assess the extent to which language services are necessary in your grant program.

Butler County Human Services , Catholic Charities and the Grapevine Center are all in compliance with Executive Order 13166, having taking reasonable steps for LEP individuals to access services. The proportion of LEP persons served across all three agencies is >1% and it is extremely infrequent that LEP individuals come into contact with the program. Butler County consists of a primarily Caucasian population; 96.3% according to the 2015 Census. Butler County Human Services has access to a phone based system called Language Line, Catholic Charities contracts with an interpretation agency; Stratus Audio and the Grapevine Center contracts with Certified Interpreting Services when needed. All agencies have a policy in place on how to use their respective interpretation services.

Butler County Human Services
2017-2018
Budget Narrative

Personnel (Positions and Fringe Benefits)- PATH funds in the amount of $92,864 will be utilized to partially fund four positions at Catholic Charities and the Grapevine Center Inc., including three Homeless and Housing Case managers, the Safe Harbor Project Coordinator and the Housing Engagement Specialist. Salaries total $ 61,533.46 and benefits total $38,600.82.

Travel- PATH funds in the amount of $1819.53 will be used to fund staff travel necessary in assisting PATH enrolled individuals in accessing mainstream resources, employment training, and other necessary services in order to begin the journey out of homelessness. Public transportation and shared rides are utilized whenever possible

Supplies- PATH funds in the amount of $150 will be used to purchase office supplies for the Housing Engagement Specialist at the Grapevine Center.

Occupancy- PATH funds in the amount of $1,979.47 will be used to partially pay for the office space used for the Homeless and Housing Case Managers and Housing Engagement Specialist.

Communications- PATH funds in the amount of $400 will be used to pay for a portion of the communications equipment, including computer, telephone, cell phone, etc., used by the Housing Engagement Specialist.

Staff Development and Contracted Services- PATH funds in the amount of $372.00 will be used for operating expenses, specifically audit fees.

Administrative- PATH funds in the amount of $4,348.72 will be used to partially pay the Administrative costs that are incurred as a result of operating the PATH program. This amount does not exceed 4% of the direct costs of the program.

Butler County Human Services
PATH Program
FY 2017-2018 Budget

*Please add additional rows as necessary

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
Housing and Homeless Case Manager	$26,850.75	0.97	$26,044.72	$26,044.72
Housing and Homeless Case Manager	$26,586.99	0.60	$15,952.20	$15,952.20
Safe Harbor Project Coordinator	$33,988.83	0.31	$10,536.54	$10,536.54
Housing Engagement Specialist	$14,731.00	0.24	9000.00	$9,000.00
sub-total				**$61,533.46**
Fringe Benefits				
Housing and Homeless Case Manager	$17,514.87	0.97	$17,004.73	$17,004.73
Housing and Homeless Case Manager	$18,644.28	0.60	$13,317.34	$13,317.34
Safe Harbor Project Coordinator	$12,301.09	0.31	$7,278.75	$7,278.75
Housing Engagement Specialist	$1,000.00	0.24		$1,000.00
sub-total				**$38,600.82**
Travel				**$1,819.53**
Equipment				**$0**
Supplies				**$150.00**
Other				
Occupancy				**$1,979.47**
Communications				**$400.00**
Staff Development & Contracted Services				**$372.00**
Administration				**$4,348.72**
Total PATH Budget	**$109,204**			

11. Butler County - Catholic Charities

120 West New Castle St

Butler, PA 16001

Contact: Amber Crowe

Contact Phone #: 7242874011

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-049

State Provider ID: 4249

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Catholic Charities will receive a total of $96,568 in federal and state match PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 200

Estimated Number of Persons to be Enrolled: 175

Estimated Number of Persons to be Contacted who are Literally Homeless: 120

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

BUTLER COUNTY
CATHOLIC CHARITIES
2017-2018 PATH INTENDED USE PLAN

120 New Castle Street
Butler, PA 16001
PDX Name: Butler; Catholic Charities

Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.

Catholic Charities of Butler County is a private, non-profit organization dedicated to championing the dignity of the person, improving the quality of life, and advocating for the social good of the human family, so that the poor and vulnerable, always welcomed and loved, embrace the opportunities necessary to realize their potential. This organization focuses on providing assistance in basic and serves as the Coordinated Entry for Butler County. Services provided include pregnancy and parenting programs, basic needs assistance, housing assistance, homeless outreach and case management, emergency shelter, permanent supportive housing, life skills training, vocational educational guidance, and referral services. Catholic Charities will receive $96,568 in PATH funds and will utilize these funds to provide outreach and case management services to individuals who are homeless or at risk of homelessness and struggle with serious mental illness or co-occurring mental health and substance abuse disorders.

Describe the organization's participation with local HUD Continuum of Care recipients and any other local planning, coordinating or assessment activities.

Butler County Human Services holds the HUD Continuum of Care grant that funds the Path Transition Age Project and Home Again Butler County. These are permanent supportive housing programs, one for youth and the other for families that are administered by Catholic Charities. Catholic Charities also has a consistent presence at the quarterly Western Region Continuum of Care meetings.

In addition, Catholic Charities was a member of the Coordinated Entry Planning committee designated by the Western Region CoC and is one of the five counties identified to pilot the process. The Coordinated Entry committee began meeting in April 2015 and Catholic Charities has been a part of the planning and implementation of this process since that time. Currently, they are one of four counties who are piloting and testing Coordinated Entry which was rolled out in PAHMIS in December 2016.

Provide a brief description of partnerships with local community organizations that provide key services to PATH eligible clients and describe coordination activities and policies with those organizations.

Catholic Charities has been in business for many years and over that time have built positive relationships with various community organizations that have come to partner with them in effectively serving homeless individuals and families. As part of the Coordinated Entry process, and in order to effectively serve PATH-eligible clients, the staff of Catholic Charities strives to connect individuals to appropriate treatment and support services in the community. These connections are critical in supporting the goal of helping homeless individuals and families overcome barriers to self-sufficiency. The following list is comprised of the community organizations that Catholic Charities partners with in serving PATH-eligible clients:

- PATH -eligible clients who are unable to secure employment due to their disability are referred to apply for Social Security benefits. A new resource to the community that Catholic Charities works closely with is the SOAR program through Center for Community Resources. Staff at Center for Community Resources are newly trained in completing SOAR applications and the agencies goal is to complete 9 applications this year. PATH eligible clients scoring with the most severe needs on the Coordinated Assessment will be referred to Center for Community Resources for the SOAR program as openings become available.
- Catholic Charities staff assists PATH-eligible clients in applying for all mainstream resources for which they might be eligible. The County Assistance Office provides many of these resources, including cash assistance (in very limited circumstances as the State of PA has eliminated general assistance), SNAP, and Medicaid to eligible individuals and families. PATH service providers then work with the program participants to access medical care through a network of primary care physicians throughout Butler County. Mental health treatment services are available to PATH-eligible clients through a number of providers, including The Care Center, Glade Run Lutheran Services and Family Services of Butler Hospital. The services available include residential, assertive community treatment, outpatient, psychiatric rehabilitation, blended case management, and mobile medication services.
- A variety of drug and alcohol treatment services are also available, both in and out of the county, to give clients an opportunity for recovery. Program participants are referred to the Butler County Drug and Alcohol Program for assessment and referral to the appropriate level of treatment.
- Services for victims of violence are provided by the Victim Outreach Intervention Center (VOICe). VOICe provides free and confidential services to individuals and families who are survivors of various crimes. VOICe works within our community to bring about social change and provide survivors with the ability to take control of their lives.
- PATH eligible clients that are not able to secure medical coverage are connected with the Community Health Clinic of Butler County. The clinic serves county residents with no health insurance and provides them with free

outpatient primary medical care, preventive medical services, referrals for specialized services, and free medications when possible.

- Salvation Army, the Lighthouse Foundation, and five local churches offer free community meals for both lunch and dinner during the week, as well as non-prepared food available through a network of over twenty-six different food cupboards across the county.
- Beyond immediate needs, PATH eligible clients are offered numerous ancillary services ranging from peer support and leisure groups, to assistance with furniture, transportation and clothing.
- PATH eligible clients are provided with assistance in accessing other housing in the community, which might involve assisting a client in applying for housing services through another provider within the homeless continuum of care, including the Housing Authority of Butler County, Center for Community Resources, the Lighthouse Foundation, and Victim Outreach Intervention Center.
- Examples of other service programs that meet the needs of PATH eligible clients and assist them in becoming self-sufficient and remaining in permanent housing include, but are not limited to:
    - Representative Payee Program: The Representative Payee program offers community support service through providing a volunteer to handle participants' Social Security benefits on their behalf. This program assists individuals with disabilities to maintain financial stability in the community.
    - Support Groups/Social/Recreational Opportunities: Many homeless individuals, especially the transition-age population, have no experience with, or knowledge of how to access positive and healthy socialization and recreation programs in the community. There are numerous support groups (AA, NA, etc.), as well as socialization and leisure activity programs, in the community available and willing to support PATH-eligible clients.
    - S.H.O.P Program: The Supportive Housing Opportunities Program (S.H.O.P) helps participants ready to enter the housing market with all the necessary skills and knowledge to become a successful renter.

Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Catholic Charities utilizes the PATH funds primarily to support the staff within their Central Intake Department as well as fund a portion of the emergency shelter coordinator. These programs serve individuals who are at risk of homeless, literally

homeless and chronically homeless. As previously mentioned Catholic Charities is currently one of the five counties piloting the Coordinated Entry process for the Western Region CoC and has been utilizing the Coordinated Assessment for all referrals for over 18 months. As such, all individuals presenting for housing and homeless services are prioritized based on need.

Provide specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services

In Butler County, individuals and families who are homeless or at significant risk of becoming homeless are one of the major target populations. As such, significant resources, including funds from PATH, MH Base, HAP, CSBG, PHARE, Act 137, and HUD, are combined to ensure a comprehensive array of services are available. Our strategy is to utilize PATH funding primarily to support the services within our continuum that focus on engaging homeless people and connecting them with the housing, treatment, and resources they need to reach a greater level of stability. At Catholic Charities, PATH funds are utilized to partially support the Central Intake Department. Case Managers in this department complete the Coordinated Assessment and provide case management services until the person or family is connected with a housing program. At that time, case management responsibilities are then shifted to the program with which they are participating.

Describe any gaps that exist in the current service systems.

For several years, the primary gap in Butler County's homeless system still remains as safe, affordable housing. In Butler County, the units of housing that are available in the private market that are affordable and accessible to the people we serve are often not safe and/or are not conducive to support their continued journey with recovery. Units that are desirable quite simply are often unaffordable to the PATH-eligible clients.

Provide a brief description of the current services available for clients who have both a serious mental illness and substance use disorder.

Butler County recognizes the high percentage of individuals who struggle with dual diagnoses. Statistics from Catholic Charities intake data show that 43% of individuals presenting for housing and or homeless assistance reported to have both mental health and drug or alcohol concerns. Catholic Charities utilizes PATH funding primarily to target homeless individuals and families with mental illness and substance abuse issue while working to provide or connect them with services such as outreach and engagement, housing, information and referral, case management, healthcare related services, and substance abuse and mental health treatment. Butler County is proud to be a Trauma Informed Care Community and is taking the steps necessary to build a trauma informed workforce amongst all the providers. The county also offers several providers who offer dual diagnosis inpatient and outpatient options. These services are often necessary in order to overcome symptoms of their disorders that have likely

contributed to their unstable housing situation. In addition, other supportive services are provided that help the target population to build the skills necessary to access and retain permanent housing and also to become productive members of the community. These services include life skills training, personal supports, advocacy, educational/vocational services, socialization, and peer support.

Describe how the local provider agency pays for providers or otherwise supports evidenced-based practices, training for local PATH-funded staff, and trainings and activities to support migration of PATH data into HMIS.

Catholic Charities supports internal training done by senior staff for new staff, free local trainings, webinars available on HUD exchange and the Housing Alliance websites as well as paid trainings and housing conferences. Examples of a training that PATH staff participated in are Bridges Out of Poverty, trauma informed care, motivational interviewing, housing first and webinars on the LBGTQ community. Specific trainings and activities to support PATH data entry into HMIS include completion of the PATH training that is posted in the support section of PA HMIS and access to the HMIS PATH data manuals for ease of reference. Senior staff and Butler County Human Services collaborate on needs and concerns and technical assistance is provided as needed. All PATH required HMIS data is placed on a worksheet and included in intake packets to ensure staff gather this information and each agency maintains policies on HMIS data entry practices. Butler County Human Services also annually monitors Catholic Charities attendance at required trainings including health disparities and cultural competency.

Provide information in whether or not your agency is required to follow 42 CFR Part 2 regulations.

Catholic Charities is not required to follow 42CFR Part 2 regulations.

Provide specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing program, job opportunities and other supports or specific efforts to minimize the challenges and foster support for PATH clients with a criminal history.

Butler County was awarded a grant to begin a Reentry Coalition whose mission is to address issues related to incarceration, recidivism and barriers to successful reintegration into the community for individuals with a criminal history. Twelve subcommittees were formed in identified areas including family, mentoring, housing, transportation, education, employment, criminal justice, mental health and drug and alcohol. A five year strategic plan was developed with the goals of making an impact on the criminal justice population, many of whom are PATH eligible. Catholic Charities is an active member of the Housing Subcommittee and provides valuable input in regards to gaps in housing services and areas that need addressed in order to reduce the percentages of at risk and homeless individuals in Butler County.

PATH staff has also went through training to have permission to complete assessments within the prison and begin working on housing, employment and healthcare concerns pre-release which helps to reduce unseen barriers and allows the opportunity for the inmate to begin building some formal supports and trust that for when they are released from prison.

Catholic Charities has also worked to identify and form collaboration with landlords who do not immediately refuse a tenant if they have a criminal background. Often times, criminal backgrounds can be a reason to refuse tenancy and is a barrier to obtaining safe and stable housing. In addition, Catholic Charities encourages individuals to attend SHOP, a financial education course offered through the Butler County Housing Authority, in which individuals take classes on being a better renting, budgeting, reducing past debts, financial literacy and others. Completion of this course offers two powerful end results, a more educated individual who has been skills to be successful and proof of that in a portfolio which can be shared with potential landlords.

Describe the provider's status on the transition to collect PATH data is HMIS.

Catholic Charities PATH funded staff are trained and entering all PATH required data into the HMIS system. They have been doing so since the implementation of the new PA HMIS system in December 2014. County administrators of PATH funded staff are educated in running required reports and pulling APR data for reporting purposes. Catholic Charities, with technical assistance from Butler County Human Services as needed, is responsible for training all staff on HMIS required entries and data is monitored monthly for accuracy by Butler County Human Services. Butler County is part of the Western Region CoC which utilizes PA HMIS, operated through the Department of Community Economics and Development (DCED). PA HMIS has several online materials, including webinars and quick reference guides that are very beneficial for training purposes.

Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Catholic Charities utilizes the PATH funds primarily to support the staff within their Central Intake Department as well as fund a portion of the emergency shelter coordinator. These program serves individuals are risk of homeless, literally homeless and chronically homeless. As previously mentioned, Catholic Charities is currently one of the five counties piloting the Coordinated Entry process for the Western Region CoC and has been utilizing the Coordinated Assessment for all referrals for over 18 months. As such, all individuals presenting for housing and homeless services are prioritized based on need.

Describe how services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

PATH funds received by Catholic Charities are consistent with the State Comprehensive Mental Health Services Plan because funds are targeted for outreach, engagement and case management of homeless and at risk individuals with a mental health or co-occurring diagnosis. Outreach to known and unknown areas where homeless reside is also completed on a bi-weekly basis. PATH funded staff provide case management to coordinate housing and mental health services as priorities and then work to connect the individuals to other mainstream services.

Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how your agencies PATH program supports the efforts to reduce/eliminate chronically homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning in continuity of care planning and the process of updating and testing emergency response plans.

Services provided using PATH funds by Catholic Charities is consistent with the State Plan to End Homelessness as this agency has been designated the Coordinated Entry site in Butler County. They are responsible for assessing individuals based on need, prioritizing them for housing services and providing case management until the individuals are successfully housed and connected to other necessary community supports. This process ultimately targets and prioritizes the chronically homeless for housing. Catholic Charities works closely with our LHOT, RHAB and Continuum of Care to focus on priority populations identified through Opening Doors and HUD.

As per the contract with Butler County Human Services, our agency as a whole is required to develop and actively maintain a preparedness plan specifically focusing on continued operations of the organization in the event of an emergency. This plan is reviewed annually, updated as needed, and shared with staff.

Indicate whether the Mental Health Block Grant. Substance Abuse Block Grant or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Indicate if any of these are earmarked for PATH services specifically.

Butler County participates in the Human Services Block Grant, which includes Mental Health Base Funds and funds from the Drug and Alcohol system. The Block Grant represents 30% of Butler County Human Services' base funding. Other than the PATH funds that are administered by Butler County Human Services, additional funding from the Block Grant is designated for individuals who are experiencing homelessness and have serious mental illness in the community. These funds are contracted to Catholic Charities to serve the target population. Funds are used to support the provision of rental assistance, case management and permanent supportive housing.

In cases where the state provides funds through intermediary organizations, describe how these organizations monitor the use of PATH funds.

Butler County Human Services is the recipient of PATH funds and monitors Catholic Charities PATH funded programs on an annual basis. Catholic Charities is PATH HMIS data quality is reviewed at least quarterly and technical assistance is provided as needed.

Describe your plan to train PATH staff on the SOAR Online Course and which staff will assist consumers with SSI/SSDI applications and track the outcomes if those applications in the OAT system.

For grant year 2016-2017, Catholic Charities did not have any staff members trained in SOAR. This is a result of staff turnover. Therefore, no PATH-eligible individuals have been assisted with SSI/SSDI applications by PATH staff. However, in the past year, another community partner and previous PATH sub-recipient, Center for Community Resources, Inc. has had three staff successfully complete the SOAR Online Course. It is the goal of the SOAR trained staff to complete 9 SSI/SSDI applications by December 31, 2017. Butler County Human Services, recipient of the PATH grant, is responsible for tracking the outcomes of those applications in the OAT system.

Indicate what strategies are used for making suitable housing available for PATH clients.

Butler County is participating in the piloting of the Coordinated Entry system for the Western CoC that will be fully implemented by January 2018. Therefore, all PATH eligible clients will be assessed based on need in accordance with the Department of Housing and Urban Developments definition of homeless and with the goals identified in Open Doors, the Federal Strategic Plan to Prevent and End Homelessness. PATH eligible clients are also connected to mainstream resources and referred to such programs as the Housing Choice Voucher through the Housing Authority. The ability to obtain and maintain income is identified and plans to find employment or a referral to SOAR is started shortly after enrollment. In addition, a factor identified as a priority in the Human Services Block Grant plan is housing. As such, initiatives such as landlord engagement, incentive plans and pursuit and obtainment of funding to increase safe, affordable housing options are in progress.

Indicate if your organization is engaged with the local coordinated entry process of your CoC. Please also describe the roles of key partners in the CoC.

The Western Region Continuum of Care, which Butler County Catholic Charities is a part of, began the process of developing Coordinated Entry in April 2015. The Coordinated Entry Committee, designated by the CoC, which Catholic Charities is also a member of, met tirelessly to develop an assessment, policies and procedures and

best practices that include the 20 county region that the CoC encompasses. Currently, coordinated entry is in the pilot process, where 4 counties, one of which is Butler County Catholic Charities, are testing the assessment and scoring, adding to the policies and procedures and providing feedback for adjustments and improvements both on the scoring tool and the layout in the PA HMIS system.

Key partners in the CoC include in Lawrence County Community Action Partnership (LCCAP) who applied for and received the Coordinated Entry Grant to move the CoC further along in the process. LLCAP has effectively taken over the responsibilities from the Coordinated Entry Committee and is working with the Department of Community and Economic Development to implement and improve the Coordinated Entry tool in PAHMIS as well as train both the General and Domestic Violence sites identified for each county. LLCAP will also be responsible for reporting Coordinated Entry outcomes and performance to HUD.

Please indicate of Crisis Intervention Team training is being used in your county/Joinder. If so, please provide approximate % of law enforcement that been CIT trained and feedback on effectiveness.

Butler County began participating in Crisis Intervention Team training in 2011. The Crisis Supervisors help organize and implement the week long training that is held twice a year, in the spring and fall. Being that there are over 10 different police departments serving Butler County, including the State Police which covers a large portion of our rural county, we don't have an accurate count of the total number of officers, or in turn, the % trained in CIT so far. However, Butler County has trained approximately 20 law enforcement personnel along with numerous other first responders and individuals from both prison and probation. In 2016, the crisis team completed a mobile with a first responder approximately 75 times and we have received excellent feedback from them regarding the effectiveness of the training in guiding them to interact differently with people exhibiting mental health symptoms.

Describe the demographics of staff serving the clients, how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients; and the extent to which staff receive periodic training in cultural competence and health disparities.

Butler County is a primarily rural county located in the southwestern section of the state of Pennsylvania with a population of approximately 183,000 residents. We have a very small percentage of racial mix within our county, however, the PATH staff of Catholic Charities are well aware of the importance of cultural competence and the need to recognize and value differences in clients, even beyond race, including age, gender, disability, sexual orientation, and health disparities. Catholic Charities as an organization prides itself in reaching out to people of all different cultures and backgrounds and have much hands-on experience working with these populations

serving PATH-eligible clients of all ages, ethnicities, religions, abilities, sexual orientations, etc. In addition, staff attends annually training that focuses on cultural competence and health disparities. All programs implemented through Catholic Charities adhere to a non-discrimination policy, which demonstrates their commitment to provide necessary and effective services to all residents of Butler County regardless of age, gender, religion, sexual orientation, race/ethnicity, other differences, and health disparities. The staff serving program clients include three Housing and Homeless Case Managers; two Caucasian female between the ages of 50 and 60 and one Caucasian male between the age of 50 and 55.

Describe the demographics of the client population, the projected number of adult clients to be contacted, enrolled, and the percentage of adult clients served using PATH funds to be literally homeless.

Catholic Charities serves PATH eligible clients regardless of age, race ethnicity, disability, sexual orientation etc. In 2016, Catholic Charities had over 1,000 new intakes through their intake department and 70% of those individuals self-reported as having mental health or mental health and drug and alcohol diagnosis. Participants are 87 % Caucasian and 13% Hispanic/Latino. Approximately 59 % of PATH eligible clients were female, with the remaining 41% male. Of the adults served, 16 % are between the ages 18-23, 34 % are between 24 -30, 24% are 31-40, 20% are 41-50, and 6% are 50 and older.

It is projected that Catholic Charities will use PATH funds to contact 200 adult clients and 175 will become enrolled. It is projected that approximately 60% of the adults served with PATH funds will be "literally" homeless. The remaining 40% will be at imminent risk of homelessness.

Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether persons who are PATH-eligible are employed as staff or as volunteers or serve on governing or formal advisory boards.

Catholic Charities recognizes the importance of providing PATH eligible clients with opportunities for employment and/or other meaningful activity in order to support them on their journey toward recovery. PATH eligible clients are often paid to provide services for the Path Transition Age Project and Home Again Butler County, such as cleaning and moving, that are necessary in making this a successful program and participants are encouraged to act as mentors for people entering into the programs. Family members are encouraged to participate in goal planning if these members are seen as a positive support and influence.

Consumers and family members are also encouraged to attend the annual strategic planning board retreat and although one is not presently formed, Butler Catholic Charities is in the process of forming a local community advisory committee in which consumers and families members will be invited to sit on.

Please identify efforts to support the Transition Age Youth (TAY) Disparity Population by providing the following:

The unduplicated Number of TAY individuals who are expected to be served using PATH funds.

It is anticipated that Catholic Charities will serve approximately 75 TAY individuals this year who are PATH eligible.

T**he total amount of PATH funds expected to be expended on services for the TAY population**

The total amount of PATH funds expected to be expended on the transition age youth population for Catholic Charities is approximately 43% of the grant total or $41,524.24

The types of services funded by PATH that are available for TAY individuals

PATH funds distributed to Catholic Charities are used specifically for street outreach and case management services. Transition age youth who are at risk or literally homeless will be outreached to and ideally engaged to enroll in case management services.

A data driven improvement plan to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population.

In our geographic region, disparities within the TAY population are can be identified as those:

- exiting the foster system
- identifying as LGBTQ
- diagnosed with behavioral health and/or intellectual disabilities

Strategies Catholic Charities will take to reduce disparities in this special population in comparison to the general population will be to increase education and training opportunities for the community and service system and as a whole. Butler County recognizes there is great significance to increase overall collaboration amongst its Human Service System and to incorporate a cross systems approach when it comes to service planning. A Youth Sub Committee was also developed out of the CoC to help

determine strategies to outreach and engage youth with the goal to reach functional zero in 2022.

Please describe your agencies ability to comply with Executive Order 13166, which requires the recipients of federal financial assistance to provide access to LEP persons in their programs and activities.

Catholic Charities is in compliance with Executive Order 13166, having taking reasonable steps for LEP individuals to access services. Catholic Charities proportion of LEP persons served is >1% and it is extremely infrequent that LEP individuals come into contact with the program. Butler County consists of a primarily Caucasian population; 96.3% according to the 2015 Census. Catholic Charities does contract with an interpretation agency; Stratus Audio to contact when needed and has a policy in place on how to use this service.

BUTLER COUNTY
CATHOLIC CHARITIES
2017-2018
Budget Narrative

Personnel (Positions and Fringe Benefits)- PATH funds in the amount of $90,134 will be utilized to partially fund three positions. PATH funds in the amount of $52,533.46 will be used for salaries and $37,600.82 for benefits at Catholic Charities, which include the homeless and housing case managers with central intake and the Safe Harbor Project Coordinator.

Travel- PATH funds in the amount of $1,219.53 will be used to fund staff travel necessary in assisting PATH enrolled individuals in accessing mainstream resources, employment training, and other necessary services in order to begin the journey out of homelessness. Public transportation and shared rides are utilized whenever possible.

Other:

Occupancy- PATH funds in the amount of $979.47 will be used to partially pay for the office space used for the Homeless and Housing Case Managers.

Staff Development and Contracted Services- PATH funds in the amount of $372.00 will be used for operating expenses, specifically audit fees.

Administrative- PATH funds in the amount of $3,862.72 will be used to partially pay The Administrative costs that are incurred as a result of operating the PATH program. This amount does not exceed 4% of the direct costs of the program.

Butler County Catholic Charities
PATH Program
FY 2017-2018 Budget

*Please add additional rows as necessary

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
Housing and Homeless Case Manager	$26,850.75	0.97	$26,044.72	$26,044.72
Housing and Homeless Case Manager	$26,586.99	0.60	$15,952.20	$15,952.20
Safe Harbor Project Coordinator	$33,988.83	0.31	$10,536.54	$10,536.54
sub-total				**$52,533.46**
Fringe Benefits				
Housing and Homeless Case Manager	$17,514.87	0.97	$17,004.73	$17,004.73
Housing and Homeless Case Manager	$18,644.28	0.60	$13,317.34	$13,317.34
Safe Harbor Project Coordinator	$12,301.09	0.31	$7,278.75	$7,278.75
sub-total				**$37,600.82**
Travel			$1219.53	$1,219.53
Equipment				$0
Supplies				$0
Other				
Staff Development and Contracted Services				$372.00
Occupancy				$979.47
Administration				$3,862.72
Total PATH Budget	**$96,568.00**			

12. Butler County - The Grapevine Center, Inc.

140 North Elm Street

Butler, PA 16001

Contact: Allyson Rose

Contact Phone #: 724-284-5114

Has Sub-IUPs: No

Provider Type: Consumer-run mental health agency

PDX ID: PA-075

State Provider ID: PA-075

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Grapevine Center will receive a total of $12,636 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 18

Estimated Number of Persons to be Enrolled: 8

Estimated Number of Persons to be Contacted who are Literally Homeless: 14

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

BUTLER COUNTY
GRAPEVINE CENTER, INC.
2017-2018 PATH INTENDED USE PLAN

140 North Elm Street
Butler, PA 16001
PDX Name: Butler: The Grapevine Center, Inc.

Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.

The Grapevine Center, Inc. is consumer operated, independent, non-profit organization formed to benefit persons with mental illnesses which offers services and supports in Butler and has 2 programs that extend into Mercer County. It offers a chance to share problems, advice and ideas with others who have similar concerns, in an atmosphere of understanding, empathy, confidentiality, and companionship. Their mission is to empower peers to mentor, inspire and support individuals and families in recovery and advocate for social justice on behalf of all people.The Grapevine Center will receive $12,636 in PATH funds and will utilize these funds to provide outreach and case management services too-hard to house individuals age 18 and older with serious mental illness or co-occurring mental health and substance abuse disorders that are at risk of or experiencing homelessness.

Describe the organization's participation with local HUD Continuum of Care recipients and any other local planning, coordinating or assessment activities.

The Grapevine Center does not receive HUD funding or administrate any housing programs, however the agency is an active participant in the Butler County Local Housing Options Team (LHOT) and the Service Integration Committee (SIC). The LHOT currently has 27 member organizations, as well as additional community members, who work on a community level to implement the regional, state and Continuum of Care goals and objectives in our county. The LHOT's role is to address program, funding, and networking problems within the homeless and housing service system. The LHOT also assesses housing and homeless service needs within the community, coordinates state and federal grant applications, and serves as an essential information and feedback source for the regional board on homeless programming, services and outcome data. The LHOT participates in many annual needs assessments within our community, focusing on such things as drug prevention, child care needs, and housing and other basic needs. This information is used on a county-wide level to drive planning and programming.

The SIC, is a group of local providers responsible for assisting in the coordination of services offered by multiple community organizations or agencies to meet the broad array of client needs. SIC's objective is to break away from the 'service silos' in order to develop intervention plans which overlap systems and involve multiple providers, and utilize existing resources more efficiently and effectively. This unique collaboration of services will ensure that PATH eligible clients receive the supports necessary to achieve and retain their ultimate goal of self-sufficiency.

In addition, The Grapevine Center works collaboratively with Catholic Charities; the agency designated for Coordinated Entry in Butler County, as well as partakes in coordination activities with other service providers on a daily basis. These organizations include Butler County Human Services, Catholic Charities, Center for Community Resources, Child Care Information Services, Career Link, Office of Vocational Rehabilitation (OVR), Mental Health Association, The Care Center, Glade Run Lutheran Services, Butler Memorial Hospital, the Butler County Assistance Office, the United Way, the Salvation Army, and the Butler County Housing Authority.

Provide a brief description of partnerships with local community organizations that provide key services to PATH eligible clients and describe coordination activities and policies with those organizations.

The Grapevine Center has built positive relationships with various community organizations that have come to partner with them in effectively serving homeless individuals and families. When the Housing Engagement Specialist, funded by PATH , works with an eligible person, they conduct a comprehensive assessment of the person's needs and then make referrals to the various programs mentioned above, as well as any other that a person may need.

In order to effectively serve PATH-eligible clients, the Housing Engagement Specialist strives to connect individuals to appropriate treatment and support services in the community. These connections are critical in supporting the goal of helping homeless individuals and families overcome barriers to self-sufficiency. The Grapevine Center partners with the following community organizations to serve PATH-eligible clients:

- PATH -eligible clients who are unable to secure employment due to their disability are referred to apply for Social Security benefits. A new resource to the community that Catholic Charities works closely with is the SOAR program through Center for Community Resources. Staff at Center for Community Resources are newly trained in completing SOAR applications and the agencies goal is to complete 9 applications this year. PATH eligible clients scoring with the most severe needs on the Coordinated Assessment will be referred to Center for Community Resources for the SOAR program as openings become available.

- Catholic Charities staff assists PATH-eligible clients in applying for all mainstream resources for which they might be eligible. The County Assistance Office provides many of these resources, including cash assistance (in very limited circumstances as the State of PA has eliminated general assistance), SNAP, and Medicaid to eligible individuals and families. PATH service providers then work with the program participants to access medical care through a network of primary care physicians throughout Butler County. Mental health treatment services are available to PATH-eligible clients through a number of providers, including The Care Center, Glade Run Lutheran Services and Family Services of Butler Hospital. The services available include residential, assertive community treatment, outpatient, psychiatric rehabilitation, blended case management, and mobile medication services.
- A variety of drug and alcohol treatment services are also available, both in and out of the county, to give clients an opportunity for recovery. Program participants are referred to the Butler County Drug and Alcohol Program for assessment and referral to the appropriate level of treatment.
- Services for victims of violence are provided by the Victim Outreach Intervention Center (VOICe). VOICe provides free and confidential services to individuals and families who are survivors of various crimes. VOICe works within our community to bring about social change and provide survivors with the ability to take control of their lives.
- PATH eligible clients that are not able to secure medical coverage are connected with the Community Health Clinic of Butler County. The clinic serves county residents with no health insurance and provides them with free outpatient primary medical care, preventive medical services, referrals for specialized services, and free medications when possible.
- Salvation Army, the Lighthouse Foundation, and five local churches offer free community meals for both lunch and dinner during the week, as well as non-prepared food available through a network of over twenty-six different food cupboards across the county.
- Beyond immediate needs, PATH eligible clients are offered numerous ancillary services ranging from peer support and leisure groups, to assistance with furniture, transportation and clothing.
- PATH eligible clients are provided with assistance in accessing other housing in the community, which might involve assisting a client in applying for housing services through another provider within the homeless continuum of care, including the Housing Authority of Butler County, Center for Community Resources, the Lighthouse Foundation, and Victim Outreach Intervention Center.
- Examples of other service programs that meet the needs of PATH eligible clients and assist them in becoming self-sufficient and remaining in permanent housing include, but are not limited to:
    - Representative Payee Program: The Representative Payee program offers community support service through providing a volunteer to handle participants' Social Security benefits on their behalf. This

program assists individuals with disabilities to maintain financial stability in the community.

- Support Groups/Social/Recreational Opportunities: Many homeless individuals, especially the transition-age population, have no experience with, or knowledge of how to access positive and healthy socialization and recreation programs in the community. There are numerous support groups (AA, NA, etc.), as well as socialization and leisure activity programs, in the community available and willing to support PATH-eligible clients.
- S.H.O.P Program: The Supportive Housing Opportunities Program (S.H.O.P) helps participants ready to enter the housing market with all the necessary skills and knowledge to become a successful renter.

Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

The Grapevine Center utilizes the PATH funds primarily to support the individuals engaged through outreach which include both, at risk of homelessness, literal homeless and chronically homeless individuals. A specific role of the Housing Engagement Specialist is to provide engagement and case management services to the hardest to serve, which ultimately reflects back to a majority of our PATH eligible, chronically homeless population or those with a significant amount of months homeless presenting with severe service needs which is also a priority in line with the CoC Prioritization Policy.

Provide specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services.

One of the major target populations for Butler County Human Services are individuals and families who are homeless or at significant risk of becoming homeless. In Butler County, PATH services are fully integrated into our local service continuum and funds from PATH, MH Base, HAP, CSBG, PHARE, Act 137, and HUD, are combined to ensure we have a comprehensive, array of services available. Specific examples of leveraged resources include: connection to the Veterans Administration, Social Security Administration, food banks, clothing stores and more. Many of these resources are utilized to serve PATH eligible individuals. Our strategy is to utilize PATH funding primarily to support the services within our continuum that focus on engaging homeless people and connecting them with the housing, treatment, and resources they need to reach a greater level of stability. At the Grapevine Center, PATH funds are utilized to partially support the Housing Engagement Specialist. Once he is able to connect and engage with a homeless individual or family, he will then accompany them to Catholic Charities where the Central Intake Department completes a comprehensive assessment. Depending

on the situation, ongoing case management services will either be provided by Catholic Charities or will continue to be provided by the Grapevine until the person or family is connected with a housing program. At that time, case management responsibilities are then shifted to the program with which they are participating. These other housing programs that are more long-term in nature are funded by other resources within our system.

Describe any gaps that exist in the current service systems.

For several years, the primary gap in Butler County's homeless system still remains as safe, affordable housing. In Butler County, the units of housing that are available in the private market that are affordable and accessible to the people we serve are often not safe and/or are not conducive to support their continued journey with recovery. Units that are desirable quite simply are often unaffordable to the PATH-eligible clients.

Provide a brief description of the current services available for clients who have both a serious mental illness and substance use disorder.

Butler County recognizes the high percentage of individuals who struggle with dual diagnoses. Statistics in Butler show that 43% of individuals presenting for housing and or homeless assistance reported to have both mental health and drug or alcohol concerns. The Grapevine Center utilizes PATH funding primarily to target homeless individuals and families with mental illness and substance abuse issue while working to provide or connect them with services such as outreach and engagement, housing, information and referral, case management, healthcare related services, and substance abuse and mental health treatment. Butler County is proud to be a Trauma Informed Care Community and is taking the steps necessary to build a trauma informed workforce amongst all the providers. The county also offers several providers who offer dual diagnosis inpatient and outpatient options. These services are often necessary in order to overcome symptoms of their disorders that have likely contributed to their unstable housing situation. In addition, other supportive services are provided that help the target population to build the skills necessary to access and retain permanent housing and also to become productive members of the community. These services include life skills training, personal supports, advocacy, educational/vocational services, socialization, and peer support.

Describe how the local provider agency pays for providers or otherwise supports evidenced-based practices, training for local PATH-funded staff, and trainings and activities to support migration of PATH data into HMIS.

The Housing Engagement Specialist is trained annually, participating in ongoing training opportunities, including evidenced-based practices, in order to perform his job as effectively as possible. The Grapevine Center will support internal training done by Butler County Human Services and attend training and conferences whenever possible. Alternative funding sources including Mental Health Base funds, assist with the cost of trainings that enhance the performance of staff. Examples of a training that PATH staff will participate in are webinars on the LBGTQ community, progressive engagement and

housing first. PATH data in HMIS for this provider is completed by Butler County Human Services, Housing Development Coordinator.

Provide information in whether or not your agency is required to follow 42 CFR Part 2 regulations.

The Grapevine Center, Inc. is not required to follow 42CFR Part 2 regulations.

Provide specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing program, job opportunities and other supports or specific efforts to minimize the challenges and foster support for PATH clients with a criminal history.

The Housing Engagement Specialist with the Grapevine Center has played a vital role in helping individuals obtain the documents necessary to enter the work force and apply for mainstream benefits. Often, the literally homeless, especially those with a criminal background, present with limited or no identification. No identification creates barriers to accessing most services and the Housing Engagement Specialist has developed contacts with the Social Security office, Department of Transportation, Vital Records and others to be able to apply for and receive these documents as quickly as possible. The Housing Engagement Specialist has also found financial resources from other community partners to assist with the cost of obtaining these when necessary. In addition, the Housing Engagement Specialist has worked to form excellent connections with landlords and employers who are open to considering individuals with a criminal history. Often times, all the situation calls for is a call from the Housing Engagement Specialist and the person is given an opportunity.

Describe the provider's status on the transition to collect PATH data in HMIS

The Grapevine Center collects all required PATH data and then provides it to Butler County Human Services, Housing Coordinator who then enters the data required for PATH funding. PATH data elements have been entered into HMIS since Grapevine became a PATH provider in July 2016.

Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

The Grapevine Center uses PATH to fund the Housing Engagement Specialist, who provides case management to individuals who are at risk of homeless, literally homeless and chronically homeless. The Housing Engagement Specialist completes outreach and provides case management services to the hardest to serve in our community in an attempt to engage them so that they will agree to assistance with housing. The Grapevine Center, located very centrally in Butler City, is also close to the outdoor location where homeless individuals choose to sleep in tents, that is commonly referred to as the "PIT". Individuals from the PIT often come to the Grapevine, the

communities' drop-in center, to shower and get a meal or hot cup of coffee. The location creates perfect opportunities for "in reach" for the literally homeless as well.

Describe how services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

PATH funds received by the Grapevine Center are consistent with the State Comprehensive Mental Health Services Plan because funds are targeted for outreach, engagement and case management of homeless and at risk individuals with a mental health or co-occurring diagnosis. Outreach to known and unknown areas where homeless reside is also completed on a bi-weekly basis. The Housing Engagement Specialist funded by PATH, attends weekly the Mental Health Service Coordination Committee Meeting, where mental health providers from inpatient and outpatient services meet to review and provide updates on individuals in all levels of care, as well as coordinate services in the best interest of the individual.

Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how your agencies PATH program supports the efforts to reduce/eliminate chronically homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning in continuity of care planning and the process of updating and testing emergency response plans.

The Housing Engagement Specialist with the Grapevine Center is responsible for identifying, engaging and supporting individuals experiencing a housing crisis or who are homeless and are considered the hardest to serve, providing more intensive case management to a smaller number of individuals who will benefit from this service. The Grapevine Center works closely with our LHOT, RHAB and Continuum of Care to focus on priority populations identified through Opening Doors and HUD

As per the contract with Butler County Human Services, our agency as a whole is required to develop and actively maintain a preparedness plan specifically focusing on continued operations of the organization in the event of an emergency. This plan is reviewed annually, updated as needed, and shared with staff.

Indicate whether the Mental Health Block Grant. Substance Abuse Block Grant or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Indicate if any of these are earmarked for PATH services specifically.

Butler County participates in the Human Services Block Grant, which includes Mental Health Base Funds and funds from the Drug and Alcohol system. The Block Grant represents 30% of Butler County Human Services' base funding. Other than the PATH funds that are administered by Butler County Human Services, additional funding from the Block Grant is designated for individuals who are experiencing homelessness and

have serious mental illness in the community. These funds are contracted to the Grapevine Center to serve the target population. Funds are used to support outreach and case management.

The Grapevine Center functions as the Consumer Drop-In Center in Butler County. We also provide services such as Certified Peer Specialists, Warm-Line, and various other programs aimed to meet the needs of people with serious mental illness. We are aware that many of the people who utilize our services are also struggling with homelessness, which was the impetus for adding the Housing Engagement Specialist position to our organization. As this time, this is the only program that we provide that is specifically designated for individuals who are homeless, though these individuals do participate in many of our other services on a regular basis.

In cases where the state provides funds through intermediary organizations, describe how these organizations monitor the use of PATH funds.

Butler County Human Services is the recipient of PATH funds and monitors the Grapevine Centers PATH funded program annually and their PATH HMIS data is routinely entered by Butler County Human Services

Describe your plan to train PATH staff on the SOAR Online Course and which staff will assist consumers with SSI/SSDI applications and track the outcomes if those applications in the OAT system.

Grapevine Center does not intend to train the PATH funded staff on the SOAR Online Course as it is the purpose of the Housing Engagement Specialist to work to engage hard to reach populations. SOAR however, is being used in our community. A local non-profit agency, Center for Community Resources, Inc.; has had three staff successfully complete the SOAR Online Course. It is the goal of the SOAR trained staff to complete 9 SSI/SSDI applications by December 31, 2017. Butler County Human Services, recipient of the PATH grant, is responsible for tracking the outcomes of those applications in the OAT system.

Indicate what strategies are used for making suitable housing available for PATH clients.

Butler County is participating in the piloting of the Coordinated Entry system for the Western CoC that will be fully implemented by January 2018. Therefore, all PATH eligible clients will be assessed based on need in accordance with the Department of Housing and Urban Developments definition of homeless and with the goals identified in Open Doors, the Federal Strategic Plan to Prevent and End Homelessness. PATH eligible clients are also connected to mainstream resources and referred to such programs as the Housing Choice Voucher through the Housing Authority. The ability to obtain and maintain income is identified and plans to find employment or a referral to SOAR is started shortly after enrollment. In addition, a factor identified as a priority in the Human Services Block Grant plan is housing. As such, initiatives such as landlord

engagement, incentive plans and pursuit and obtainment of funding to increase safe, affordable housing options are in progress.

Indicate if your organization is engaged with the local coordinated entry process of your CoC. Please also describe the roles of key partners in the CoC.

The Grapevine center is engaged with the coordinated entry process. Once the Housing Engagement Specialist engages the individual and they are open to PATH services, they are accompanied to Catholic Charities, a key partner in the CoC and the identified site for Coordinated Entry in Butler County. Catholic Charities then completes the coordinated assessment and makes referrals for housing based on the individuals need. The Housing Engagement Specialist then assesses the individual's best interest and either then gives a warm hand off to the PATH staff at Catholic Charities who officially enroll the client into PATH services or the Housing Engagement Specialist will continue with the PATH enrollment and provide case management until the individual becomes stably housed.

Please indicate of Crisis Intervention Team training is being used in your county/Joinder. If so, please provide approximate % of law enforcement that been CIT trained and feedback on effectiveness.

Butler County began participating in Crisis Intervention Team training in 2011. The Crisis Supervisors help organize and implement the week long training that is held twice a year, in the spring and fall. Being that there are over 10 different police departments serving Butler County, including the State Police which covers a large portion of our rural county, we don't have an accurate count of the total number of officers, or in turn, the % trained in CIT so far. However, Butler County has trained approximately 20 law enforcement personnel along with numerous other first responders and individuals from both prison and probation. In 2016, the crisis team completed a mobile with a first responder approximately 75 times and we have received excellent feedback from them regarding the effectiveness of the training in guiding them to interact differently with people exhibiting mental health symptoms.

Describe the demographics of staff serving the clients, how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients; and the extent to which staff receive periodic training in cultural competence and health disparities.

All programs implemented through the Grapevine Center adhere to a non-discrimination policy, which demonstrates their commitment to provide necessary and effective services to all residents of Butler County regardless of age, gender, religion, sexual orientation, race/ethnicity, health disparities and other differences. Butler County is a primarily rural county located in the southwestern section of the state of Pennsylvania with a population of approximately 183,000 residents. Although there is only a very small percentage of racial mix within our borders, the PATH staff of The

Grapevine Center are well aware of the importance of cultural competence and the need to recognize and value differences in clients, even beyond race, including age, gender, disability, sexual orientation, and health disparities..

Cultural competency within the Grapevine Center's PATH funded services will further be ensured through the participation of consumers and family members in the planning, implementation, and evaluation of the program. These populations will have constant input regarding the operation of PATH services and represent a valuable source of information regarding cultural competency, particularly relating to the target population. In addition, staff attends training a minimum of annually that focuses on cultural competence and health disparities. The Grapevine Center plans serves PATH-eligible clients regardless of age, ethnicity, religion, ability, sexual orientations, familial status etc. The staff member providing case management services to the clients is a Caucasian male, over the age of 60.

Describe the demographics of the client population, the projected number of adult clients to be contacted, enrolled, and the percentage of adult clients served using PATH funds to be literally homeless.

The Grapevine Center serves PATH-eligible clients of all ages, ethnicities, religions, etc. Approximately 92% of program participants are Caucasian and 7% report as Hispanic /Latino. Approximately 39% of program participants are female and 61% are male. It is projected that The Grapevine Center will use PATH funds to contact 18 adult clients and 8 will become enrolled. It is projected that approximately seventy-five (75%) of the adults served with PATH funds will be "literally" homeless. The remaining twenty-five (25%) will be at imminent risk of homelessness.

Describe how individuals who experience homeless and have serious mental illnesses, and family members will be involved at the organizational level in the planning implementation, and evaluation of PATH-funded services. For example, indicate whether persons who are PATH-eligible are employed as staff or as volunteers or serve on governing or formal advisory boards.

The Grapevine Center's mission is: with respect and dignity for all, the Grapevine Center will empower peers to mentor, inspire and support individuals and families in recovery. Grapevine Center will advocate for social justice on behalf of all people. The Grapevine Center proudly boasts a full time Drop-In Center, Consumer/ Family Support Teams, the Certified Peer Specialist Program and the Warmline Program.

The Drop-In Center is open 7 days a week, and an ongoing, recreational, social and educational program to meet the needs of consumers, including monthly activities including parties, dances, picnics, trips to points of interest, shopping expeditions, softball, visits to other centers, etc. The C/FST's provide an invaluable service in improving Behavioral Health services by bringing the input and voice of consumers to the relevant organizations and authorities, providing feedback and corrective action. Grapevine Center Peer Specialist Services are conducted by self-identified

current or former consumers of behavioral health services who are trained and certified to offer support and assistance to others in recovery. Services are based on the principles of respect, shared responsibility, and empowerment. They are voluntary, person-centered and designed to promote recovery through self-determination, understanding, developing coping skills, and resilience through relationship building. The Warmline Program offers services from 6pm-9pm daily including holidays, offering a sympathetic ear for anyone who needs it. In addition, the Grapevine Center offers a full range of resources and support including ; showers to those who need it, free coffee, frequent free meals, access to free local phone calls, free use of computers, a lending library, cable television, movies, pool tables, cards and games. With limited paid staff, many who identify as having a mental illness and others who volunteer their time, all of these services are ran by consumers and families members who have a very active role in the provision of services.

Please identify efforts to support the Transition Age Youth (TAY) Disparity population by providing the following:

The unduplicated Number of TAY individuals who are expected to be served using PATH funds.

It is anticipated that the Grapevine Center will serve approximately 4 TAY individuals this year who are PATH eligible.

The total amount of PATH funds expected to be expended on services for the TAY population

It is anticipated that 50 % of PATH funds will be expended on the TAY population which is approximately $6,318.00.

The types of services funded by PATH that are available for TAY individuals

The Grapevine Center utilizes PATH funding primarily to target the homeless transition age youth with mental illness and substance abuse issues while working to provide or connect them with services such as outreach and engagement, housing, information and referral, case management, healthcare related services, and substance abuse and mental health treatment.

A plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population.

In Butler County**,** The Grapevine Center will reach the general TAY population by talking with the transition age youth already being served through case management to identify known outreach locations and areas frequently visited by the transition age population. Path funded outreach staff will attempt to engage the TAY population they are working with to assist in their biweekly outreach

activities as well. In addition, outreach flyers and information will be targeting to assist in reaching this population, paying special attention to appearance and wording to make information more appealing.

In our geographic region, disparities within the TAY population are can be identified as those:

- exiting the foster system
- identifying as LGBTQ
- diagnosed with behavioral health and/or intellectual disabilities

Strategies the Grapevine Center will take to reduce disparities in this special population in comparison to the general population will be to increase education and training opportunities for the community and service system and as a whole. Butler County recognizes there is great significance to increase overall collaboration amongst its Human Service System and to incorporate a cross systems approach when it comes to service planning. In addition, it is important for service providers to begin developing relationships with foster care providers and other supervised settings before TAY leave these living situations and potentially fall through the system.

Please describe your agencies ability to comply with Executive Order 13166, which requires the recipients of federal financial assistance to provide access to LEP persons in their programs and activities.

The Grapevine Center is in compliance with Executive Order 13166, having taking reasonable steps for LEP individuals to access services. The proportion of LEP persons served is >1% and it is extremely infrequent that LEP individuals come into contact with the program. Butler County consists of a primarily Caucasian population; 96.3% according to the 2015 Census. The Grapevine Center does contract with an interpretation agency, Certified Interpreting Services, to contact when needed and has a policy in place on how to use this service.

Grapevine Center, Inc.
2017-2018
Budget Narrative

Personnel (Positions and Fringe Benefits)- PATH funds in the amount of $10,000 will be utilized to partially fund salaries and benefits for the Housing Engagement Specialist at the Grapevine Center.

Travel- PATH funds in the amount of $600 will be used to fund staff travel necessary in assisting PATH enrolled individuals in accessing mainstream resources, employment training, and other necessary services in order to begin the journey out of homelessness. Public transportation and shared rides are utilized whenever possible.

Supplies- PATH funds in the amount of $150 will be used to purchase office supplies for the PATH workers to aid them in doing their jobs effectively.

Occupancy- PATH funds in the amount of $1,000 will be used to partially pay for the office space used for the PATH worker.

Communications- PATH funds in the amount of $400 will be used to partially pay for the communications equipment, including computer, telephone, cell phone, etc., used by the PATH worker.

Administrative - PATH funds in the amount of $486 will be used to partially pay the Administrative costs that are incurred as a result of operating the PATH program. This amount does not exceed 4% of the direct costs of the program.

Butler County –Grapevine Center Inc.
PATH Program
FY 2017-2018 Budget

*Please add additional rows as necessary

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
Housing Engagement Specialist	$14,731	0.24	$9,000	$9,000
sub-total			$9,000	**$9,000**
Fringe Benefits				
Housing Engagement Specialist	$1,000	0.24	$1,000	$1,000
sub-total			$1,000	**$1,000**
Travel			$600	**$600**
Equipment			0	0
Supplies			$150	**$150**
Other				
Occupancy			$1,000	$1,000
Communications			$400	$400
Administration			$486	$486
sub-total			$1,886	**$1,886**
Total PATH Budget	**$12,636**			

13. Cameron-Elk Behavioral and Developmental Programs

94 Hospital St.

Ridgeway, PA 15853

Contact: Karol Hill

Contact Phone #: 8147728016

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-027

State Provider ID: 4227

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 64,421	$ 21,474	$ 85,895	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 64,421	$ 21,474	$ 85,895	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 64,421	$ 21,474	$ 85,895

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 64,421	$ 21,474	$ 85,895	

Source(s) of Match Dollars for State Funds:

Cameron/Elk County's PATH program will receive a total of $85,895 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 92

Estimated Number of Persons to be Enrolled: 46

Estimated Number of Persons to be Contacted who are Literally Homeless: 46

Number staff trained in SOAR in grant year ending in 2017: 2

Number of PATH-funded consumers assisted through SOAR: 0

CAMERON ELK BEHAVIORAL AND DEVELOPMENTAL PROGRAMS

PATH Intended Use Plan
2017-2018

Local Provider Description -Provide a brief description of the provider organization receiving PATH funds including name, type of organization, region served, and the amount of PATH funds the organization will receive**:**

Cameron & Elk Counties Behavioral and Developmental Programs receive the PATH funds for Cameron, Clearfield, Elk, Jefferson, McKean, and Potter Counties, all located in rural Northwest Pennsylvania. Services are provided directly from this County Office; PATH services are not sub-contracted with a local provider.

The program continues to employ two full-time PATH Liaisons who work with homeless adolescents between the ages of 17-30, diagnosed with a serious mental illness that are homeless or at risk of being homeless. The PATH Liaisons assist consumers in accessing safe affordable housing and identify, as well as, attempt to address gaps in services. One PATH liaison primarily covers Elk, Clearfield and Jefferson Counties while the other covers McKean, Potter and Cameron counties. Territory is divided between the two.

CE Behavioral and Developmental Programs PATH allocation for fiscal year 2017-2018 is $85,895. These funds are used to support two full-time PATH Liaisons (please see section titled staff information for a more detailed report on the function of these two positions). Attached is a detailed budget regarding this PATH allocation.

Collaboration with HUD Continuum of Care Program- Describe the organization's participation in the HUD Continuum of Care (CoC) program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities.

Cameron and Elk Counties PATH Program has a representative in attendance at the following meetings to satisfy the above mentioned criterion. This helps planning, coordination and access to services and activities within the continuum of care and to continue to make others aware of our services. We recently had a PATH liaison apply to membership for a seat on the Regional Housing Advisory Board (RHAB) to prepare for coordinated entry, as well as, gain knowledge of the assessment tool the CoC will recommend using effective January 2018. That application was denied and Cameron-Elk continues to be the only county program not represented on that board.
Housing Specialists in various counties are always seeking new funding sources to increase our ability to house and serve our individuals.

Participation Includes:

McKean County Housing Stability Coalition
Cameron/Elk Counties LHOT
Clearfield County LHOT

Jefferson County Shelter Task Force
Clarion County Shelter Task Force by invitation
Western Region Housing Option Coalition
Consortium Housing Committee
Youth Consortium/Transition Cameron Elk
Youth Consortium/Transition McKean
Youth Consortium Dubois
Youth Consortium Clearfield
Youth Consortium Jefferson
Youth Consortium Potter
Transition Council Clearfield/Centre Counties
Appeal Hearings at Housing Authorities
IEP upon invitation
Family Group Decision Making sessions and referral meetings
McKean County Collaborative Board
Cameron County Collaborative Board
Elk County Family Resource Network Collaborative Board
Potter County Collaborative Board
Clearfield County Collaborative Board
Jefferson County Collaborative Board – COFAC
Independent Living meetings by invitation
Community Connections Dual diagnosis by invitation
Pennsylvania's Homeless Children's Initiative
Recovery in the Stix
Clearfield Jefferson CSP Day
Local Health Fairs
Community Support Programs
WRHOC-Biennial Summit/Conference
NW Landlord Association
Point-In-Time Counts
Homes Within Reach Conference
Continuity of Care
Youth Standing Committee
Forensic treatment teams at County Prison
Forensic treatment teams in the community
Clearfield/Jefferson Provider Resource Meeting
Continuum of Care

Collaboration with Local Community Organizations- Provide a brief description of partnerships with local community organizations that provide key services (i.e., outreach teams primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

Close collaboration with community organizations providing key services has proven to be beneficial to connecting individuals more efficiently and effectively. Recently we have had

growth in our collaborative agencies resulting in newer programs. By constant communication both in and outside of meetings we continually network to provide outreach through PATH or other focused services to meet individual needs. Programs and agencies that work closely with PATH to offer services and outreach to our population are:

ELCAM Transition Apartment
Cenclear Transitional Housing Program
The Public Housing Authorities and Section 8 programs
Shelter + Care Rental Assistance through the DuBois Housing Authority
CLIP (Community Living for Independent Persons) through Community Connections
Housing Plus, Permanent Supported Housing, Elk & Cameron Counties
AHEAD Permanent Supported Housing Elk County
NW9 Clarion Housing Authority Master Leasing/Bridge Program
Lawrence County Phase I & Phase II
Home Again
Housing for Homeless &Disabled Persons through Clarion Jefferson Community Action
Fairweather Lodges
Fairweather Training Lodge
Evergreen Elm
Northwest Regional Housing Alliance
Local Housing Assistance Programs (HAP)
Community Action Agencies
Homeless shelters-YWCA of Bradford, C.A.P.S.E.A., Marian House, Just for Jesus, Good Samaritan Shelter, Holmes House, Haven House, Tomorrow's Hope (veteran's only)
Area Transportation Authorities
Office of Vocation and Rehabilitation
Blended Case Management (multiple providers)
Forensic Case Management (multiple providers)
Outpatient Therapy at the local Mental Health Clinics
Med Management (multiple providers)
Department of Human Services (former CAO)
Supported Living Programs – multiple providers
Independent Living Programs - multiple providers.
Certified Peer Specialist (multiple providers)
Forensic Peer Specialist
Local food banks
Local clothing giveaway programs (i.e. Guardian Angel Center)
Free meal programs (Multiple Providers i.e. Kings Table)
Catholic Charities
Agape
Mobile Psych Rehab
NAMI
COPE Drop-In Center
The Cove Drop-In Center

School Districts and Intermediate Units 6, 9, and 10
Center for Community Resources
Workforce Investment and Opportunities Act – Youth Consortia at North Central
Regional Planning and Development Commission
Social Security Administration
Goodwill Industries of North Central PA
New Choices/New Options
Drug & Alcohol Counseling and treatment facilities
Local jails and Probation/Parole
Children & Youth Agencies
Children's placement facilities such as Residential Treatment Facilities and Therapeutic Foster Care
Project Rapport serves pregnant and parenting youth.
Nurse Family Partnership offers services for first time pregnant youth
Recovery Supports
Employment Supports
Family Group Decision Making Process
Veteran's Affairs
Transition Age Support Services Program (TASS)
Community Guidance

Coordination with those organizations – When not working with these services directly, contact is maintained through several meetings listed in section 4. An example of coordination across systems is The WIOA Summit to connect education and industry, educating our youth for jobs in our local industries and our rural environment.

Service Provision- Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

- Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

  As we continue to strengthen relationships with landlords in an effort to utilize resources, we continue to gain knowledge of new housing initiatives, trainings, webinars, as well as, keeping current with housing regulation changes, such as, new definitions, coordinated entry, and Housing First.

  The building of relationships with shelter staff, church groups, police, hospitals, and County Assistance offices remains a priority. PATH in collaboration with CAPSEA's Housing Coordinator will be conducting a sheltered count on January 24, 2017 to increase the numbers for our Outreach. Due to living in such a rural area, outreach has always been very difficult. However, we continue to see an increase in word of mouth referrals from past PATH participants.

- Provide Specific examples of how the agency maximizes the use of PATH funds by leveraging use of other available funds for PATH client services.

CE PATH funding supports wages of liaisons. We constantly refer to other available funds for client services. We have access to PHARE dollars, HAP money, and CAO funding along with several other small funding streams in our rural communities.

- Describe any gaps that exist in the current service systems.

  Gaps in services that arise while working with this population are as follows:

  - Marcellus Shale continues to have an impact on our fair market rents.
  - Applications to Housing Authorities are not accepted prior to the individual turning 18 at which time they are placed on a waiting list of 1 to 2 years. This holds true for the majority of public housing programs. Most of the housing voucher programs are closed.
  - Very limited number of shelter beds. Cameron and Potter Counties have no homeless shelters. McKean and Elk Counties have female shelters and they limit vouchers to males for hotels for up to 1 or 2 days. Clearfield County has a men's shelter, a women's shelter and a family shelter. Jefferson County has a women's shelter. All shelters only take youth 18 and older and domestic violence shelters take homeless only depending on availability. They are usually full.
  - The push to house the chronically homeless population first has left a huge gap for first time homeless families. The new definition has created a barrier making it more difficult to house individuals. This is a large problem for the rural areas.
  - There are only two transitional housing project in any of the counties that can address the limited independent living skills of this population. There continues to be a need for a "step down" program for the population that is aging out of placements such as Residential Treatment Facilities, foster care or Juvenile Justice Placements. The program offered in Jefferson County is not supervised 24/7 and does not offer services specific to the population.
  - Accessing identification (i.e. Photo I.D., Birth Certificate, and Social Security Card) for individuals has also been difficult; and now there is an increased cost to obtain them as well. Yet, without it, consumers cannot apply for other needed benefits, such as public assistance, social security, and housing.
  - An individual over 19 or out of school has difficulty qualifying for any benefit program.
  - Skepticism of landlords willing to rent to young people with limited independent living skills. Some landlords raise rents to avoid working with the programs. In addition, landlords are unwilling to include water and sewage in the monthly rent amount.
  - Difficulty in coordinating employment opportunities through OVR.
  - Difficulty finding employment for youth who often have limited skills and experience.

- Lack of transportation, especially during non-traditional hours and weekends coupled with very limited county to county routes.
- Young people leaving a Children & Youth placement upon turning 18 while still enrolled in High School.
- Lack of natural supports. These individuals have burned bridges with family, friends, and agencies.
- Accessing services and housing for individuals with a history of sexual offending.
- Accessing housing for individuals with a history of felony convictions and sometimes even misdemeanors
- Very limited psychiatric time makes it difficult to get evaluations and prescriptions in a timely manner especially for those leaving jail.
- Medical Assistance Transportation Programs discontinue the service for individuals that have missed rides without cancelling.
- Local Behavioral Health and Physical Health providers will close individuals after too many missed appointments.
- Changes in medical coverage at the CAO level that leaves some people without coverage for behavioral health services.

- Provide a brief description of the services available to clients who have both a serious mental illness and a substance use disorder.

  Although services are available to dually diagnosed individuals; access is not always immediate. Throughout the six counties the following programs are available:

  Bradford Recovery Systems Inpatient Psychiatric Unit.
  Maple Manor short term residential facility
  Recent expansion of Alcohol and Drug Abuse Services Cameron, Elk, McKean and Potter Counties
  Erie City Missions
  Community Guidance
  Clearfield Jefferson Drug and Alcohol Program
  Pyramid Healthcare
  Penn Highlands DuBois Behavioral Health
  DCI
  CenClear Services
  The Guidance Center
  Blue Dog Counseling
  Beacon Light Behavioral Health
  Mental Health services in the county prison
  Service Access Management

- Describe how the local provider agency, pays for or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data into HMIS.

- PATH staff attends trainings as applicable.
- Attendance at HMIS TA in April 2016.
- Attendance at upcoming PATH conference scheduled for June 2017.
- Participation in available webinars.
- CHIPP and MH Base dollars to support Evidence Based Community based services.

- Please provide information on whether or not you agency is required to follow the 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

  CE MH/MR is not required to follow the 42 CFR Part 2 regulations because we have not Drug and Alcohol programs at our agency. Therefore our PATH reporting is not bound to these regulations.

- Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry).
  - Frequent communication with County Prison Staff and Forensic Treatment Team, which include Probation to address building upon current strengths, barriers that exist with the transition age population.
  - Development of a community reentry plan at start of incarceration.
  - Collaboration with County Assistance to ensure more immediate access to benefits, psychiatric time and medications after release from prison.
  - Funding of a Forensic Blended Case Manager to assist with completing county assistance applications prior to discharge, as well as ensuring appointments are scheduled with County Assistance on the day of release.
  - Enhanced housing/supported services available to reduce/divert individuals from entering the Criminal Justice System.
  - Commitment of CHIPP Dollars to continue supporting the Forensic Program to ensures individuals have access to Mental Health Services while incarcerated. This includes but is not limited to Psychiatric time, Outpatient Therapy and Medication Management provided by an RN. In addition, case management, peer specialists, employment support and drug and alcohol services connect with this population prior to reentry into the community.
  - Continued active participation in Criminal Justice Advisory Board (CJAB) meetings to address the needs of the Forensic population, which includes the transition age.

Data- Describe the provider's status on HMIS transition plan, with accompanying timeline for collecting all PATH data in HMIS by FY 2017. If providers are fully utilizing HMIS for PATH services, please describe plans to continued training and how you will support new staff. Indicate specific PATH HMIS Directors (those who write the code) and the organization which is in charge of HMIS for each provider.

Currently PATH liaisons are reporting data to housing programs (Shelter + Care, AHEAD, and Home Again)
C/E attended training on PA PATH HMIS in July 2013 and is moving forward in the implementation of HMIS at this time. We have started entering data beginning with July 1, 2015. PATH Liaisons attended the April 2016 TA HMIS training as well. Our Director for HMIS is Brian Miller from the PA HMIS System.

Alignment with PATH goals- Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

PATH services have always provided street outreach when able in our rural community which is limited on encampments and street homeless. We provide case management to obtain Housing First when beds are available and then refer to provider agencies to continue needed services. We will comply with coordinated entry as per our CoC once it rolls out in January 2018. Until that time, we will continue to focus on our vulnerable populations.

Alignment with State Comprehensive Mental Health Services Plan- Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plan.

CE's PATH program follows the Housing First model to stay with the states plan to end homelessness. Our agency has CoC funded HUD dollars to administer a chronic housing program, making chronically homeless a priority. This is applied to all of our housing programs in an effort to reduce/eliminate homelessness.

Alignment with State Plan to End Homelessness- Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH Program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

As mentioned previously, we are limited on the number of street homeless in our rural area, but that does not mean they don't exist. We will continue to provide case management in an effort to obtain Housing First. Once initiated, we will also use our CoC's coordinated entry plan and assessment to ensure we continue to serve the most vulnerable of our population.
PATH program workers plan to attend another disaster preparedness program when offered in our region in the near future to further our readiness. PATH staff has been trained in the past and were registered for additional training which was cancelled by the organizer due to low

registration numbers. Currently our PATH Liaisons follow the Agency Disaster Preparedness Plan.

Other Designated Funds- Indicate whether the Mental Health Block Grant, Substance Abuse Block Grand, or general revenue funds are designated specifically for serving people with experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for APATH series specifically.

CE Behavioral and Developmental Programs do not utilize Block Grant Funding from any source for PATH Services. CE MH funds are utilized to provide services to the MH population.

Programmatic and Financial Oversight-
In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

PATH services are provided by CE. Financial oversight is completed internally by CE's Fiscal Department.

SSI/SSDI Outreach, Access, Recovery (SOAR)- Describe the provider's plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR during the grant year ended in 2017 (2016-2017), the number of PATH funded consumer assisted through SOAR.

CE Behavioral and Developmental Programs were SOAR trained October 28 & 29 2013. There were 2 PATH workers trained along with administration, supervisors, and BCM's from our Provider Agencies. Since both PATH workers have been trained, we have no plans for additional trainings in the 2017 grant year. To date, we have had 2 SOAR eligible consumers, both being awarded in a timely manner. CE's Housing Specialist represents the SOAR lead and provides technical assistance as needed.

Housing- Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Individuals involved in the PATH Program are linked with housing based upon their needs and wants. When the PATH Liaison receives a referral and meets with the individual, they discuss their housing needs and what would be acceptable to the individual before exploring options. In some circumstances other temporary housing options are used due to waiting lists being long and closed. Most individuals are moved into apartments and then given the supports they are willing to accept. Support services are geared to development of independent living skills and employment outcomes for them.

Types of Housing Programs Include:

AHEAD-CE Behavioral and Developmental Programs
Shelter + Care-DuBois Housing Authority

Section 8-Local Housing Authorities
Public Housing-Local Housing Authorities
Fairweather Lodge- Clearfield/Jefferson Counties
Housing Plus-CAPSEA
Lawrence County Phase I & Phase II-LCCAP
NW9 Master Leasing / Bridge-Clarion Housing Authority
Home Again- Cameron/Elk Behavioral and Developmental Programs
Housing for Homeless and Disabled Persons-Jefferson/Clarion Community Action
Transitional Housing Program- Cenclear
Transition Apartment-ELCAM
PHARE Housing Stability Project-Cameron-Elk Behavioral & Developmental Program/CAPSEA

Coordinated Entry- Indicate if your organization is part of the coordinated entry program. If so, explain the coordinated entry process and through whom it is governed/monitored.

CE will follow the Western CoC coordinated entry plan once it is implemented in January 2018.

Justice Involved- Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

Cameron-Elk does not have a Crisis Intervention Team available.
A contracted Provider Agency is licensed for Mobile, walk-in and telephone crisis for Elk County residents.

PATH counties currently are not utilizing specialized courts (i.e. veteran courts, drug courts). Our county MH program has funding for services to decrease recidivism in our forensic population. PATH Liaisons work to connect consumers to these services. PATH workers are also kept abreast of CJAB meetings and planning. Approximately 35% of PATH individuals being served are justice involved.

Staff Information- Describe the demographics of staff serving the clients; how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, transgender, racial/ethnic, and differences of clients; and the extent to which staff receive periodic training in cultural competence and health disparities. A strategy for addressing health disparities is use of the recently revised National Culturally and Linguistically Appropriate Services (CLAS) standards: (http://www.ThinkCulturalHealth.hhs.gov)

The CE PATH Program employs two female Caucasians who are life-long residents of the area. They have both raised children of their own, so they understand some of the issues this population has to deal with. Both come to the position of PATH Liaison with a multitude of employment experiences –Partial Hospitalization Program staff, inpatient D&A treatment counselor, inpatient mental health treatment counselor, face to face evaluator in an ER, domestic violence volunteer, Children and Youth Services County Caseworker, YWCA Housing and

Employment Services Caseworker, Recovery worker, Forensic case manager, Forensic Mental Health Specialist and Blended Case manager. This experience gives them a broad based understanding of the population served and knowledge of how to relate and engage these young adults.

Once a referral is received by the PATH Program, the Liaison meets with the individual to assess their needs. PATH has been successful in linking individuals with services to deal with racism, language barriers, sexuality, and other stereotypes. In this rural area there has been an increase in diversity among our population. All our youth are treated with respect and sensitivity. We have contacts with the Self-Determination housing Project through our Regional Housing Coordinator. We also have contacts in the Fair Housing realm.

Staff of the PATH Program attends training in Cultural Competency (most recent training held in April 2017). and will continue to do so as trainings are offered. The PATH Liaisons attended trainings specific to mental health disorders, treatment options, and cross systems training. Many of these trainings offered a cultural competency component. We will continue to take advantage of any Webinars that help us better serve our population, as well as, attendance at the upcoming PATH conference in June 2017.

Client Information- Describe the demographic of the client population, the projected number of adult clients to be contacted/enrolled and the percentage of adult clients served using PATH funds to be literally homeless.

CE Behavioral and Developmental Program's PATH Project serves homeless adolescents between the ages of 17 and 30 diagnosed with a serious mental illness. The majority of individuals carry a diagnosis of Major Depression, Anxiety, or Bipolar Disorder. The population served last fiscal year was 36% male and 64% female and the majority was Caucasian. At the time of referral 66% had graduated from High School or received their GED. Of that, 11% had some post secondary education. Our youth usually have little or no income. At the time of referral 22%were employed. Many are applying for SSI or waiting for an appeals hearing. Prior to becoming homeless, the individuals referred to PATH came from family, "couch surfing", Residential Treatment Facilities, Foster Care, friends who take them in temporarily, jail or shelters. Of those engaged w/ PATH 34% are diagnosed with a substance abuse disorder, as well as, a serious mental illness. We have noticed an increase in co-occurring individuals.

> It is predicted, based on looking at previous figures, that this PATH Program will serve at least 92 new individuals during fiscal year 17-18 and continue to serve at least 74 individuals who are already in the program for a total of 166 people. Because of the length of waiting lists and new criteria for "chronic first", the number of those still in the program will continue to grow.
>
> Path Liaisons project that 46 individuals will be enrolled into the PATH Program.

The PATH Liaisons estimate that approximately 50% of these individuals will be literally homeless in addition to those who are at risk of homelessness. The trend of seeing increased numbers of single parents finding themselves without a place to live continues.

Consumer Involvement- Describe how individuals who experiences homelessness and have serious mental illnesses, and family members will be *meaningfully* involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See **Appendix I** for Guidelines for consumer and family participation.

When meeting with a PATH eligible youth for the first time they are told about the program and how it can assist them in finding safe affordable housing. If they are interested in enrolling with PATH we discuss various other services and options available to them. These include but are not limited to connections with other services in the community as well as connections with family and friends for support. All PATH services are voluntary and these individuals choose what they feel will best meet their needs.

Currently the budget does not allow for PATH eligible people to be hired by the program. If employment is what they seek we can refer them to Employment Support Services or our local Career Links.

We encourage volunteering and participation on formal or governing boards. We continue to have a PATH consumer on our Local Housing Options Team (LHOT). She has been a member for over 3 years now and was active in planning the Team's Housing Expo. She now handles all PR for the LHOT via the web. PATH Liaisons will continue to encourage individuals to become involved in the Certified Peer Specialist program as they work towards their own recovery.

Health Disparities Impact Statement- Please identify efforts to support the Transition Age Youth (TAY) Disparity population by providing the following:

- The unduplicated number of TAY individuals who are expected to be served using PATH funds.

  We expect to serve 166 TAY individuals with PATH funds. This will include current and new individuals who will pass through our program throughout the fiscal year. Our PATH grant was written only to serve TAY; therefore, all funds serve this population. We continue to see a need for assistance in this population and plan to continue serving only TAY with our PATH funds.

- The total amount of PATH funds expected to be expended on services for the TAY population.

  PATH funding covers 6 counties in this rural area of Pennsylvania. These dollars are used to fund 2 PATH Liaisons to assist individuals with housing, as well as, connect them with services and supports within the community. In addition, when individuals

have no payment resources for services, CE MH Base and CHIPP dollars can be requested for said service.

- The types of services funded by PATH that are available for TAY individuals.

  PATH funds two full time liaisons that cover Cameron, Clearfield, Elk, Jefferson, McKean, and Potter Counties. Our allocation does not allow for us to directly fund services for our consumers. Our Liaisons are a direct link to services and make referrals to outside providers for the following services:

  Blended Case Management
  Recovery
  Mobile Psych Rehab
  Outpatient
  Peer Support
  Employment Support Services
  Food banks
  Transportation
  Med Clinics
  Security Deposits
  Utility Assistance
  TASS
  Medication Management

  Although PATH does not fund these services directly, we encourage their use and can have them authorized through other funding sources.

- A plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population.

  As previously mentioned, our PATH allocation is only for TAY. In serving this population we are continuously reaching out to area providers regarding their policies and terms of services. In some instances, their policies have a negative effect by increasing these disparities. We do have a county mental health plan in place that addresses some of these issues on a larger scale. However, for PATH, we address these issues as they arise with the providers as necessary. For example, some of our providers have a no show policy that if you miss 3 appointments you can only re-enter services after attending 3 consecutive group sessions at their site. This creates a hardship for some of our consumer's schedules. CE will continue to have discussions with Provider agencies to ensure the quality and quantity of service delivery remains consistent.

Limited English Proficiency –
Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* available at:

https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.

Cameron –Elk has limited resources for LEP individuals. Because the need is minimal in our area, on an as need basis, we will access the following:

- Local Public Libraries reading program.
- Cameron and Elk County Assistance offices as a resource to translation services.
- Utilize, on an as needed basis, via phone/video, *Language Line Solutions*.

Budget Narrative-

Our allocation for PATH is going to be used on Personnel, Fringe Benefits, Travel, Supplies and various categories under Other including Occupancy, Insurance, Telephone, Postage, Training and Computer Expenses. We are projecting that total expenses for the PATH program in 2017/2018 will be $85,895 which will be funded by the Federal and State allocation dollars. The accompanying Budget will total this amount.

Personnel - We have 2 case managers who provide PATH services. One of the case managers spend 60% of her time on the program and will be paid 60% out of the allocation and the other spends 75% of her time on the program, and will be paid 75% out of the allocation. We have arrived at these figures with a time study.

Fringe Benefits - FICA, Healthcare, Retirement, Unemployment Compensation, Worker's Compensation and Life and Disability Insurance are all included as fringe benefits. All of the calculations are based on the time study as well, with each expense charged at the PATH percentage of time for each Case Manager.

Travel - Travel is calculated using 2 categories of expenses. Projected expenses for 2 Case Managers traveling for both outreach and consumer contact equals $2,194 for the year. Aside from this expense which will cover gas and a $0.40 per mile reimbursement when necessary, another $494 has been added for incidental vehicle maintenance according to our cost allocation plan.

Supplies - Projected expenditures for this category total $400. Included are expenses for office supplies, $311, and for the cost of copies for various files, $89. Both of these are based on historical use over the past few years.

Other - As mentioned, we have several categories under the "Other" line item:

Occupancy - Total cost for occupancy is $2,573 for the year which is calculated using our cost allocation plan which takes our overall price per square foot times the amount of space our Case Managers occupy times the percentage of their time spent on the PATH program.
Insurance - Total cost for insurance is $2,023 which includes all required coverage for Professional Liability, Auto, Property, etc. The amount is calculated using our cost allocation plan which, depending on what kind of coverage, is based on time, office space, vehicle use as tracked by the mile, or a combination of several of these items.

Telephone - Telephone expenses are budgeted at a total cost of $1,015. Verizon cell phone expenses and Windstream telephone service are paid at the percentage of use as tracked by usage per program.

Postage - This Expense is estimated to be around $60 from prior year comparisons to send out various correspondences.

Staff Training - $145 for various Training opportunities that's may benefit the program throughout the year.

Computer Expense - $97 for Internet, updates, upgrades, etc.

Submitted by:

Judy Smith, Mental Health Program Director
Karol Hill/Jennifer Quiggle, PATH Liaisons
Jacob Gardner-Chief Fiscal Officer
Cameron-Elk Behavioral and Developmental Programs
94 Hospital Street, 4th Floor
Ridgway, PA 15853
814-772-8016

Cameron and Elk Counties
Cameron Elk County Behavioral and Developmental Programs
FY 2017-2018 PATH Budget

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
Position				
Case Manager	$ 41,080	.60	$ 24,648	$ 24,648
Case Manager	$ 28,548	.75	$ 21,411	$ 21,411
sub-total	**$ 69,628**		**$ 46,059**	**$ 46,059**
Fringe Benefits				
FICA Tax	$ 5,292		$ 3,500	$ 3,500
Health Insurance	$ 32,948		$ 22,400	$ 22,400
Retirement	$ 5,083		$ 3,362	$ 3,362
PA Unemployment	$ 899		$ 674	$ 674
Worker's Compensation	$ 480		$ 361	$ 361
Life Insurance	$ 718		$ 539	$ 539
sub-total	**$45,420**		**$30,836**	**$30,836**
Travel				
Clients/Outreach	$ 2,194		$ 2,194	$ 2,194
Vehicle Exp	$ 494		$ 494	$ 494
sub-total	**$ 2,688**		**$ 2,688**	**$ 2,688**
Supplies				
Office Supplies	$ 311		$ 311	$ 311
Copies	$ 89		$ 89	$ 89
sub-total	**$ 400**		**$ 400**	**$ 400**
Other				
Occupancy	$ 2,573		$ 2,573	$ 2,573
Insurance	$ 2,023		$ 2,023	$ 2,023
Telephone	$ 1,015		$ 1,015	$ 1,015
Postage	$ 60		$ 60	$ 60
Staff training	$ 145		$ 145	$ 145
Computer Exp	$ 97		$ 97	$ 97
sub-total	**$ 5,913**		**$ 5,913**	**$ 5,913**
Total PATH Budget				**$ 85,895**

14. Clarion County - Center for Community Resources

214 South 7th Avenue

Clarion, PA 16214

Contact: Sarah Knepper

Contact Phone #: 8142261080

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID:

State Provider ID:

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 34,814	$ 11,605	$ 46,419	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 34,814	$ 11,605	$ 46,419	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 34,814	$ 11,605	$ 46,419	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 34,814	$ 11,605	$ 46,419	

Source(s) of Match Dollars for State Funds:

Clarion Co will receive a total of $46,419 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 75

Estimated Number of Persons to be Enrolled: 60

Estimated Number of Persons to be Contacted who are Literally Homeless: 8

Number staff trained in SOAR in grant year ending in 2017: 1

Number of PATH-funded consumers assisted through SOAR: 0

Clarion County
PATH IUP
FY 2017-2018

Local Provider Description

The Clarion County Mental Health is the PATH program of record. The region served is limited to Clarion County. The PATH provider is "Center for Community Resources" (CCR). CCR became the PATH provider on January 1, 2015.

CCR is a non-profit human services company that originated in Butler County. Their location in Clarion County is 214 S. 7th Ave., Clarion Pa 16214. The services they provide in Clarion include the base service unit functions, crisis services, the mental health Drop-In Center, transitional/supported housing services, Early Intervention Service Coordination, Intellectual Disabilities Supports Coordination and Representative Payee. The Clarion County Mental Health Administration is the pass-through agent for PATH funding and monitors the services provided.

The PATH program is located in the MH/DD Program's Mental Health Base Service Unit (BSU), located at the above listed address. The BSU serves as a point of intake and referral for mental health related services, information and resources.

The services and programs available in Clarion County are available to persons with serious mental illness, including those with serious mental illness who are homeless or at imminent risk of homelessness.

Collaboration with HUD Continuum of Care (CoC) Program –

Clarion County is a partner in the Northwestern Region Continuum of Care, Regional Housing Collaborative, Local Housing Options Team, and the Clarion County Shelter Task Force. Currently the Shelter Task Force is working to establish additional emergency housing options in Clarion as well as sharing resources and ideas in a collaborative effort to secure a better solutions to the chronic homeless situation in Clarion County. Clarion County participates in the point-in-time homeless counts. Locally we work closely with the Housing Authority to assess homelessness, monitor housing availability and costs, and coordinate housing for the homeless and at risk of homelessness population. We also work with the Housing Authority to help clients meet HUD eligibility requirements and to maintain them in permanent housing. Both programs keep each other informed of needs and opportunities. The Housing Coordinator also utilizes Behavioral Health Alliance of Rural Pennsylvania (BHARP) to assist individuals financially with their housing needs in an effort to keep individuals from becoming homeless and to collaborate on getting more help to those in need through referral resources. To date the Housing Coordinator has been granted $38, 492.94 through BHARP funds.

Collaboration with Local Community Organizations –
The County does have a Local Housing Options Team (LHOT) in conjunction with Jefferson County. We continue to have active representation at team meetings, which includes representatives from HUD, Community Action, domestic violence shelter (SAFE), Haven House, local ministries, Salvation Army, and other human services agencies such as CYS and Adult Services/Housing Assistance Program.

The Shelter Task Force of Clarion collaborates to explore funding and programming options for emergency and transition housing solutions in Clarion. The Shelter Task Force presents to various groups highlighting the homeless and housing issues in our area. We continue to educate the community about homelessness and create community support for funding and programs to serve the homeless in Clarion. The Task Force is currently working with the Bridge Builders for funding sources, and has held several successful fundraisers including an annual soup luncheon.

As a member of the Northwest Regional Housing Alliance (NWRHA), we have two funding slots available for housing in Clarion County. This pays 100% of rent for persons who meet chronically homeless criteria.

The Clarion County Human Services Council serves as a venue to exchange program information and provides opportunities to network and coordinate services among all the public and private social services in the County. Clarion County MH/DD and CCR are active participants in the Council.

A Federally Qualified Health Center (FQHC) operates in Clarion County providing primary care, behavioral health care, drug and alcohol treatment, and dental care. We are active with the Task Force that planned for the FQHC and refer consumers to their services. PATH promotes its services through the FQHC.

PATH refers consumers to the Career Link that serves Clarion County for employment services, Office of Vocational Rehabilitation (OVR), and Workforce Investment Board (WIB) for transition age skill development and employment opportunities. The PATH Administrator attends service organization meetings with representatives from these agencies for updates and for sharing program information.

The PATH Housing Coordinator is also active in the Drop-In Center. This outreach not only helps with identifying and assisting at risk populations, but allows CCR to promote the services, supports and resources available to this population.

Service Provision

Clarion County utilizes BHARP (Behavioral Health Alliance for Rural Pennsylvania) funds in addition to the PATH funds. During the 16/17 fiscal year, the Housing Coordinator was able to apply and be approved for over $30,000 of BHARP dollars.

The Housing Coordinator also utilizes other agencies to help support homeless individuals in Clarion County. We have utilized SSVF (Supportive Service for Veteran Services) for homeless veterans in Clarion County. We have also utilized Community Action to assist in paying for a hotel for an emergency homeless situation.

The Housing Coordinator leverages PATH funds by utilizing other funds in the community such as assisting individuals with applying for medical assistance, food stamps and utility assistance. This helps alleviate their payout and open up their funds for their housing needs.

Our agency is not required to follow 42 CFR Part 2 regulations.

Center for Community Resources has a Forensic Liaison in house that works closely with the housing coordinator. When the Forensic Liaison is completing the intake, she is able to assess their housing needs and refer them to the Housing Coordinator as needed. The Housing Coordinator also works closely with probation to ensure that individuals are following their probation guidelines. If our PATH client is released from jail and becomes a resident of Hope Homes, the Housing Coordinator meets with the individual weekly to make sure the individual is meeting their goals. These meetings will include any other agencies that are currently working with the individual.

The Mental Health Housing Coordinator (HC) contacts the owners of businesses and requests permission to leave information at their sites and to contact him if they believe someone might be in need of our services. Once potential consumers are identified and located, the HC will attempt to make contact and offer case management services and other resources and services. Resources include but are not limited to MH services within the County, Drug and Alcohol Services within the County, transportation, other housing programs, furniture needs, rentals in the community, public housing, churches, food banks, etc.

The Housing Coordinator will continue to visit the Drop-In Center and other places such as 24 hour convenience stores and Laundromats, points where homeless people may seek refuge for the night or might be in transition to or from different locations, wherever homeless individuals are likely to be found and engage in a face-to-face contact with potential or current consumers for the purpose of engaging or re-engaging in services.

The services provided with PATH funding include:

1) Screenings – The Housing Coordinator will provide screening to determine the consumer's eligibility for PATH services.

2) Referrals – When appropriate, the Housing Coordinator will provide referrals to primary and behavioral health services, job training, and educational services. The Housing Coordinator will also refer the

consumer to other services, resources and supports that will be appropriate in helping them to remain in or access housing.

3) Supportive Services- Designed to stabilize and maintain the individual in a residential setting. The Housing Coordinator provides assistance on a one-to-one basis in those areas which are needed for the individual to be able to maintain their housing. This includes activities such as budgeting, housekeeping skills, self-advocacy skills, scheduling, utilizing community resources, time management and other daily living skills.

Describe any gaps that exist in the current service systems

- Emergency and transitional housing has been an ongoing issue. The Mental Health Administration, in collaboration with CCR opened a 30 day emergency housing unit to aid homeless individuals and families. However, this is very short term and can only provide assistance to one person/family at a time.

- Ongoing housing assistance on a short and long term basis for people who are temporarily without sufficient income, i.e. those waiting for their social security income (SSI) to begin or those who are unemployed/underemployed.

- Housing that will accept clients with a serious mental illness, who have a history of destructive or criminal behavior. This includes those being released from jail and the prison system. The NW9 Master Leasing and Bridge Housing previously filled some of this gap, however Clarion County does not currently have a sustainability plan and with the funding ending in September of 2017, is no longer accepting NW9 applications.

- Assistance with rent and utilities- available on a limited basis through the Housing Assistance Program (HAP), BHARP and from other community agencies. However, the amount available is considerably less than the need. Sustainable, ongoing assistance is also a need.

Provide a brief description of the current services available to clients who have both a serious mental illness and a substance use disorder

The Mental Health Program has a variety of services available to persons with a serious mental illness who are homeless or near homeless. These services are also available to those who are co-occurring. These services include:

- Outpatient counseling
- Crisis intervention
- Case management
- Housing services
- Psychiatric Rehabilitation
- Representative Payee
- Drop-in Center for socialization and recreational activities
- Peer Support services

Because the PATH Program is an integral part of the MH BSU, access to mainstream MH services is readily facilitated and becomes part of the overall service planning process. Once releases are obtained, the PATH Housing Coordinator works closely with MH case managers and other mental health staff, keeping them informed of the consumer's housing situation.

Substance abuse services include the Armstrong-Indiana Clarion Drug and Alcohol Commission which provides prevention and education programs, case management and referrals to more intensive services, such as detoxification, inpatient or residential treatment and peer support services. Outpatient counseling, intensive outpatient counseling and referral for inpatient treatment is provided by ARC Manor, a subcontractor located in the Primary Health Network building right off the exit of Interstate 80. Additional drug and alcohol treatment programs are available through a second subcontractor, Cen-Clear which began July 1, 2015. They are providing D&A counseling services, outpatient groups and a partial program.

Coordination of services for those with co-occurring issues is done via collaborations between mental health providers, the BSU, case management and the Armstrong Indiana Clarion Drug and Alcohol Commission, with treatment provided by ARC Manor and Cen-Clear.

Describe how the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data in HMIS

The provider does support evidence-based practices through least restrictive, consumer choice, and recovery oriented services. We encourage all employees who work with housing programs to familiarize themselves with these practices. We support a recovery model and offer choice in housing and services to all PATH consumers.

The MH provider staff, including the PATH Housing Coordinator, attends and receives training on family and consumer related issues on a regular basis. The Housing Coordinator also attends informational trainings and conferences on current trends, issues, resources and programs. To support collection of PATH data in HMIS, the Housing Coordinator has access to free PA HMIS trainings as well as HMIS TA Conferences (mileage and meals not included).

Data

PATH liaison is currently using HMIS on a daily basis to enter all enrolled and non-enrolled PATH consumers that are assisted in PATH. PATH liaison will use HMIS program to generate approximately 100% of the annual report for 16/17. 100% of the annual report will be generated from HMIS in year 17/18. Currently PATH liaison utilizes the IT representative for HMIS to troubleshoot any problems he may encounter with HMIS and participates in on-going training provided for HMIS users. The PATH liaison also participates in webinars that are related to HMIS.

Alignment with PATH goals

The PATH Liaison will continue to provide outreach by hanging flyers at local laundry mats, fast food restaurants, local libraries, etc. The PATH Liaison will also attend local events to promote PATH services and awareness within the local community. The PATH Liaison will continue to serve as a member of the Shelter Task Force to collaborate with local agencies in an effort to identify adults who are literally and chronically homeless within Clarion County.

Alignment with State Comprehensive Mental Health Services Plan

The PATH Liaison works closely with the Hospital Liaison to support client's being discharged from Mental Health facilities. Once these clients are identified, the PATH Liaison, the MH Deputy Administrator and the Hospital Liaison collaborate with the Mental Health facility to create a "home plan" for the discharge of the client. CCR currently provides transitional housing for clients for up to one year after discharge if there is space available. The PATH Liaison will provide support and put other supports in place to aid in the client's recovery. The PATH Liaison will implement the CCR Emergency Plan in the event of an emergency or disaster. The CCR Emergency Plan is reviewed annually and updated as needed. The CCR Emergency Plan was last updated on 7/1/2016.

Alignment with State Plan to End Homelessness

The PATH Liaison will continue to provide outreach by hanging flyers at local laundry mats, fast food restaurants, local libraries, etc. The Path Liaison will also collaborate with local schools to offer services and resources to students and their families, who may be experiencing homelessness. The PATH Liaison will also attend local events to promote PATH services and awareness within the local community. The PATH Liaison will continue to serve on the Shelter Task Force to collaborate with local agencies in an effort to adults who are literally and chronically homeless within Clarion County. The PATH Liaison will continue to seek out the agencies serving people experiencing domestic violence, incarceration, hospitalization. Clarion

County is a rural area and outreach to the outlying areas of the County is imperative. The PATH Liaison will also collaborate with Community Action to serve veterans and Children and Youth Services to serve children and families.
Center for Community Resources (CCR) works closely with the Emergency Preparedness Team in Clarion County. CCR is the single point of contact for emergency disasters. The Housing Coordinator is also part of DCORT (Disaster Crisis Outreach and Referral Team) and attends trainings as needed. The Emergency Preparedness Team is in charge of testing the emergency response plan. Should an emergency occur the Housing Coordinator has the contacts available to continuity of care.

Other Designated Funds
The Clarion County PATH program does not participate in the Mental Health Block Grant. Clarion County does have CHIPP dollars which are being used to fund two transitional homes with 5 units that consumers can live in for up to a year and emergency housing that can be used for up to 30 days. The PATH Liaison assists consumers in getting into transitional and emergency housing and eventually with finding a permanent home. None of these funds are specifically earmarked for PATH.

Programmatic and Financial Oversight
Center for Community Resources, Inc. (CCR) monitors PATH funds through yearly audits. Clarion County Administration monitors how Center for Community Resources, Inc. uses the PATH funds through quarterly audits performed by the Mental Health Deputy Administrator. CCR is given an improvement plan for areas of concern and a date to make the changes.

SSI/SSDI Outreach, Access, Recovery (SOAR)
The Housing Coordinator is currently participating in the SOAR training. Until the training is complete, the Housing Coordinator refers to Blended Case Managers through other agencies to assist individuals with the SSI/SSDI application process, and is available to assist consumers as needed with gathering the necessary documentation. The Housing Coordinator plans to be SOAR certified by July 1, 2017. No SOAR applications have been completed by this agency to date.

Housing
- Ministerium- church donated funds provide overnight emergency shelter funds for those who are transient and passing through Clarion. This includes money to return to their home county.
- Liberty Hills Apartments- a (10) unit HUD apartments, located in Clarion Borough. This project is exclusively for mental health consumers.
- Ten low-income subsidized housing projects located throughout Clarion County. These are available to SMI consumers as long as they meet the income criteria, have a clean credit record, and do not have a history of destructive or criminal behavior.

- Through the Clarion County Housing Authority, there are Section 8 housing vouchers. These are available to SMI consumers based on income and availability.
- Through managed care reinvestment funds and in conjunction with nine other counties, we are able to offer Bridge Housing Subsidies and Master Leasing.
- The Housing Coordinator also works with local landlords to secure and maintain housing for consumers in private rentals.
- If appropriate, personal care or assisted living facilities may also be utilized. There are four personal care/assisted living facilities located in Clarion County.
- Clarion County MH is funding a short term (30 day), transitional apartment for those who are in need of short term emergency shelter.
- HSDF provides emergency funds for a 3 night hotel stay.
- Housing Assistance Program provides rental assistance and payment of security and utility deposits, for those who do not meet PATH criteria.
- Community Action has a four person men's shelter located in Clarion. Availability is limited.
- The MH Administration and CCR have developed a 2 unit apartment building as well as a 3 bedroom unit with shared living space to provide supported housing (up to one year) to consumers with a mental illness who have no or low income. These units are currently full and the program is successful.

Coordinated Entry

The Housing Coordinator at Center for Community Resources, serves as the Coordinated Entry for Clarion County. He screens all clients to see if they meet the criteria for PATH and it not, refers them to the appropriate agency for assistance. This provides a point of contact so that housing support is easily accessible to people in the community in need. Our goal for 2017/2018 is to create a coordinated entry plan along with other agencies in the community.

Justice Involved

-Crisis Intervention Team training is not currently being used in the county/joinder by state or local law enforcement. CCR is collaborating with Clarion Psychiatric Center to offer CIT training to the local and state law enforcement staff. CCR is trying to tailor the CIT training so that it is not a five day/1 week commitment but that it will be done one day a week over a period of time. This will help local and state law enforcement with staffing shortage during the training. Law Enforcement has been presented with this information by CCR and are interested in the training. The training is slated for Fall of 2017.

Staff Information

- There is one staff person, a Caucasian male in his mid-50's who holds a BA in Psychology and has 15 years' experience in Case Management and Housing Coordination and Peer support. His position is 60% funded by the PATH program. He is employed by the Center for Community Resources as part of the Base Service

Unit. She has been in this role as the PATH Coordinator for approximately 10 months. His office is located at 214 S. 7th Avenue, Clarion, PA 16214.

- Staff members are trained to work sensitively with a wide variety of populations and annual cultural competence trainings are held. The Housing Coordinator is trained on renter- landlord rights and dispute resolution, as well as LGBTQI issues. Our provider is also involved in several PH/BH (physical health/behavioral health) initiatives to address the "whole person" when working with consumers. The Community Support Program made up of consumers, families, and professionals, meets regularly to discuss County mental health programming and concerns or suggestions to improve training and programming. The HC discusses with consumers individual preferences, such as living "in town" versus in a rural setting, lifestyle, access to services and any special needs they may have. Because of the size of the PATH population, services are specifically tailored to the needs and preferences of the consumer as availability allows.
- As outlined in the state information: "All 47 County MH/MR Program Offices (through which all MH services are delivered to Commonwealth residents) are required to meet certain planning efforts with regard to cultural competency. These efforts must be outlined annually in their county plan which is received and reviewed annually at PA Department of Public Welfare – Office of Mental Health and Substance Abuse Service (OMHSAS)."
- Staff are required to receive 1 hour of training in cultural competency and health disparities whether it be online or in person.

Client Information

- The demographics of the client population in Clarion County range in age from 21 through to 60 years old. The client population for Clarion County is comprised of 51% Female, 49 % Male.
- Clarion County PATH projects the number of adult clients to be contacted to range from 50 to a hundred within the 2017-2018 year.
- Clarion County PATH identifies the expected number of adult clients to be enrolled in PATH for the 2017-2018 year to be 50 to 70 people.
- The estimated percentage of adult clients served using PATH funds to be literally homeless is 10 %

Consumer Involvement

The Mission of Center for Community Resources is to make a positive difference in everyday lives by connecting people to a network of supports and services essential for actively learning, working and living in the community.

The agency's goal is to coordinate supportive services for individuals and families seeking information & referral for mental health, intellectual disabilities, substance abuse and other human service needs.

We are an integrated point of contact working in collaboration with other human service agencies to identify needs in the community and effectively respond to assist anyone seeking help.

CCR offers free trainings to individuals and families in the community including Youth Mental Health First Aid.

Individuals are given a consent to services to sign and review during each intake to ensure that they understand their right to accept or decline services. Individuals are also given information on the President's Advisory Commission's Healthcare Consumer Bill of Rights and Responsibilities: information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and non-discrimination, confidentiality of

Individuals are given satisfaction surveys at initial contact and at discharge. Individuals can also opt to be contacted for a Consumer Satisfaction Survey for any mental health services that were received.

In this case, people who are experience homelessness and are seeking funding work on goals to improve their current situation, whether it is finding employment or seeking out help for their mental illness and take an active role in their recovery, and ultimate have a say in their future and their future role in the community. They will do this by actively establishing goals and working on them with community members. Most of the people general serve their community and the place they are staying by helping others in a peer driven role although they don't usually understand that all of the trails they went through can help them help someone else who is in the same position that they were in.

Family members are seen as a support to individuals in PATH and are sometimes called upon for assistance in housing or moving in certain situations. It is important to surround our PATH individuals with natural supports and family and friends that will support them in their daily living. Family members may be involved in the home search and the moving process. Family members may also provide feedback on what may be best for each individual.

Health Disparities Impact Statement
Please identify efforts to support the Transition Age Youth (TAY) disparity population by providing the following:

- The unduplicated number of TAY individuals who are expected to be served using PATH funds is 8 % of the population.

- The total amount of PATH funds expected to be expended on services for the TAY population is $4,800.00.
- The types of services funded by PATH that are available for TAY individuals include transitional housing and permanent housing as well as establishing a good rental history for future housing.
- As part of CCR's data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population CCR has been meeting with Homeless Liaisons in all 7 School Districts to increase homelessness collaboration and provide resources to the schools. CCR is also collaborating with local agencies to provide a youth shelter in Clarion County. With these improvements, our goal is to decrease the TAY population from 8% in Clarion County to 5% or less.

Limited English Proficiency

CCR has a contract with Optimal Phone Interpreters (OPI) that will provide interpretation in any language to engage with individuals via phone. CCR also has contracts with interpreters that are local that are willing to attend intakes and other appointments as necessary with the individual and housing coordinator.

Budget Narrative

Personnel:

Funding of $19,500 is being requested to provide for the full-time salary, 65% time, of a MH Housing Coordinator. This position will be located through Center for Community Resources, Inc., whose work concentration is to increase and create housing resources in the county for homeless or at imminent risk of homelessness persons with serious mental illness. Total request for salaries is $19,5000

Fringe Benefits:

Funding of $9,008 is being requested to provide for the full-time fringe benefits of a MH Housing Coordinator. Fringe benefits include the following costs: FICA at $1,607 health insurance at $5,777, retirement at $1,260 life insurance at $93 and state unemployment at $271. Total request for fringe benefits is $9,008.

Travel:

Funding is requested to pay for meal and travel costs for the MH Housing Coordinator. Costs include monies for the MH Housing Coordinator to be able to attend specific trainings on housing/homeless issues and mental health issues that are within the Northwestern region (sponsored by HUD, PHA, NAMI, etc.) to have the latest information that will assist in PATH program success. Costs associated with the trainings include per diem meals at $100, lodging at $250, gas & maintenance of county vehicles at $276. and estimated registration fees of $0. Other costs associated with the PATH program include the MH Housing Program Coordinator's local travel to housing entities, shelters, Shelter Task Force meetings, evaluation meetings and regional housing/homeless meetings at $620. Total travel request: $1246.

Supplies:

Funding is requested for supplies necessary to ensure efficient operation of the PATH program and to supply individuals experiencing homelessness with greater access to needed emergency, safety, hygiene, and habilitation resources. The following supplies enable the MH Housing Program Coordinator to efficiently and successfully implement the PATH program: general office supplies—paper, pens, stapler, etc. at $150 and safety/emergency/hygiene/habilitation supplies at $250 for a total of $400 for Supplies.

Other:

Other costs include the delivery of case management and support services for consumers in the PATH program; security deposits and one-time rental assistance payments for approximately 35 individuals experiencing homelessness or at imminent risk at approximately $308 each, not to exceed $10,472. Internet/computer service for a year at $1270, postage costs at $148; administrative costs are computed at 8.3% of the total budget and include amounts for rent and utilities, with any excess expense amounts to be covered by in-kind funds. Administrative costs included here of 8.3% ($4000), include the costs of space and utilities to house the PATH staff at $6.24 a square foot in Occupancy (254 sq. ft, with additional amounts for these administrative costs included as an in-kind expense.) Total request for other expenses: $16,265.

In-Kind:

In-kind services provided toward the project include the following items as outlined below at a value of $11,576:

MH Dept. Supv. of MH Housing Program Coordinator @ 1%	*$571.00*
MH Dept. Fiscal Officer Time @ 1%	*$505.00*
BSU Housing Coordinator @ 35%	*$10,500.00*

In addition, although Clarion County MH is continuing a PATH program to specifically expand existing housing and increase new housing programs for homeless/near homeless mentally ill individuals, currently Clarion County MH housing components provide ***$296,794.00*** *in current supportive housing program costs and expenses for mental health individuals, of which, if openings existed, could possibly benefit PATH program eligible individuals in the future. Supportive housing costs and expenses through Clarion County MH and HUD:*

NW9 (As Reinvestment funds are available & shared by nine counties)	*$144,230.00*
Hope Homes	*$127,534.00*
Emergency Housing Apartment	*$25,030.00*

Federal allocation	**$34,814.00**
State match	**$11,605.00**
County Match	**$1,076.00**
Total	**$47,495.00**

Clarion County
Center for Community Resources
PATH Program
FY 2017-2018 Budget

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
Housing Coordinator	$30,000.00	.65	$19,500	$19,500
Fringe Benefits				$9,008.00
Travel				$1,246.00
Equipment				$750.00
Supplies				$400.00
Communications				$720.00
Rental Assistance				$7,000.00
Security Deposits				$2,095.00
Consumer Supplies				$500.00
Other				$1,200.00
Admin Fees				$4,000.00
Total				$46,419.00

*Please enter additional rows as necessary

15. Crawford County - CHAPS

944 Liberty Street

Meadville, PA 16335

Contact: Lynn McUmber

Contact Phone #: 8143332924

Has Sub-IUPs: No

Provider Type: Consumer-run mental health agency

PDX ID: PA-028

State Provider ID: 4228

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 47,087	$ 15,696	$ 62,783	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 47,087	$ 15,696	$ 62,783	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 47,087	$ 15,696	$ 62,783	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 47,087	$ 15,696	$ 62,783	

Source(s) of Match Dollars for State Funds:

Crawford Co will receive a total of $62,783 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 90

Estimated Number of Persons to be Enrolled: 60

Estimated Number of Persons to be Contacted who are Literally Homeless: 45

Number staff trained in SOAR in grant year ending in 2017: 1

Number of PATH-funded consumers assisted through SOAR: 0

PATH Grant Intended Use Plan

2017 – 2018

Crawford County Mental Health Awareness Program (CHAPS)
944 Liberty Street ~ Meadville, PA 16335 ~ (814)333-2924

Local Provider Description – *Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.*

Crawford County Human Services will subcontract with Crawford County Mental Health Awareness Program (CHAPS) to provide all work pertaining to this PATH Award.

CHAPS is a nonprofit mental health consumer organization founded in October 1988. CHAPS' mission is to support consumers of mental health services, to encourage and enhance the formation of a consumer self-help and support network in Crawford County, and to engage in activities that better the lives of persons with mental illness.

CHAPS provides an array of services that meet the needs of consumers. These services include:

- Drop-In Center
- Community Education and Outreach
- Representative Payee / Money Management
- Mobile Psychiatric Rehabilitation (Supported Living)
- Transitional Housing
- McKinney Housing Advocacy
- Clubhouse and Vocational Counseling (Journey Center)
- Fairweather Lodge
- Warmline
- Housing Now
- Certified Peer Specialist
- Family Voucher Program
- Emergency Solutions Program
- CHIPP Diversionary Shared Housing
- Bridges Housing

Crawford County Mental Health Awareness Program, Inc. (CHAPS) will receive $62,783 in federal PATH allocation and state cash match with an additional county cash match of $1,956 for a total of $64,739 for this PATH Project. These funds will be utilized to provide 38 hours per week of Homeless Outreach and case management to eligible participants throughout Crawford County.

Collaboration with HUD Continuum of Care (CoC) Program – *Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the areas where PATH operates.*

CHAPS actively participates in the region's Continuum of Care process in a number of ways. CHAPS staff are board members of the Western PA CoC, and also attend general meetings and trainings. In addition, CHAPS staff have been members of CoC subcommittees.

CHAPS has attended trainings and webinars, and is prepared to fully participate in the Coordinated Entry process when it expands to all western region counties in the fall of 2017.

Consistent with HUD's definition, our community recognizes that a community plan must exist to organize and deliver services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. In our community, the Crawford County Coalition on Housing Needs spearheads this effort by bringing all players together for a common goal of permanent, decent, affordable housing for all citizens of Crawford County. In existence since 1986, the Housing Coalition's Board is comprised of numerous social service agencies (including CHAPS), the Meadville and Titusville Housing Authorities, Realtors, Clergy, government representatives, businesses, and persons who represent the low-income and/or disabled population.

Crawford County Coalition on Housing Needs has an established LHOT as a subcommittee of the Coalition. The LHOT focuses on identifying available resources, gaps, and solutions, to meet the housing needs of persons with mental illness.

Numerous agencies in conjunction with the Housing Coalition have worked diligently to establish a system of housing and services which assist persons who are homeless move to stable housing and self-sufficiency. This work has included: development of numerous affordable housing units, homeowner programs for persons with low income and/or disabilities, Transitional Housing, Emergency Shelter, Shelter Plus Care Vouchers, Furniture Closet, Section 811 Housing Units, Housing Counseling and Advocacy Programs, and the expansion and/or creation of various support services. Among the newly expanded services are the Emergency Solutions Program and the CHIPP program which is designed to assist consumers being released from state hospital with their transition back to community living.

This strong network has made it possible for individuals to have increased access to permanent housing, often directly from homelessness.

Collaboration with Local Community Organizations – *Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.*

An array of community agencies are involved with providing services to PATH participants in Crawford County. CHAPS works in close partnership with numerous programs to help

participants access the supports and resources needed to move forward in their lives. Referral systems are in place to access services (as well as referrals for CHAPS services). The same system is utilized for PATH participants

Key services include:

Primary Health: Numerous primary care physicians practice throughout Crawford County and are included in the Physicians Referral Service. Also, Meadville Community Health and Conneaut Valley Medical Center serve as the primary care clinic and Dental Office for persons in Crawford County with Medical Assistance Cards or those with no ability to pay. The Meadville Free Clinic is also available to persons in need of treatment who have no insurance. In addition, CHAPS assists individuals with accessing and understanding available medical benefit programs including: Medical Assistance, Medicare Private Insurance, Veteran's Benefits, Medicare Part D, and Medical Assistance for Workers with Disabilities (MAWD).

Mental Health: All Mental Health services are coordinated through the Base Service Unit at Crawford County Human Services. Once an individual accesses the BSU, they can be referred to an array of services including: Outpatient, Partial Hospitalization, Medication Monitoring, Blended Case Management, Mobile Medication Nurses, Mobile Psychiatric Rehabilitation, Site-based Psychiatric Rehabilitation, Housing Advocacy, Rep Payee / Money Management, Shared Housing and Transitional Housing. There are also two Drop-In Centers and a Mobile Crisis Program which do not need BSU referrals. The primary providers of Mental Health services in Crawford County are Crawford County Human Services, Stairways Behavioral Health, Crawford County Drug and Alcohol Program Executive Commission, CHAPS and the Titusville YWCA. Two new options for psychiatric care have recently opened in Crawford County. They are private psychiatrist offices located in rural county areas and they accept Medical Assistance and Medicare Payments.

Substance Abuse: Substance Abuse services are readily available to consumers and are primarily coordinated through Crawford County Drug and Alcohol Executive Commission. Services available include: Intensive Case Management, Resource Coordination, Recovery Specialists, Outpatient, Intensive Outpatient, Dual-Diagnosis Support Groups, access to Detox programs, Halfway Houses, and Residential Treatment Programs. Also, there are faith-based Day Program and Residential Treatment options available including Mercy House and Life Building Ministries. In addition, there are numerous AA and NA groups held throughout the county.

Housing Continuum: Crawford County, through much collaboration and support, has made great progress in developing a wide range of housing options for low-income, disabled, and homeless persons. The Crawford County Housing Coalition and many provider agencies have worked diligently to ensure there is a continuum of decent housing-first options.

Service Provision – *Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:*

- **How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless**

This program will maximize the use of PATH funds to serve literally homeless adults through the Homeless Outreach/Case Manager position. This worker will provide street outreach services, engage, and support PATH eligible individuals by assisting them with developing the resources and skills needed to access and remain in decent affordable housing. A housing first model will be utilized, with the goal of helping persons move from homelessness to permanent housing as quickly as possible. Also, an emphasis is placed on strong inter-agency collaboration to meet the needs of PATH clients. CHAPS partners with numerous programs in the community to ensure that participants are able to develop the knowledge, resources and skills needed to become responsible and empowered tenants and citizens.

- **Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services**

This program will maximize the use of PATH funds to serve literally homeless adults with mental illness through the PATH Outreach Worker/Case Manager Position. The PATH Outreach Worker/Case Manager will provide street outreach services, engage, and support PATH eligible individuals by assisting them with developing the resources and skills needed to access and remain in decent affordable housing. PATH Outreach Worker performs outreach once per week hanging PATH Outreach fliers throughout Crawford County as well as searching for homeless persons on the streets, in wooded areas, and in areas identified as "tent cities." The worker uses a variety of methods to engage the consumer such as offering them a comfortable place to spend time (CHAPS' Drop-In-Center) and offering them a cup of coffee. We strive to get the homeless person off the street immediately and place them in an emergency shelter, if they are willing. A housing first model will be utilized, with the goal of helping persons move from homelessness to permanent housing as quickly as possible. The goal is to get the person out of shelter and into permanent housing in less than 30 days. Also, an emphasis is placed on strong inter-agency collaboration to meet the needs of PATH clients. CHAPS partners with numerous programs in the community to ensure that participants are able to develop the knowledge, resources and skills needed to become responsible and empowered tenants and citizens.

In Crawford County, there is access to many housing resources along with other resources which help the consumer maintain and remain in permanent housing. This includes housing programs CHAPS administers, such as Fairweather Lodge, Shelter + Care, and Housing Now along with support services such as Mobile Psychiatric Rehabilitation, Certified Peer Support, Site-Based Psychiatric Rehabilitation (Clubhouse Model), Drop – In – Center, and Rep Payee/Money Management Program. The opportunity for affordable housing with strong supports maximizes the chance for success.

- **Gaps that exist in the current service systems**

There is much more competition for entry level jobs in our community. The PATH Outreach Worker/Case Manager will work with PATH eligible individuals to connect to employment resources such as Crawford County Careerlink and temporary employment agencies. The worker will help the consumer learn skills related to obtaining and

maintaining employment, such as resume-writing, completing applications, communication with prospective and current employers, employment expectations and good practices. The worker will also aid in job search as well.

Transitional age individuals also need assistance establishing themselves as a separate household and learning the skills necessary to maintain their household. Relationships have been established with Child to Family Connections, Children and Youth Services, Juvenile Probation, and the schools to identify and coordinate services for homeless and near homeless individuals in need of services.

There is limited housing for individuals on Megan's Law and individuals with other significant felony offenses. We are coming up with creative solutions to house individuals with forensic backgrounds, such as master leasing temporary and permanent housing options.

There are long waiting lists for one bedroom subsidized housing units. CHAPS' utilizes housing voucher programs such as Shelter + Care for literally homeless individuals with mental illness. CHAPS' Housing Now voucher is used for chronically homeless individuals (per HUD's definition) with mental illness. CHAPS' has a positive working relationship with the various subsidized housing agencies in the county.

- **Brief description of the current services available to clients who have both a serious mental illness and a substance use disorder**

  The Crawford County Drug and Alcohol Executive Commission Inc.'s (CCDAEC) outpatient treatment program provides drug and alcohol services for individuals who are dually diagnosed, which includes both individual and group sessions. The group sessions are psycho-therapeutic in nature and include a number of relevant topics such as:

  - Understanding Dual Illness and Recovery
  - How to Benefit from Services in Your Dual Recovery
  - The Role of Medication in Recovery
  - Dual Illness and the Family
  - Developing a Dual Recovery / Relapse Prevention Plan
  - Using Support Systems in Dual Recovery
  - Dual Disorders, Understanding: Depression, Borderline Personality, Bipolar Disorder, Panic Disorder, among others.

The psycho-therapeutic group series incorporates workbooks and related information. During individual sessions, the Primary Counselor reviews each psycho-therapeutic group attended by the client to confirm the client's understanding and application of the information. Counselors work closely with the agency's Case Coordination department with regard to referrals for possible mental health counseling, pharmacotherapy, and other support services. Recovery support is also offered by a Certified Recovery Specialist to county eligible adults (age 18 and over) struggling with co-occurring substance abuse and mental health issues in need of outreach, mentoring and peer support in all stages of the recovery process.

Additionally, if the client requires a higher level of care, CCDAEC contracts with a number of dually licensed residential treatment facilities throughout the state that eligible clients can be referred to for services.

- **How the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data in HMIS**

All CHAPS' staff receives at least 24 hours of training per year. CHAPS strive to offer staff an array of job relevant trainings which include evidence-based practices. Some recent trainings attended by Housing staff include: Trauma Informed Care, Fundamentals of LGBT, Fair Housing, Poverty and Mental Health and other homeless related programs. A new consumer driven group has formed at CHAPS to support LGBT members.

CHAPS ensures that all involved employees are properly trained to utilize the HMIS system.

- **Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.**

  Our agency is not required to follow 42 CFR Part 2 regulations.

- **Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)**

  There are numerous proactive initiatives occurring to increase housing options and supports for the forensic involved population.

  CHAPS Executive Director is an active member of our County's Criminal Justice Advisory Board (JAB), and is able to share challenges and suggest solutions to our judges, probation, and other stakeholders. Also, CHAPS staff actively participates in a Mental Health Forensic Subcommittee, where best practices, barriers and solutions are discussed. CHAPS has very positive working relationships with our police departments, probation offices, and District Justices.

  CHAPS has had significant success working with forensic related individuals. Some examples include: master leasing units for diversion or returning to the community, coordination with the jail to ensure a smoother re-entry to the community, writing letters and appearing in court to testify on behalf of clients, which result in jail diversion, and immediate engagement upon release from jail (utilizing a Mental Health Court Model).

  During the 2016-2017 service year, 43% of our PATH clients had a criminal history.

Data – *Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff.*

CHAPS's currently enters all PATH clients into the HMIS system**.** CHAPS' staff participates in regularly scheduled HMIS trainings, webinars, and conference calls. New staff would be fully trained on HMIS procedures and would also participate in the trainings, webinars, and conference calls. PATH case file forms have been redesigned to capture the information required for data entry in HMIS.

CHAPS employs a PATH Outreach Worker/Case Manager, who serves single adult consumers with mental illness who are literally homeless, while prioritizing those consumers who are chronically homeless. The PATH Outreach Worker/Case Manager searches for homeless individuals in Crawford County in an attempt to engage and assist them in securing permanent affordable decent housing. Street outreach efforts occur on a weekly basis, and the worker visits previously identified sites where homeless individuals have set up camp sites. The worker also searches for homeless individuals in wooded areas, under bridges, and near abandoned buildings. PATH Outreach fliers are hung throughout Crawford County at a variety of community agencies, fast food restaurants, and grocery stores. CHAPS makes every effort to place the homeless individual in an emergency shelter, if they are willing. Consumers are also brought to CHAPS' Drop in Center, which offers a friendly comfortable environment for consumers to spend time and have a cup of coffee. Individuals are introduced to other consumers and staff in an effort to make them feel more comfortable engaging with the PATH Outreach Worker/Case Manager. The worker partners with a variety of community agencies to help meet the immediate and ongoing needs of the homeless individual. A Housing First Model is utilized, and it is our goal to help consumers move from homelessness to permanent housing within 30 days or less. Ongoing case management services occur after the individual has obtained permanent housing to ensure that the individual develops the knowledge and skills necessary to maintain housing and become a responsible tenant.

Alignment with PATH goals – *Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.*

This program will maximize the use of PATH funds to serve literally homeless adults with mental illness through the PATH Outreach Worker/Case Manager Position. The PATH Outreach Worker/Case Manager will provide street outreach services, engage, and support PATH eligible individuals by assisting them with developing the resources and skills needed to access and remain in decent affordable housing. PATH Outreach Worker performs outreach once per week hanging PATH Outreach fliers throughout Crawford County as well as searching for homeless persons on the streets, in wooded areas, and in areas identified as "tent cities." The worker uses a variety of methods to engage the consumer such as offering them a comfortable place to spend time (CHAPS' Drop-In-Center) and offering them a cup of coffee. We strive to get the homeless person off the street immediately and place them in an emergency shelter, if they are willing. A housing first model will be utilized, with the goal of helping persons move from homelessness to permanent housing as quickly as possible. The goal is to get the person out of shelter and into

permanent housing in less than 30 days. Also, an emphasis is placed on strong inter-agency collaboration to meet the needs of PATH clients. CHAPS partners with numerous programs in the community to ensure that participants are able to develop the knowledge, resources and skills needed to become responsible and empowered tenants and citizens.

Alignment with State Comprehensive Mental Health Services Plan – *Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.*

The PATH Outreach Worker/Case Manager provides weekly street outreach services in order to locate and engage homeless individuals and connect them to permanent housing. A variety of housing options are available, which prioritize individuals with mental illness who meet the chronic homeless definition. CHAPS has a limited number of housing vouchers through Shelter + Care, Housing Now, and Family Housing Program. When there is an opening in one of those programs, the Executive Director sends an email to the CoC informing them of the vacancy. If a member of the CoC has a chronically homeless consumer who meets the HUD criteria for the program and wishes to relocate, they are required to respond to the email within 7 days in order to quickly connect the consumer to permanent housing.

CHAPS was an active participant in the Crawford County Human Services Mental Health Block Grant planning and implementation meetings. Many community stakeholders (i.e. Drug and Alcohol, Educators, Housing Advocates, Shelter Managers, Veteran's Assistance Workers, Child Welfare) presented data and discussed the needs of the underserved residents of Crawford County. It was evident that homelessness was a priority among residents with mental illness. With funding from the Crawford County Human Services Mental Health Block Grant, CHAPS was able to implement the BRIDGES Program, a temporary supportive housing program which serves as a bridge to permanent housing for homeless individuals with mental illness (target population to be served in the PATH Program).

When homeless consumers who are enrolled in PATH Program require more intensive mental health treatment or primary health treatment, the PATH Outreach Worker/Case Manager completes referrals and supports the individual with obtaining the mental health or primary health services. Internal referrals at CHAPS can also be made to Mobile Psychiatric Rehabilitation or Certified Peer Support Services.

Alignment with State Plan to End Homelessness – *Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.*

The target population for our region's Continuum of Care Coordinated Entry System is chronically homeless individuals and families. The CoC has developed a ranking system and identified vulnerable populations (i.e. transition age youth, chronically homeless, domestic violence victims, veterans, etc) for the Coordinated Entry System that must be implemented by 2018. Efforts to begin using the Coordinated Entry System have already begun. When there is

an opening in one of CHAPS' Housing Voucher Programs, chronically homeless individuals and/or families are targeted. CHAPS' Executive Director sends an email to our region's CoC advertising the opening and providing details about eligibility criteria (must meet HUD's definition of chronically homeless and have mental illness). Members of the CoC have 7 days to respond with an eligible individual or family, who meets the criteria. If the consumer meets all of the eligibility criteria, plans are made for them to be placed in permanent affordable housing.

In the event of a housing disaster, CHAPS collaborates with the Red Cross. We also have established a working relationship with Meadville City Fire Dept, who regularly inspects our buildings for safety and suggests areas of improvement in relation to disaster preparedness. Fire drills occur in the main CHAPS building as well as off-site buildings (i.e. Fairweather Lodges, CHIPP House and CHIPP Apartment).

Other Designated Funds – *Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.*

The Mental Health Block Grant funds various support services including an emergency apartment, Housing Advocates at CHAPS, Drop-In Center, Representative Payee/Money Management services, and the BRIDGES temporary housing program. The local match for our county's PATH program is funded by the Mental Health Block Grant. In addition, the Mental Health Block Grant completely funds the Bridges program, which is a temporary housing option for persons who experience mental illness and are homeless.

Programmatic and Financial Oversight – *In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.*

PATH funds are monitored through an Internal Compliance Committee and with an Independent Financial Single Audit by a Certified Public Accountant. In addition, CHAPS reports on all aspects of service provision to Crawford County Human Services.

SSI/SSDI Outreach, Access, Recovery (SOAR) – *Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. For the grant year 2016-2017, include all of the following data:*

- **The number of staff trained in SOAR**
- **The number of staff who provided assistance with SI/SSDI applications using the SOAR model;**
- **The number of consumers assisted through SOAR**
- **Application eligibility results (i.e., approval rate on initial application, average time to approve the application)**

- **The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.**

  CHAPS recognizes the value of SOAR in assisting homeless consumers with completing applications for Social Security and Supplemental Security Income. All appropriate CHAPS staff and supervisors, including the PATH Outreach Worker/Case Manager participated in SOAR training in September 2013. Eight staff members are SOAR-trained. Updates to SOAR training have been provided through various webinars, which PATH staff continue to attend. Staff has a thorough understanding of SOAR philosophy and procedures. Trained staff serve as SOAR liaisons and assist consumers with completing Social Security and SSI applications. CHAPS continues to build a partnership with the local Social Security Administration, through multiple conversations with John Johnston, Public Affairs Specialist at the Social Security Administration. Mr. Johnston has recently identified Crawford County's local SOAR lead, so a partnership with the local office in relation to SOAR applications and the SOAR process will be able to be established. During the first 10 months of the 2016-2017 year, zero SOAR applications were submitted.

Housing – *Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).*

Consistent with the services being presently provided at CHAPS, a Housing First Model is followed when assisting PATH clients. A variety of housing options are available depending on each participant's unique circumstances. Intensive advocacy and support will be provided in an effort to help participants establish decent affordable housing. Whenever possible, permanent housing is the primary goal and often the initial and only placement. Emergency shelter and transitional housing options are utilized only when necessary or as a very temporary bridge to allow time for locating a suitable permanent dwelling. Crawford County's continuum of housing includes the following options, which can be accessed at any level rather than having to start at the beginning:

Emergency Shelter Options*:*

- Emergency Shelter Program (Crawford County Coalition on Housing Needs) – for men, women, and families.
- Women's Services Greenhouse – for women and children.
- St. James Haven – for men.
- Titusville YWCA (St. James House) – for women and children.

Transitional Housing Options:

- Liberty House - CCCHN – for families

- Titusville YWCA St. James House – for single women and women with children.
- Transitional Apartment - CHAPS – for persons with mental illness.

Permanent Housing Options:

- Bartlett Gardens – Cambridge Springs, PA – housing for seniors
- Shryrock Apartments – housing for seniors
- South Main Place – CCCHN – for individuals and families.
- Snodgrass Building - CCCHN – for single persons
- HANDS Triad, Jefferson Street and Terrace Overview – Section 811 for persons with mental illness and/or developmental disabilities.
- HANDS Highland Pointe- Section 811 for persons with mental illness
- Meadville and Titusville Housing Authority – Affordable Housing for individuals and families.
- Shelter Plus Care – CHAPS – for homeless single persons with mental illness.
- Housing Now – CHAPS – for chronically homeless single persons with mental illness.
- Fairview Fairmont – Affordable Housing for individuals and families.
- Forest Green - Affordable Housing for individuals and families.
- The Housing Authority of the City of Meadville – Affordable housing for individuals and families. Section 8 Program
- Private Landlords – numerous apartments available through participating landlords for singles and families.
- Fairweather Lodge – CHAPS – for persons with mental illness who are homeless or at imminent risk of homelessness.
- Rural Development – Homeownership and Homeowner Rehabilitation programs for individuals and families.
- Family Housing Voucher – CHAPS – for homeless families where an adult member is experiencing mental illness.
- VASH vouchers available through the Veterans Administration.
- Emergency Solutions Grant and SSVF for Veterans.

Coordinated Entry – *Indicate if/how your organization is engaged with the local coordinated-entry processes of your CoC. Please also describe the roles of key partners in the CoC.*

CHAPS has attended trainings and webinars, and is prepared to fully participate in the Coordinated Entry process when it expands to all Western Region counties in the fall of 2017. The Western Region CoC Board, along with the Coordinated Entry Subcommittee is continuing to prepare for full implementation. They are offering ongoing communication, webinars and trainings to all providers.

Justice Involved – *Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.*

CIT training is not being used in our county at this time.

Staff Information –

- **Describe the demographics of staff serving the clients**
- **Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients**
- **Discuss the extent to which staff are receptive to differences of clients**
- **Identify the extent to which staff receive periodic training in cultural competence and health disparities**

CHAPS has a solid history of hiring qualified consumers for professional positions and will continue to value this position. There are presently 47 CHAPS employees, and 22 individuals or 46% of them have shared that they have a mental illness and receive treatment. Of the 47 staff at CHAPS, 98% are White, and 2% are Black. This is consistent with the diversity of the overall population of Crawford County.

CHAPS is committed to cultural sensitivity and competency toward those we serve. Ongoing opportunities are provided to ensure staff receives training focusing on sensitivity to gender, age, disability, lesbian, gay, bisexual and transgender status. Opportunities for training in racial/ethnic sensitivity, cultural competence, and health disparities will be accessed by staff. When working with specific groups (such as transitional-age youth or present or previous members of the Amish community), staff will be supported with training and opportunities for more intensive study. In addition, staff would have training and understanding of both persons with mental illness and co-occurring substance abuse disorders (MISA).

Efforts will be made to assist clients needing any accommodations during the evaluation process. This may include assistance with transportation, reading and writing challenges, language barriers, scheduling conflicts, health disparities and any other unique situations.

Access and enrollment in services for the above named subpopulations will be tracked using the PATH Demographic form which has been updated to collect information regarding gender and LGBT status , and language disparities in addition to racial and ethnic information already collected on the form.

Client Information –

- **Describe the demographics of the client population**
- **Project the number of adult clients to be contacted**
- **Identify expected number of adult clients to be enrolled**
- **Give estimated percentage of adult clients served using PATH funds to be literally homeless**

Crawford County is a rural county which has over 2600 active mental health consumers receiving mental health services. Sixty percent of this group falls within the fifteen to forty-four year old age range, with 20% in the TAY range. During the first 10

months of the current year, the Crawford County PATH project has served the following demographics: 6% TAY range, 1% Veterans, 16% were Black, 1% were Native American, 1% Hispanic and 82% were White, 100% of participants were below poverty level, 53% of PATH participants were male and 47% were female. Also one hundred percent of those served had mental illness and 30% had co-occurring disorder (mental illness and substance abuse).

During the 2017-2018 fiscal year it is projected that 90 clients will be contacted using PATH funds. It is projected that 60 individuals will be enrolled utilizing PATH funds. It is estimated that 50% of adult clients served using PATH funds will be literally homeless.

Consumer Involvement – *Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See* ***Appendix I*** *"Guidelines for Consumer and Family Participation".*

Homeless consumers and their family members will be encouraged to participate in the planning, implementation and evaluation of the PATH program. As previously discussed in Question 8, CHAPS is a consumer-driven organization in all aspects of its operation; CHAPS bylaws require that 60% of Board Members are consumers of mental health services or family members. One board member has previously been homeless. CHAPS currently employs 21 individuals who experience mental illness. Many of these employees were PATH eligible. Also, CHAPS offers an array of volunteer opportunities for participants, which build skills, self esteem and opportunities for future employment. Many PATH participants are active in volunteer roles at CHAPS.

All CHAPS programs, including the PATH programs, receive ongoing consumer input and are evaluated on a regular basis through focus groups, surveys, suggestion boxes, and open dialogue. CHAPS believes it to be essential for stakeholders to have a significant voice in all programming.

Health Disparities Impact Statement – *Please identify efforts to support the Transition Age Youth (TAY) disparity population by providing the following:*

- ***The unduplicated number of TAY individuals who are expected to be served using PATH funds***
  During the first 10 months of the 2016-2017 program year, 8 TAY individuals were served with PATH funds. 9 TAY were contacted but not enrolled in the PATH program. We anticipate that 12 TAY individuals will be served in the 2017-2018 program year.

- ***The total amount of PATH funds expected to be expended on services for the TAY population***
  During the fiscal year 2017-2018, we anticipate spending $12,557 of PATH funding

on the TAY population.

- ***The types of services funded by PATH that are available for TAY individuals***
  The PATH Outreach Worker/Case Manager will assist TAY individuals in searching for appropriate housing, completing/submitting affordable housing applications, completing/submitting applications for private landlords, applying for SNAP benefits and medical insurance benefits, searching for employment, applying for Social Security/SSI, obtaining security deposit for housing, obtaining furniture and household items, teaching independent living skills, and supporting TAY individuals with maintaining permanent housing. When appropriate, referrals will be made to other service providers for assistance with mental health concerns, physical health concerns, drug and alcohol abuse, education, employment, and trauma. Internal referrals at CHAPS will also be made, if applicable. The PATH Outreach Worker/Case Manager can connect TAY to various CHAPS programs such as Drop In Center, Representative Payee, Certified Peer Support, Mobile Psychiatric Peer Support, Community Support Services, BRIDGES, and Journey Center Clubhouse.

- ***A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population***
  CHAPS staff will continue to visit schools and outreach to common sites where TAY frequently spend time (YMCA, Diamond Park, etc). CHAPS has positive working relationships with agencies that serve youth; such as Children and Youth Services, school guidance counselors, probation, and mental health/behavioral health agencies. We will continue to further foster these relationships. CHAPS staff will refer TAY to relevant services and assist them with attending appointments, if needed. Transportation is often a barrier, so CHAPS will help TAY arrange transportation to appointments. Ongoing staff training on engagement techniques, supportive strategies, and addressing special needs of the TAY population will occur. HMIS is used to track outcomes for the general population and TAY population.

Limited English Proficiency – *Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.*

CHAPS is committed to cultural sensitivity and competency toward the consumers we serve. Ongoing opportunities are provided to ensure staff receives training focusing on cultural competence and health disparities. Efforts will be made to identify and assist individuals with limited English proficiency or in need of special accommodations during the evaluation process. This may include assistance with transportation, reading and writing challenges, language and

cultural disparities, scheduling conflicts, health disparities and any other unique situations. CHAPS makes persons with LEP aware that we will provide an interpreter free of charge for all appointments to make communication meaningful and accurate. CHAPS also allows and encourages friends or family members to serve as an interpreter, if that is what the consumer wishes.

Budget Narrative – *Provide a descriptive budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example: $10,000 federal allocation, $3,333 state match, $1000 PATH specific base fund match.*

Crawford County

Crawford County Mental Health Awareness Program, Inc.
PATH Program
FY 2017-2018 Budget

	Annual Salary	**PATH-funded FTE**	**PATH-funded Salary**	**Match-funded Salary**	**TOTAL**
	Position				
PATH CaseMan/Outreac	34,505	0.950	23,842	8,938	32,780
Housing Services Coor.	46,350	0.125	4,214	1,580	5,794
Housing Admin Assist.	34,107	0.160	3,969	1,488	5,457
sub-total	**$114,962**	**1.235**	**$32,025**	**$12,006**	**$44,031**
	Fringe Benefits				
FICA Tax/WC/UI			3,893	1,459	5,352
Health Insurance			6,913	2,591	9,504
Retirement			1,922	720	2,642
Staff Development			454	170	624
sub-total			**$13,182**	**$4,940**	**$18,122**
	Other				
Admin			1,880	706	2,586
sub-total			**$1,880**	**$706**	**$2,586**
Total Budget			**$47,087**	**$17,652**	**$64,739**
Total PATH Budget			**$47,087**		
State cash Match				**$15,696**	
County Cash Match				**$1,956**	
Total Allocation			**$47,087**	**$17,652**	**$64,739**

Crawford County Mental Health Awareness Program, Inc.
Budget Narrative PATH 2017-2018

Personnel: CHAPS full time work week = 40
The PATH Case manager/ Outreach worker provides 38 hours a week of PATH direct service work.
The Housing Services Coordinator will provide 5 hours a week of supervision to the PATH Case manager/ Outreach worker.
The Housing Admin Assistant will provide 6 hours a week of assistance to the PATH program including migrating PATH data into HMIS.

Fringe Benefits:
Insurance-Individual health, dental and vision insurance are provided to employees.
Insurance costs are pro-rated based on hours worked per week.
Retirement-after one year of service, CHAPS contributes 6% of annual salary to a 401K on the employees' behalf. All PATH employees are eligible for retirement benefits.
Staff development for all PATH staff some trainings provided: Cultural Competency, Housing First, Documentation

Admin:

Executive Director	3 hr per month @ 37.14	1,337.04
Financial Director	2 hr per month @ 30.93	742.32
Fiscal Assistant	2 hr per month @17.96	431.04
Payroll Taxes		597.62
Benefits		311.30
Audit expense – additional for Single audit		650.00
Total		$4,069.32

In-Kinds Supports

-CHAPS Administrative costs not included on budget page	$ 1,483
-HUD Grant for Housing Now	$92,231
-County MH base service dollars CHAPS Drop in Center, Clubhouse,	$32,878

Mobile Psych Rehab, Rep Payee program will be available to PATH Consumers
-Agencies offering in-Kind support: Housing Authority of City of Meadville, NAMI, Consumer Empowerment Project, Crawford County Assistance Office, PA Career Link , READ Program, Crawford Area Transportation Authority, Penn State Cooperative Extension, Crawford County Drug & Alcohol Executive Commission, Inc., Visiting Nurse Association of Crawford County, Inc., US Dept of Agriculture Rural Development - Crawford office, Court of Common Pleas-Probation/Parole Department, Crawford County Coalition on Housing Needs, Crawford County Human Services.20

16. Dauphin County

100 Chestnut Street

Harrisburg, PA 17101

Contact: Rose Shultz

Contact Phone #: 7177807054

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID:

State Provider ID:

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 83,480	$ 27,827	$ 111,307	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 83,480	$ 27,827	$ 111,307	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 83,480	$ 27,827	$ 111,307	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 83,480	$ 27,827	$ 111,307	

Source(s) of Match Dollars for State Funds:

Dauphin County will receive a total of $111,307 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

Estimated Number of Persons to be Contacted who are Literally Homeless: 0

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

DAUPHIN COUNTY MH/ID PROGRAM
PATH COMPREHENSIVE INTENDED USE PLAN AND CONTINUATION OF FUNDS REQUEST
FY 2017-2018

LOCAL PROVIDER DESCRIPTION

The Dauphin County MH/ID Program has the legal responsibility to provide administration, fiscal management, and assure the provision of treatment and support services to adults and children with and at-risk of a serious mental illness and co-occurring disorders (MH and drug & alcohol) under the Mental Health/Mental Retardation Act of 1966. The Dauphin County Mental Health/ Intellectual Disabilities Program is a department within the County of Dauphin and is the local recipient of the Commonwealth's allocation of PATH funds. The Dauphin County MH/ID Program oversees the operations of the PATH services and is the responsible fiscal entity. The contact persons for PATH at the Dauphin County MH/ID Program are:

Rose M. Schultz MSW rschultz@dauphinc.org	Deputy MH Administrator	717/780-7054
Frank Magel fmagel@dauphinc.org	MH Program Specialist 2	717/780-7045

Address: Dauphin County MH/ID Program
100 Chestnut Street, First Floor
Harrisburg, PA 17101

With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the County MH/ID Program office as OMHSAS does not have a contract directly with the Counties' PATH providers.

The Dauphin County Crisis Intervention Program (CIP), is a direct service under the supervision of the Dauphin County MH/ID Program and is an important provider of PATH services. The CIP program is most frequent point of first contact for PATH funded services to individuals with a serious mental illness and/or a co-occurring disorder and homelessness. Services include but are not limited to 24-hour, 7day per week availability via telephone, walk in or mobile outreach to individuals experiencing a crisis. The CIP provides MH assessments, brief counseling, service planning and referral information as well as MH stabilization. Agreements are in place with our local case management entities establishing roles and responsibilities in response to emergencies for individuals currently enrolled in services with the Base Service Unit. For individuals in which a language is a barrier to services, the CIP utilizes the Language Line to meet linguistic needs and they have one bilingual/bicultural Hispanic staff.

Downtown Daily Bread (DDB) is another point of contact for PATH services contracted by Dauphin County MH/ID. This program provides outreach and homeless case management services, including in reach and street outreach to individuals dealing with homelessness. The program has operated a soup kitchen that provides hot lunches on a daily basis for over thirty

(30) years. Approximately fifty (50) persons at any given time receive case management/ housing support.

DDB also operates a drop in center during the day. Individuals have access to computers and information regarding resources available in the community. The census ranges from 20-45 persons per day. The center is staffed by activity aides and volunteers to assist individuals in accessing needed services and supports. In FY16-17 the County and several MH providers met with DDB to offer crisis, MH case management services at the center. If these are successful, outpatient services will also be explored in FY17-18.

Central Pennsylvania Supportive Services (CPSS) will no longer be a contracted PATH provider for Dauphin County in FY 2017-18. For two consecutive years, CPSS provided no services to the PATH homeless population.

Dauphin County MH/ID Program has added CMU (Case Management Unit) as a provider of PATH funds Housing Support services, specifically to screen and enroll individuals for PATH eligibility and use PATH funds to support the need for security deposits or first/last month rents. This service can provide quicker access to more permanent housing options for individuals.

The CMU will use PATH funds to assist PATH eligible/enrolled individuals and families with rental application fees, furnishings, moving expenses and establishing good credit/reducing or eliminating bad debts. One-time Rental Payments to Prevent Eviction are provided for PATH enrolled individuals so as to receive a one-time rental assistance to prevent eviction. The CMU has access to limited PATH funds for preventing eviction on a one-time basis. In FY17-18 CMU will also serve as the fiduciary for the Annual PATH Training.

The amount of PATH funds allocated to Dauphin County MH/ID Program by the Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) in FY 2017-18 is $111,307 of which $27,827 consists of State Funds and $83,480 are Federal Funds. Based on data collected in the PATH Annual Report for FY2015-16, it is projected that outreach efforts will be made to approximately 400 individuals and approximately 300 individuals will be enrolled in PATH services. Table 1 illustrates the projected enrollment and service goals in FY17-18 by provider.

Table 1 – Projected PATH Services FY 2017-18

Provider	MH/ID Crisis Intervention Program	Downtown Daily Bread	CMU	TOTAL
Estimated Number Outreach	150	250	Persons are enrolled with CMU	400
Estimated Number Enrolled	125	155	Referrals from Crisis/DDB or new enrollees/ 20	300

Estimated Number Literally Homeless	70	85	10	165 (55%)

COLLABORATION WITH HUD CONTINUUM OF CARE

The Dauphin County MH/ID Program and its provider network participates actively in the local HUD Continuum of Care. The Capital Area Coalition on Homelessness (CACH) is the lead agency for the planning and development of Continuum of Care for the County of Dauphin and routinely has over 40 agencies actively participating in this leadership group. CACH resources are leveraged and coordinated to maximize the efficient and effective use of HAP funds, HUD Emergency Solutions Grant funds managed by both the County of Dauphin and the City of Harrisburg, HUD Continuum of Care funds and local and private funds such as The Foundation for Enhancing Communities and the United Way of the Capital Region.

Dauphin County MH/ID Program and PATH providers participate directly in several CACH committees. Dauphin County MH/ID Program collaborates in many CACH activities such as the point in time surveys, trainings, networking as well as the Project Connect events that occur yearly basis. CACH has been designated the Local Lead Agency (LLA) for Dauphin County by DHS and PHFA (PA Housing Finance Agency) to assist with the development and monitoring of the HUD 811 PRA demonstration project awarded in 2015.

COLLABORATION WITH LOCAL COMMUNITY ORGANIZATIONS

Dauphin County MH/ID Program contracts with a network of private non-profit agencies and for-profit agencies in collaboration with the CIP staff and the homeless provider network for uninsured individuals or services that are not eligible for Medicaid funding. There are also additional community services and supports available that are not contracted by MH/ID or PATH funded through Dauphin County MH/ID.

Dauphin County's Medicaid behavioral health managed care organization is PerformCare, a company of AmeriHealth *Caritas.* All of the resources will be available to individuals served as needed and eligible within the limitations of available funding.

The County Department of Drugs & Alcohol Services functions as the Single County Authority (SCA) for the County and is responsible for the provision of prevention, screening, assessment, treatment, case management and recovery support services in Dauphin County for the uninsured. Most services are available and can accessed directly from private-non-profit contracted agencies. PerformCare (BH-MCO) is also responsible for maintaining a network of drug & alcohol services for Medicaid recipients. Collaboration occurs frequently between mental health and drug & alcohol service providers as MH case managers make many referrals for D&A services for individuals with co-occurring issues.

The CMU (Case Management Unit) is the MH/ID contracted agency responsible to perform the duties of the Base Service Unit and registers all individuals for county-funded mental health

services. By conducting walk-in intake interviews four-days per week, mental health assessments and financial liability assessments determine eligibility and the individual's ability to participate in the cost of services, if any, according to PA regulations.

The CMU also provides targeted case management services called Blended Case Management for eligible adults and children. Administrative case management is also provided by the CMU. CMU has an administrative case manager specifically to serve the homeless adult population and serves as the SSI/SSDI Outreach, Access, Recovery (SOAR) Coordinator position in Dauphin County. No PATH funded staff were trained in SOAR and there is no plan to do so at this time. SOAR is not funded with PATH dollars. The current Homeless MH case manager has adequately met this demand. Intensive case management services for eligible individuals in Dauphin County are also available from Keystone Service System.

CMU, Philhaven, and Keystone offer Certified Peer Specialist services that are approved by OMHSAS and credentialed by PerformCare (BH-MCO). Certified Peer Specialists are imbedded in Dauphin County's local psychiatric inpatient unit Pennsylvania Psychiatric Institute (PPI), psychiatric rehabilitation, employment and social rehabilitation services. There are eighteen (18) employed Certified Peer Specialists.

Dauphin County has nine (9) contracted licensed outpatient psychiatric clinic providers that offer medication management, outpatient therapies and psychiatric evaluations to adults, older adults, transition-age youth and children with serious mental illness or serious emotional disturbance and/or adults and children with co-occurring disorders. Two clinics offer tele-psychiatry.

Some outpatient providers have unique characteristics or serve specific populations of Dauphin County residents. There are also several licensed psychiatric outpatient clinics that have a Medicaid HealthChoices BH-MCO contracts but not a county contract. Two of the clinic also have a D&A outpatient clinic license for the same clinic site, and two COD clinics using the Hazelden model are currently offering integrated MH and D&A treatment. There are clinics that are specialized for the following populations: LGBTQI, HIV/AIDS, homeless, Evidenced based outpatient interventions, sex offenders, open access, older adults, Hispanic, dual MH/ID, and school-based. The FQHC, Hamilton Health Center also provides some outpatient services.

Northwestern Human Services (NHS) of PA Capital Region provides Assertive Community Treatment Team (ACT) services. NHS of PA, PPI, and Philhaven also offer partial hospitalization services. Pennsylvania Psychiatric Institute (PPI) operates an acute rapid access adult partial program developed in effort to reduce high MH inpatient re-hospitalization rates in Dauphin County.

Dauphin County has two (2) social rehabilitation programs: Aurora Social Rehabilitation and a consumer-run drop-in center, Patch-N-Match. Keystone Service Systems operates a licensed Psychiatric Rehabilitation site and mobile service. In FY17-18 Keystone will also be MA funded.

Community Residential Rehabilitation (CRR) services offer many choices to individuals to gain independence in their recovery journey. Licensed residential programs offer varying

degrees of support and are in a group setting, as well as, in scattered apartment settings. The Dauphin County contracted residential providers are NHS of PA, Elwyn, (KMHS) Keystone Mental Health Services. Supportive living services are provided by Volunteers of America (VOA), Keystone and Central Pennsylvania Supportive Services (CPSS).

CAPSTONE, a first episode psychosis program, for person ages 16-26 began services in March 2017. CMU, YWCA and Pennsylvania Psychiatric Institute are the three (3) collaborating agencies. Case management, peer support, clinical services and supported employment/supported education are all offered.

Short-term temporary residential services are available to PATH eligible individuals until a more permanent housing solution is identified. There are two providers contracted with Dauphin County MH/ID Program for specialized CRR services: NHS of PA's Windows Program in Harrisburg, and Community Services Group (CSG), Crisis and Diversion Program in the Steelton community. Both programs provide short-term 45-day residential support with a capacity of 24 persons and two (2) 5-day crisis beds with 24-hour, 7-day per week staff oversight.
Ongoing collaboration with many of the Dauphin County contracted providers and the homeless provider network, assist in providing the right combination of supportive services with individuals in securing permanent housing for PATH eligible individuals to live successfully in the community.

Dauphin County MH/ID Program has developed a strong collaborative working relationship with the Housing Authority of the County of Dauphin (HACD) and jointly link individuals to approved landlords that accept HUD funded Shelter + Care and Project Access vouchers. Keystone Service System's Supportive Living Program has a designated housing locator position for individuals that secure HUD or Bridge Rental Subsidy vouchers. Dauphin County MH/ID implemented a Bridge Rental Subsidy program with that currently serves 15 individuals who have a serious mental illness. The goal for FY16-17 is 18 individuals or families. Through ongoing collaboration and support the landlord/tenant relationships have been strengthened, and there is stability in permanent housing options.

Employment services in Dauphin County are comprised of varying degrees of support and independence. Employment is viewed as a measure of personal success and recovery. The YWCA's Supported Employment program is funded through Dauphin County to assist individuals in securing and maintaining competitive employment. Most programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

A Safe Haven (men only) program is operated by Christian Churches United and offers transitional and housing first living for up to 25 men. The YWCA transitioned the women's safe haven program in 2015 to a Permanent Supportive Housing Program. This transition has significantly improved the housing services available to eight (8) chronically homeless women by providing permanent housing to women who have been challenged with maintaining hosing independence in our community.

HUD 811 projects in Dauphin County for potential PATH enrolled persons include Creekside Village and New Song Village; both are operated by Volunteers of America (VOA). These programs are permanent affordable housing projects for individuals with serious mental illness.

The HUD 811 project-based vouchers are a project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) and have available safe and affordable permanent housing for individuals with disabilities. Dauphin County was approved for two 2 bedroom unit vouchers at Felton Lofts in Steelton PA. and mental Health was involved with individuals leased up in 2016. Two – two (2) bedroom apartments are currently available in suburban areas. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH). The vouchers will serve a varied group such as individuals with a physical disability, mental illness, intellectual disabilities, Autism and transition age youth with disabilities, with the priorities given to those in institutions, living in congregate living situations and those at risk of being institutionalized.

Sunflower Fields is capital investment LIHTC housing project in Dauphin County using FY 2013-14 HealthChoices reinvestment funds. There are a total of 35 single family homes of which Dauphin County MH has preference for 5 of the homes. Availability of housing contingency funds and completion of PREP were positive aspects of assisting persons and families in this application/approval process.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals. The employment component is called Paxton Cleaning Solutions with competitive contracts in the surrounding area..

Mission of Mercy provides mobile medical outreach and care to homeless individuals and those who are uninsured or underinsured to obtain appropriate medical care. Catholic Charities continues to provide outpatient therapy services to individuals served by Mission of Mercy.

The HELP Office is the primary program for assistance with basic needs and emergency housing and is operated by Christian Churches United. Emergency shelters include: Bethesda Mission, Salvation Army, Shalom House, Interfaith Shelter and the YWCA Domestic Violence services. Several local church organizations run soup kitchens and food pantries to assist individuals in obtaining needed food.

All MH case management entities and the Crisis Intervention Program have access to consumer support and emergency housing funds available to assist individuals with first month's rent and security deposits or back rent and utilities as needed. Dauphin County continues its commitment to improving the wellness of individuals served in the MH system: ongoing information sharing on effective strategies among provider agencies to promote healthy lifestyle choices, team building on how to make lifestyle changes in group living arrangements, in addition to improved communication between primary care physicians and psychiatrists facilitated by outpatient clinics and case managers.

SERVICE PROVISION

A list and description of services to be provided using PATH funds in Dauphin County during Fiscal Year 2017-18 include:

1. Outreach services (partially funded)
2. Screening and assessment for treatment services (partially funded)
3. Staff training (fully funded)
4. Case management (partially funded)
5. Housing services
   - Housing-technical assistance in applying for housing (partially funded)
   - Housing-improving coordination of housing services (partially funded)
   - Housing-security deposits (partially funded)
   - Housing-matching individuals with appropriate housing (partially funded)
   - Housing-rental payments to prevent eviction (partially funded)

A detailed description of the PATH funded services in Dauphin County are listed below:

Outreach Services

Downtown Daily Bread (DDB) has an outreach specialist designed to conduct outreach and in reach services in a location where most homeless individuals frequent. In addition to outreach and case management services, individuals have access to a hot nutritious meal and case management/support which provides information/referrals, lockers for personal storage, mail service, and showers. Outreach is also done on city streets to engage and desensitize persons to homeless and mental health services. DDB determines PATH eligibility and provides outreach, initial screening, service planning, information and referrals. DDB works collaboratively with homeless network and mental health providers that are not PATH funded to assure individuals are receiving the services they need.

The Crisis Intervention Program (CIP) also continues to provide outreach to the targeted population of persons experiencing homelessness with a serious mental illness and/or co-occurring disorders. PATH eligible individuals may be identified by providers, community hospitals, businesses or residents. Individuals may be self-referred or referred by others, including law enforcement, healthcare personnel, and concerned individuals. CIP determines PATH eligibility and provides outreach, initial screening, service planning, information and referrals.

Screening and Assessment for Treatment Services

Crisis Intervention Program (CIP) performs initial assessments of individuals when conducting an outreach. The information provided to CIP is documented in a case progress note, and the PATH Eligibility and Support Plan form for individuals in need of and willing to accept mental health services and supports. Following an outreach and enrollment, many individuals are referred to the CMU to be registered in the MH system and referred for additional supportive services as needed. Individuals needing emergency psychiatric treatment will be assessed by CIP and referred to appropriate settings as needed.

The Outreach Specialist at Downtown Daily Bread is trained to screen and identify individuals that have mental health and/or co-occurring drug & alcohol needs and assist the individual with enrolling in case management services and linking them to needed MH and D&A services. The goal is to engage literally homeless individuals in treatment and supports by using engagement and relationship building strategies to identify individuals in need of mental health and/or co-occurring treatment and supports. Supports for meeting immediate needs and referrals to appropriate housing resources are made as needed. Direct face to face interactions in locations that homeless individuals frequent and are comfortable with allows for sustained contacts in order to build rapport and trust. These are key factors in working with a population of individuals who often experience or have experienced fear and distrust of formal community institutions and services. Downtown Daily Bread staff addresses an individual's basic and immediate needs first and then works toward assisting individuals in accessing additional services.

Staff Training

PATH training is selected each year by identifying the needs of PATH providers and the homeless provider network. In FY17-18 CMU will serve as the fiduciary for the Annual PATH training. Training is scheduled in 2017 with the topic Choices in Healing: "Approaches and Methods that Support Recovery" conducted by Drexel University.

Case Management

Case management services provided at Downtown Daily Bread by the Outreach Specialist position are intended to sustain the relationship built through outreach/in reach efforts through the assessment, planning and implementation of services and treatment and housing resources. Services are provided to assist individuals in meeting their basic needs including; meals, access to showers, mail service, clothing, applications for entitlements, housing, and other requested services. Case management with persons experiencing homelessness will develop rapport and build relationships and demonstrate sensitivity to the fears and anxieties in using formal services, stigma associated with mental illness, trauma, recovery, and illness management. The goal of case management at DDB is to engage persons in meeting their basic needs, as well as addressing mental health and/or drug& alcohol concerns through treatment and recovery supports. The Outreach Specialist at Downtown Daily Bread works with the CMU to assure a connection is made with the mental health system for treatment and supports for individuals enrolled in PATH.

Housing Services

Dauphin County continues to offer a way to individualize our responses to the housing challenges faced by PATH eligible persons.

- Planning of Housing: Efforts are made to keep direct care and support staff informed and knowledgeable about housing opportunities. The information is then used to assist PATH enrolled persons with their housing plans. Dauphin County MH staff are one of many entities that facilitate housing information to aid in planning. The actual

planning with the consumer is done by their interagency team and are not funded through PATH.

- Technical Assistance in Applying for Housing Services: Knowledge and understanding of the complex application process and the documents required to apply for subsidized housing, can be difficult for individuals. Assistance is available to PATH eligible individuals in identifying available housing resources, completing applications and accessing the documentation necessary to successfully secure affordable housing subsidies. Case managers and supportive living staff are well-informed about housing resources both public and private, short term and long-term. Their technical knowledge is used with individuals to develop housing plans and put those plans into action. Crisis Intervention Program, Downtown Daily Bread, CMU and other mental health agencies continue to participate in Project CONNECT events.

  Dauphin County MH staff have been instrumental in improving technical assistance on applying for Housing as well as the Dauphin County LLA.
- Improving the Coordination of Housing Services: Ongoing coordination and collaboration within the homeless service network, CACH and mental health providers for PATH enrolled individuals continue to be developed. Relationships with landlords, shelters, other housing programs, churches and community agencies are essential in meeting the needs of individuals or families who are literally homeless, chronically homeless, or at imminent risk of homelessness. Dauphin County utilizes the revised landlord-tenant protocol developed by the Dauphin County Local Housing Options Team (LHOT). CACH, the designated Local Lead Agency, provides ongoing information regarding newly developed housing projects in the area and alerts providers and individuals they serve in the system on location of the properties and the application process to apply for these available units and maintains MOU's with referring provider agencies.
- Security Deposits: The CMU is contracted to provide PATH funds to assist individuals in securing permanent housing. CIP and case management entities have additional but limited funds to provide this assistance, other than PATH funding. This service can provide quicker access to more permanent housing options for individuals, rather than relying on limited shelter space. The funding assists PATH eligible individuals with securing safe, affordable and permanent housing.
- Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: When individuals secure appropriate housing, there are additional costs associated with that housing other than security deposit or first/last month rent. Some costs may involve rental application fees, furnishings, moving expenses and establishing good credit/reducing or eliminating bad debts. CMU is contracted to provide this assistance to prevent eviction and homelessness and assist individuals in securing permanent housing. CIP and all case management entities have access to additional, but limited funds other than PATH funds for transition purposes that result in more stable housing.
- One-time Rental Payments to Prevent Eviction: PATH enrolled individuals can receive a one-time rental assistance to prevent eviction. CMU is contracted to provide this assistance to prevent eviction and homelessness. CIP and all case

management entities have access to additional, but limited funds, other than PATH for preventing eviction on a one-time basis.

Dauphin County MH/ID Program is a department also in the Block Grant and our office also manages MATP, HAP (Homeless Assistance Program) funds and ESG (Emergency Solutions Grant) funds. Dauphin County MH/ID administrator is also an officer in CACH (Capital Area Coalition on Homelessness) which also functions as the Local lead Agency (LLA) The mental health funds managed through the Block grant constitute 71.5% of the Block Grant funding. Administrative costs are only 4.5% of the MH funding in Dauphin County. The MH Program is positioned to understand a wider range of funding than a typical mental health program and persons that may be PATH eligible need to access funds through other components of the homeless network funding prior to using PATH funds. For example, individuals must seek HELP Office resources for assistance with utility bills and though the LIHEAP program before seeking help from PATH providers. Another example is sharing costs of assisting a PATH eligible person in housing by agencies sharing the costs of a security deposit or providing some basic household items to establish housing. Collaboration maximizes the use of all appropriate and eligible homeless/housing resources.

Service Gaps

PATH-funded services continue to be flexible and address the unique needs of the homeless individuals served in Dauphin County. However, there are service gaps where capacity does not meet demand. The needs of homeless individuals for psychiatric services are prioritized along with several additional target groups such as persons with forensic involvement and acute inpatient discharges in order to prevent readmissions. Several providers such as Catholic Charities, TW Ponessa and NHS of PA have attempted to provide appointments for individuals with urgent need to access psychiatric services. Catholic Charities operates a specific clinic for homeless persons. Additional service gaps identified include:

- Limited availability of emergency shelter space.
- Limited number of safe and affordable housing units, due in part to rental costs that have risen tremendously in Dauphin County, which makes it very difficult for low income and very low income individuals to afford rent.
- Programs continue to be challenged with complex mental health needs and chronic medical conditions among persons with a serious mental illness or co-occurring disorder.
- Individuals being released from the criminal justice settings are not a good fit in shelter settings or are not eligible for subsidized housing due to past criminal charges. Dauphin County has a disproportionate number of persons sent to community correctional centers and halfway houses under early release that are not Dauphin County residents.

Needs of the Co-Occurring Population

Addressing the needs of the co-occurring population has been very challenging and complex in Pennsylvania, including Dauphin County, since the most effective treatment is to offer integrated

approaches. Co-occurring training for professionals is essential for staff. The proposed consolidation of State departments under one administrative and licensing entity should help establish co-occurring services without the burden of separate administrative and licensing entities.

Dauphin County mental health system is charged with assuring there are established services to meet the needs of individuals who also have substance use disorders and a serious mental illness. While the regulatory authority of services lies with both the Department of Human Services (mental health) and the Department of Drugs and Alcohol, County administered programs face challenges to implement integrated treatment model services to meet the needs of individuals with co-occurring disorders. Among individuals who are medical assistance eligible, services are administered through the same behavioral health managed care organization, PerformCare.

Individuals with co-occurring disorders have access to the following array of mental health services and supports: outpatient services, partial day programs, residential services, and support services such as targeted case management, supportive living, social rehabilitation, peer support and inpatient care through county /state funding streams and Medicaid managed care. The Drug & Alcohol system is disproportionately funded at the community level and the lack of integrated treatment adds additional barriers to recovery.

Evidenced Based and Promising Practices

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) (a function of the CMU) is an essential first step in providing the individual access to the array of services that are available. Once registered with the BSU through walk-in access, an individual will have access to evidence based and promising practices that operate with fidelity throughout the MH system. These services can benefit literally homeless, including chronically homeless individuals and those at imminent risk of homelessness who we are seeking to engage in mental health and co-occurring services. Table 2 represents evidence based and promising practices that are available in Dauphin County currently.

Table 2 – Evidenced Based and Promising Practices in Dauphin County

Evidenced Based and Promising Practices	**Service Available in County**	**Staff Trained in EBP/PP**	**Comments**
Assertive Community Treatment	Yes	Yes	Urban Team
Supported Housing	Yes	No	
Supported Employment	Yes	Yes	
Integrated Treatment Co-Occurring (MH/SA)	Yes	Yes	Located with Two (2) OPT D & A Providers
Dialectical Behavioral Therapy	Yes	Yes	Adult and Teen models; two (2) certified providers

Mobile Psychiatric Nursing	Yes	Yes	
Shared Decision Making	Yes	Yes	CAPSTONE (FEP)
Psychiatric Rehabilitation	Yes	Yes	Site and Mobile
Cognitive Behavior Therapy	Yes	Yes	
Trauma-Focused CBT	Yes	Yes	
Consumer-operated Services	Yes	Yes	Drop-in Center
MHFA Adults and Children	Yes	Yes	
Illness Management Recovery	Yes	Yes	Four (4) providers
Certified Peer Specialist	Yes	Yes	Free-standing and Embedded
Parent-Child Interaction Therapy	Yes	Yes	Two (2) certified providers
Guiding Good Choices	Yes	Yes	Parents are facilitators
First Episode Psychosis	Yes	Yes	CAPSTONE
WRAP & WRAP Facilitator	Yes	Yes	
Family Psycho-education	Yes	Yes	NAMI Family-to-Family

Dauphin County relies upon State and County Base MH funds to support the use of evidenced based and promising practices, as well as Medicaid managed care under HealthChoices.

PATH services are available for non-service connected veterans who may also be homeless and their families by accessing the same array of services available to any individual that is PATH eligible. For persons and their families who are service connected veterans assistance is provided through information and referral in applying for and accessing benefits and services that individuals and their families are entitled to receive through the Office of Veterans Affairs administrative office. In some cases, due to gaps in services, veterans and their families are served by both the MH and VA systems based on their need and eligibility for services. The County's Veteran Affairs Office annually coordinates a Stand Down program, and veterans and their families take part in the Project CONNECT events. Following these events, further outreach and follow-up is provided to individuals to assist in linking them to needed services.

Dauphin County embraces the Principles of Recovery and Resilience. Most activities include all stakeholders and all individualized teams supporting persons have a common message to be recovery/resiliency oriented, work with a person's strengths, consumer-driven, and emphasize the use of natural, peer, and family support. In Dauphin County, a Community Support Program (CSP) Committee is actively involved in the system planning as well as improving person involvement in leadership roles and evaluation activities. As a Block Grant County, Dauphin MH/ID Program documents their recovery and resilience priorities and activities.

Dauphin County MH/ID and its contracted PATH providers are not required to follow 42 CFR Part 2 regulations since they do not provide any direct drug & alcohol services, diagnosis or treatment to PATH funded individuals. Referral are made as needed with the assistance of PATH providers to drug & alcohol treatment as needed, however they are not involved in providing any direct treatment services.

Dauphin County is implementing a STEPPING UP initiative. The goal of this initiative is to reduce the number of individuals with mental illness and co-occurring disorders in prison. Currently Dauphin County is currently collecting data and will develop an action plan to address issues. Dauphin County is also actively involved with re-entry of persons in local jails and State prisons.

DATA

The Dauphin County Mental Health administration and CIP staff have completed training on the use of the Federal Homeless Management Information System (HMIS). Downtown Daily Bread is already using HMIS to collect data under the CACH umbrella. The Capital Area Coalition on Homelessness (CACH) is the local planning group in Dauphin County and the CACH funds the HMIS training and activities around data collection. Bowman is the selected HMIS contractor. Dauphin County MH/ID Program and its PATH contracted providers have worked diligently in conjunction with the HMIS Program Director to assure PATH data is successfully entered into the HMIS system. HMIS training will be done with the CMU.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH provider agency staff will be supported on a day-to-day basis by Dauphin County MH administrative staff and the HMIS program administrator. There are ongoing data entry and reporting issues with HMIS that continue to be addressed with HMIS Administrator in Dauphin County. Ongoing technical support is being used to further develop the data quality and integrity of the PATH data entered into HMIS.

ALIGNMENT WITH PATH GOALS

The Dauphin County MH/ID Program is commitment to PATH goals for literally homeless persons and we have devoted PATH funds and other funds to this end. Dauphin County Crisis Intervention Program (CIP) has a homeless outreach worker who conducts street outreach as well as our DDB homeless outreach specialist who focuses on conducting ongoing weekly street outreach as well as in-reach to this this most vulnerable population. Ongoing efforts by Case Management entities and the homeless outreach specialist at the CMU (not funded by PATH) provide ongoing support and assistance to individuals they serve that are homeless or at risk of homelessness. The homeless outreach workers work closely and collaboratively with traditional mental health providers and the local homeless provider network as well as other local church and volunteer organizations to assist these individuals. It is clear that the most effective approach in assisting homeless individuals is ongoing and persistent outreach along with building rapport and trust with individuals will has the greatest impact and success in reducing homelessness.

ALIGNMENT WITH STATE MENTAL HEALTH SERVICES PLAN

Dauphin County MH/ID PATH providers focus and prioritize the needs of the most vulnerable individuals, especially those who experience chronic homelessness. Street outreach is provided primarily by the Crisis Intervention Program and Downtown Daily Bread outreach worker. Unfortunately, this population is one of the most challenging groups to serve due to the lack of trust with formal services that may be government-

sponsored/funded and or religiously based. Dauphin County PATH providers are engaged with the ongoing efforts spearheaded by CACH to increase available resources for the homeless community.

The Dauphin County MH/ID Program has maintained a collaborative relationship with Dauphin County Emergency Management Agency (EMA) and provides a Mental Health Response Team when an incident occurs which requires mental health disaster intervention. Under a collaborative agreement, the EMA will support the efforts of the MHRT and will provide whatever appropriate resources it may have at its disposal to intervene in a disaster incident (including activating ancillary agreements the EMA may have with other resources such as the Red Cross). The County Emergency Management Agency and local EMAs in municipalities will notify the county program by telephone or by fax if any incident has occurred that may, in their opinion, require the mental health response.

Crisis Intervention Program staff also participates in the County-wide TMI disaster preparedness drill, which occurs every other year. The Program staff's role is "rumor control" to the general public and support to the State and local EMA staff. Further, on a daily basis, suicide callers to the EMA 911 Center are routinely patched through to the Dauphin County Crisis Intervention Program. The Program also maintains a mutual aid agreement with the local Red Cross that will be updated in the coming fiscal year. All homeless providers have developed individual emergency preparedness plans to address the needs of the individual they serve.

ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS

As outlined in various sections of the comprehensive Intended Use Plan (IUP) including the individual IUPs for both Downtown Daily Bread and Crisis Intervention Services provide street outreach and focus on the most vulnerable population of homeless and chronically homeless persons in Dauphin County. This is consistent with the State's Plan to End Homelessness.

With the adoption of HOME RUN by the County of Dauphin and the City of Harrisburg, and the continued leadership of CACH as the Blueprint Manager, the stage has been set to make homelessness *rare, brief and non-recurring in our community*.

The 2017 Blueprint presents six (6) Primary Objectives with several strategies and action steps to achieve the U.S. Department of Housing and Urban Development's definition of "ending homelessness", where *homelessness is rare, brief, and non-recurring:*
1) Strengthen Leadership to End Homelessness;
2) Achieve a Continuum or County-Wide Coordinated Entry, Assessment and Referral System;
3) Preserve Existing, and Increase Affordable Housing Supply;
4) Ensure Access to and Availability of Supportive Services;
5) Increase Public Awareness and Education about Homelessness, the Coalition, and its resources; and
6) Prevention of Homelessness. Each Primary Objective has outcome measures based on "System Performance Measures" by the US Department of Housing and Urban Development (HUD) on how a continuum or catchment is progressing towards ending homelessness.

As stated in the previous section Dauphin County MH/ID program and all the PATH funded agencies are involved in disaster preparedness and emergency planning. The Dauphin County MH/ID Program has maintained a collaborative relationship with Dauphin County Emergency Management Agency (EMA) and provides a Mental Health Response Team when an incident occurs which requires mental health disaster intervention. Under a collaborative agreement, the EMA will support the efforts of the MHRT and will provide whatever appropriate resources it may have at its disposal to intervene in a disaster incident (including activating ancillary agreements the EMA may have with other resources such as the Red Cross). The County Emergency Management Agency and local EMAs in municipalities will notify the county program by telephone or by fax if any incident has occurred that may, in their opinion, require the mental health response.

Crisis Intervention Program staff also participates in the County-wide TMI disaster preparedness drill, which occurs every other year. The Program staff's role is "rumor control" to the general public and support to the State and local EMA staff. Further, on a daily basis, suicide callers to the EMA 911 Center are routinely patched through to the Dauphin County Crisis Intervention Program. The Program also maintains a mutual aid agreement with the local Red Cross that will be updated in the coming fiscal year. All homeless providers have developed individual emergency preparedness plans to address the needs of the individual they serve.

OTHER DESIGNATED FUNDS

Dauphin County has an Emergency Solutions Grant (ESG) Program authorized by subtitle B of title IV of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11371–11378). This program authorizes the Department of Housing and Urban Development (HUD) to make grants to states, units of general purpose local government, and territories for the rehabilitation or conversion of buildings for use as emergency shelters for the homeless, for the payment of certain expenses related to operating emergency shelters, for essential services related to emergency shelters and street outreach for the homeless, and for homelessness prevention and rapid re-housing assistance. Dauphin County uses this funding for emergency shelters, rapid rehousing, rental assistance, homeless prevention and HMIS.

Dauphin County's Homeless Assistance Services (HAP) Program serves individuals and families whose income is below 200% of Federal Poverty level and who are homeless, near homeless, and who meet the specific HAP program component requirements. HAP services include; bridge housing, case management, rental assistance, emergency shelter.

Dauphin County uses MH Block Grant funds to support many homeless positions in the provider network not funded by PATH dollars. Medicaid expansion has facilitated the use of HC funds to support the provision of treatment for the homeless population, including families.

Any of the above mentioned funds could intersect and support a person who is also PATH eligible. This would primarily occur in the area of rental assistance or supports to establish housing to end homelessness and may be configured on an individual basis.

PROGRAMATIC AND FINANCIAL OVERSIGHT

Dauphin County MH/ID receives state and federal funds PATH directly from the Office of Mental Health and Substance Abuse Services, OMHSAS. These PATH funds are allocated to the subcontracted PATH providers; DDB, CMU, Crisis Intervention Services. Quarterly reviews are conducted by MH program specialist staff of HMIS data. Internal audits are conducted by Dauphin County MH/ID Fiscal Officer and PATH Financial quarterly reports are provided to the OMHSAS for review reflecting all contracted PATH funds in Dauphin County. At a minimum quarterly programmatic meetings are held with the Downtown Daily Bread staff regarding service delivery and reporting issues. The CMU has monthly monitoring contacts with Dauphin County MH/ID program. Crisis Intervention Program has a Compliance Committee for monitoring purposes.

SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)

SOAR training was provided by OMHSAS in coordination with a SOAR Implementation Team. SOAR activities are not PATH funded in Dauphin County. The Dauphin County SOAR coordinator also manages a homeless caseload in the CMU agency. The position continues to work collaboratively with improving ongoing communication with Mid-Penn Legal Services, the Social Security Administration (SSA) and the Bureau of Disability Determination (BDD). All potential SOAR applicants are screened and the process has been used to secure benefits for 28 persons since SOAR was introduced to Dauphin County in 2012. The process is very time-consuming, detail oriented and comprehensive. During FY 16-17 five (5) persons have been approved through SOAR. Dauphin County designated the homeless outreach worker at CMU for the coordination and processing of all SOAR applications in Dauphin County in part due to the detailed and technical process involved.

HOUSING

PATH funds continue to assist individuals who are literally homeless, chronically homeless, and at imminent risk of homelessness in securing permanent housing. PATH services continue to remain flexible and sensitive to the unique needs of individuals. Downtown Daily Bread, Crisis Intervention Program and CMU continue to provide outreach to build rapport and engage individuals in accessing appropriate mental health treatment and support services and available housing. Several temporary options are considered first in addressing immediate housing needs and once established can lead to a permanent housing situation, which include the following options:

General shelter/housing programs:

- Bethesda Mission, supplying emergency shelter services for men in some extended stay options, in the city.
- Shalom House, a shelter site available to single women and to women with children in the city.
- YWCA, providing transitional housing services for women, in the city. Provides overnight shelter for homeless women during the winter months
- Delta Housing, operated by Gaudenzia, provides transitional services in small apartment settings for women and women with children.
- Interfaith Shelter, a facility for intact families operated by Catholic Charities in the Colonial Park suburb area of Harrisburg.

Private and public resources outside the conventional human service agency framework:

- Harrisburg Housing Authority, in Harrisburg city.
- Housing Authority of the County of Dauphin, with units outside the boundaries of Harrisburg city and the balance of Dauphin County.
- Hotel and motel proprietorships, allowing short-term stays with sponsorship for people, both in the city and in the suburbs.

- YMCA Single Room Occupancy for men not limited to city residents.
- Susquehanna Safe Haven, a housing first program for 25 homeless men with serious mental illness.
- YWCA Supportive Housing programs have been recognized for their veteran housing services.

Housing Partnerships: The Dauphin County MH/ID Program has been working collaboratively with the following partners in developing affordable housing options for individuals with serious mental illness: CACH, Housing Authority of the County of Dauphin, Volunteers of America, and Paxton Ministries as well as new developers being established in the County. CACH is the designated Local lead Agency for Dauphin County with key responsibilities including coordination with area service providers and building owners regarding new HUD 811 projects and tax credit housing projects funded through PHFA in assuring there are eligible individuals ready to move into available units when they become available.

The MH/ID Program continues to further develop potential partners with whom we need to improve our relationship with such as Dauphin County's Department of Community and Economic Development and the Harrisburg City Housing Authority.

In FY 2016-17 Dauphin County developed a Bridge Rental Subsidy program using reinvestment dollars in collaboration with the Housing Authority of the County of Dauphin (HACD) . A total of 15 individuals have received funding through the Bridge program and two individuals have successfully completed one year. The FY16-17 goal is for 18 individuals or families. Changes were made to the Administrative Plan and a procedure was developed to consider persons purged from the Section 8 list to be considered for reinstatement. All applicants were required to complete a PREP (Prepared Renters Program) curriculum and PREP classes are offered to any interested consumer/family in the MH system.

Paxton Ministries developed two (2) Community Lodges which serve a total of eight (8) persons. The lodges are managed by the individuals living in the home. All expenses are paid for by the individuals living there and any decisions made regarding the Lodge are made by its members. There is a part-time Lodge coordinator for oversight. Paxton developed a cleaning company, Paxton Cleaning Solutions, and has contracts with several area businesses.

COORDINATED ENTRY

CACH is the PA-501 Harrisburg/Dauphin County Continuum of Care and therefore, the PA-501 coordinated entry process is the same as CACH's process. CACH has the following Coordinated System of Entry and Referral for persons seeking homeless services and housing programs in the City of Harrisburg Dauphin County. CACH has developed a Coordinated Entry Referral Tool (CERT) and is used universally by any agency or person in initial contact with a homeless person or family for referral to the first proper and appropriate housing option. Once a homeless individual is identified, a CEAR assessment is completed by the provider that is in contact with the individual and a priority number is assigned based on the outcome of the assessment and data entered in HMIS by name list which ranks the individual's priority for the housing. Individuals who are chronically homeless or unsheltered and especially the Transition Age Youth (TAY)

population are prioritized. Monitoring is conducted by CACH CEAR Committee until persons have secured permanent housing.

Emergency Shelter:
Women and families needing immediate emergency shelter in order to avoid becoming unsheltered are all assessed through the HELP Office and at Dauphin County Crisis during off-hours and weekends. Single (unaccompanied) men access shelter directly through the Bethesda Men's Mission.

Unsheltered Persons who are Homeless (Non-Chronically Homeless):
Those who are unsheltered but do not have a disability or who do not have a recurring history of being unsheltered or in emergency shelter defined as chronically homeless will be referred to Transitional Housing Programs. Such referral TH is often done through informed outreach workers, agency, or self-referral. Immediate referral to ES may be required in the event that TH is not available or requires more time to process.

Persons who are Chronically Homeless:
Those who are unsheltered or in an emergency shelter who have a disability and repeated history of being unsheltered or in shelters (12 months in 3 years) that meet the federal definition of chronic homeless will be referred first and foremost to Permanent Supportive Housing (PSH).

Person who are in Rural Areas and Homeless:
Persons in rural Northern Dauphin County will be assisted by the HELP Office with housing/rental assistance for up to six months, using up to 20% of HP and RRH Dauphin County funds, in coordination with the Dauphin County Human Services Office in Elizabethville.

Veterans who are Homeless:
Homeless Veterans can be assisted through any program but they should quickly be referred to Veteran specific housing and service programs offered by the YWCA, Shalom House, Volunteers of America, and Lebanon VA Medical Center i.e. VA Per Diem TH, HUD-VASH, Supportive Services for Veteran Families (SSVF), and Homeless Veterans Reintegration Program (HVRP). If a homeless Veteran moves from a non-specific homeless housing program to one dedicated for Veterans only that then releases bed vacancy for non-veterans candidates.

VAWA Victims Immediately Homeless due to Fleeing**:**
Victims who are homeless because they are immediately fleeing domestic violence, dating violence, sexual assault or stalking, or fleeing any actual or threat of violence can access any portal of housing and homeless service, but are immediately referred and transferred where possible to housing and services provided by the VAWA services agency which in Dauphin County is the YWCA of Greater Harrisburg.

JUSTICE INVOLVED

Dauphin County was selected as a STEPPING UP Initiative County in Pennsylvania to undertake a planned effort to assess cross-system data and develop a six-step action plan to reduce the number of person with mental illness that the Court/law enforcement has put in jail.

Resources and supports are available to the local steering group through NACo, Federal Bureau of Justice Administration, The Council of State Governments and the American Psychiatric Foundation. Dauphin County is currently in the data collection phase of the project.

Dauphin County has many programs that address the needs of justice involved individuals. In 2008 Dauphin County MH/ID opened a full-care Community Residential Rehabilitation (CRR) program for 16 individuals managed by Gaudenzia Inc. to serve those released from Dauphin County Prison and those who are actively involved in the criminal justice system. Dauphin County operates a Drug Court that has been very successful in improving treatment participation and outcomes that promote recovery.

Dauphin County has a Jail Diversion & Reentry program. The Jail Diversion program is beneficial for avoiding or radically reducing jail time by using community-based treatment as an alternative, leading individuals with mental illness or mental illness and substance use problems away from criminal incarceration or cutting it short. The Reentry program works with individuals with a serious mental illness who are court ordered or sentenced to county jail time and connects them to community mental health services prior to or shortly after release from prison.

Dauphin County opened a judicial center for centralized booking several years ago. Pre-Trial staff screen admissions and request a MH assessment from Crisis Intervention Program staff or, if active, targeted mental health case managers. Recommendations are made to Magisterial District Justices in determining bail, release or incarceration.

Dauphin County is not required to and does not collect specific PATH data on individuals that are PATH enrolled and justice involved. However based on the statistics of the general population in Dauphin County that are justice involved, it is estimated the percentage of justice involved persons would be relatively high.

STAFF INFORMATION

Cultural Competence is fundamental to a recovery-oriented mental health system in Dauphin County; building competence needs to be deliberate and overt. Dauphin County MH providers continue to pursue cultural competence in each of their respective agencies by utilizing their own diverse staff to conduct training as well as using outside sources to further develop the agencies overall cultural competency.

The Crisis Intervention Program has one staff member that is Hispanic bilingual/bicultural. Crisis has an agreement with the Language Line service; through which providers and individuals may have telephone access to interpreter services in many languages. The Crisis Intervention Program's agency brochure is available in Spanish and in English. Crisis Intervention staff including the lead homeless caseworker, have many years of experience with understanding and responding to the sensitive to needs of individuals with diverse back rounds.

Downtown Daily Bread (DDB) has a diverse staff working in their soup kitchen and support program. The newly hired individual for the DDB Outreach Specialist position has experience

working with a diverse population of individuals in assisting individuals in mental health treatment and obtaining public housing. Sensitivity to age, gender, and cultural differences is highly valued in the Downtown Daily Bread environment because the ability to successfully engaged individuals is a foremost goal of the program. Training needs in the area of cultural diversity/competence will be assessed and addressed through monthly meetings and periodic administrative reviews.

Keystone Mental Health Services and the CMU are two examples of agencies that continue to cultivate staff sensitivity to cultural and ethnic differences and have many language competencies at particular programs they operate. Mental health agencies may also use contracted interpreter services when needed. Several agencies also periodically offer staff and individuals in service training on cultural topics and skills. The CMU specifically recruits persons that are representative of the communities they serve throughout Dauphin County.

A survey of the demographics of the staff hired in programs that are partially funded by PATH dollars has not been undertaken. Service providers and the County-operated Crisis Intervention Program and contracted PATH providers are encouraged to hire staff representative of the population they serve demographically by age, race/ethnicity and gender while hiring the best qualified candidate for the position. The Crisis Intervention Program is also part of the County's Merit Hire system and County Human Resources Department reviews and monitors staff composition and equal employment opportunity criteria. Dauphin County continues to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

CONSUMER INFORMATION

Table 1 (Section: Local Provider Description) reflects the goals for each PATH providers in number of adults to be outreached, enrolled, and percentage to be literally homeless being served with PATH Funds. Estimated number for outreach is 400; estimated number for enrollment is 300 and the estimated number of enrolled persons to be literally homeless is 55% (or 165 persons).

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 17-18 to be similar to the previous year's PATH annual data. The chart below illustrates the demographics of individuals served in the PATH program for FY 2015-16 (n=287):

Table 3-PATH Consumer Information Demographics for PATH Planning

Demographic Information	FY15-16 Persons Served	FY15-16 Percentage Persons Served
Age: 18-30	78	27%
31-61+	208	73%
Gender: Male	193	67%
Female	94	33%

Race:	African American	106	37%
	Caucasian	162	56%
	Other	19	7%
Hispanic Ethnicity:		170	59%
Diagnosis:	MH Only	113	38%
	COD MH/DA	156	54%
Veteran Status:	Yes	7	3%
	No	277	97%
Housing Status:	Emergency Shelter/ Not meant for Habitation	161	56%
	Transitional Housing	108	38%

The Capital Area Coalition on Homelessness conducted a 2017 Point in Time Survey of individuals and families who experience homelessness. The final report is not completed. The tentative data below is shared in Table 4. There were a total of 355 households with a total of 460 individuals. The chart below illustrates the raw data collected (n=460):

Table 4- Dauphin County Point in Time (PIT) Survey Data (Preliminary)

Demographic Information		**2017 Persons Identified**	**Percentage Persons Identified**
Housing Status:	Safe Haven	22	5%
	Unsheltered or ER Shelters	308	67%
	Transitional Housing	130	28%
	Homeless (Chronic)	45	10%
Gender:	Male	298	65%
	Female	162	35%
Race:	African American	238	52%
	Caucasian	170	37%
	Other	52	11%
Hispanic Ethnicity:		73	16%
Veteran Status:	Yes	39	9%
Diagnosis:	Serious Mental Illness	92	20%
	Substance use (chronic)	96	21%

CONSUMER INVOLVEMENT

The Dauphin County MH/ID Program is committed to having individuals in service take on leadership roles and continue to be involved in all aspects of mental health planning process. The Dauphin County Community Support Program (CSP) Committee is very involved in evaluation as well planning for mental health services and new initiatives. The expertise of the County Quality Assurance staff is utilized to compile and analyze the data received and assists in exploring next steps or recommendations that can be pursued. The survey data outcomes and reports are shared internally with program staff, the Adult MH Committee of the MH/ID Board and the Dauphin County Community Support Program (CSP) Committee. Information is incorporated into annual Block Grant Plan and an Annual Report. The Dauphin County MH/ID

Program has not taken any steps in the past to evaluate the specific PATH funded services by the persons benefiting from them. Concerns about their privacy and guardedness are perceived to interfere with service delivery. The County's Quality Assurance staff is available to investigate complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns.

Downtown Daily Bread has homeless and formerly homeless volunteers that assist with various operations of the homeless services offered, such as with the drop in center operations and with the homeless outreach specialist to provide assistance and to identify locations typically not known by the outreach worker. In allowing volunteers to assist with services has proved beneficial in providing feedback from individuals that receive services offered by the program.

Dauphin County has three (3) contracted agencies that provide certified peer specialist services that conduct their own recruiting and hiring of individuals and search for the best suited candidate. Many agencies also have peer specialists positions imbedded into their program staffing in programs such as social rehabilitation, inpatient services, psychiatric rehabilitation, employment and ACT.

The CMU has an Advisory Committee that reports to their Management Board of Directors. The groups is comprised of representative from the various populations they serve. Recently, the group has been reviewing the paperwork used for intake interviews at the CMU.

The RASE Project has employed Recovery Specialists and Project CONNECT has persons who are literally homeless involved in the planning process for Project CONNECT events in Dauphin County. Individuals in service or that have been homeless are encouraged and attend our local CACH coordination meetings on a regular basis to provide insight and input into the direction of homeless service needs.

HEALTH DISPARITIES IMPACT STATEMENT

Health disparities are not new to the Dauphin County mental health system, including for persons who are homeless, chronically homeless, or imminently homeless. Dauphin County is highly committed to addressing disparities within the County using local, State, and federal resources available to us. For the past several years, an examination of subpopulations in the county-funded system as well as in the Medicaid managed care system has been undertaken to improve the overall wellness of persons we serve. Furthermore, the relationship between health and mental health are fully understood and prioritized. The Commonwealth of Pennsylvania provides for a County-operated and managed mental health system for persons who are uninsured. While services exist, current budgetary cuts and prior cost of living increases not tied to real costs continue to impact the availability of services leading to waiting lists and the need to triage care.

The county behavioral health system is also the primary planner and implementer of service supports and rehabilitation services not funded by Medicaid and Medicare. These are typically services which support persons living in communities. In a recovery and resilience based system, these services are as important as treatment to the individual and their family. Many of

our efforts have not been solely for the benefit of PATH eligible persons; however this population has benefited from these focused efforts.

The Outreach Specialist position at Downtown Daily Bread specifically was established because we found that persons needed a community-based agency for outreach, including in reach. The County's Crisis Intervention Program was too much associated with inpatient psychiatric assessments to function as the sole outreach program for PATH. A specialty psychiatric clinic for persons who are homeless is monitored for access and the consistent issue has been follow-up appointments and locating unsheltered persons for subsequent appointments.

Alder Health Services provides integrated physical and behavioral health services for individuals they serve. Agencies are encouraged to address coordination and communication with primary care physicians. Hamilton Health Center, a federally qualified health center, provides mental health counseling through staff LCSWs. Case management agencies focus on the referral of insured and uninsured persons to primary care programs and services, such as Mission of Mercy and Hamilton Health Center while attempting to secure benefits and insurance barriers.

Dauphin County MH/ID Program, as well as the Medicaid BH-MCO has in place policies and procedures to support agencies in addressing the language and linguistic support needs of persons in service. This is particularly necessary when the mental health workforce does not represent the cultural, language, and ethnic demographics of the community population. The last comparative survey of workforce demographics to the persons in mental health services occurred in the mid 1990 during a period of cultural diversity efforts across the Commonwealth, especially in children's mental health services.

Wellness activities undertaken include efforts with the BH-MCO PerformCare: Medication reconciliation Toolkits and a Natural Supports Toolkit for family, friends and other to support an individual with a serious mental illness. The Natural Supports Toolkit is still pending review with OMHSAS. Efforts to implement a Nurse navigator model are also pending locally.

Dauphin County is involved in a county based grievance and complaint process to address identified disparities related to lack of access and service use. A full time Quality Assurance Program Specialist is support by all County MH staff to track and address concerns about the system. All mental health staff also play a role in grievance and complaints from members under the Medicaid managed care program. Dauphin County MH/ID Program excels at finding solutions to access and service use issues within our budgetary limitations.

Information on the persons in County-funded mental health services, including PATH eligible persons are documented annually in State reporting. PATH reporting is not integrated to the State data system and when an individual becomes registered for the provision of County-funded service there is not currently a PATH designator to track service use even though their homeless status may have improved. The system includes annual data on race, ethnicity, gender, age, income and living arrangement. Continued homelessness has not been a barrier to treatment and support access in Dauphin County while efforts continue on addressing homeless issues/status.

Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly basis to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served in both systems.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. SAMHSA PATH includes TAY persons ranging in ages from 18-30 year old age group. Transitioning young adults have unique challenges at any chronological age since their emotional and social development may have been impacted by socio-economic and mental health factors. According to Dauphin County's PATH annual report data in FY 2015-16, 27% of the individuals served were between the ages of 18-30 years. In FY17-18 the estimate for the number of TAY individuals served through PATH is 25%, but that will be reassessed based upon the complete data for FY16-17 as well as, the % of funds used for the TAY population. Year-to-date 56 person categorized as TAY have been identified but the total number served is pending. The types of services funded by PATH for the TAY population are similar to all PATH funded services: outreach, homeless case management, and housing supports.

Dauphin County takes a flexible approach to determining with a person's support system and interagency team which system (child/adolescent or adult) may fit their needs best and how to individualized the transition period to gain the most success and recovery. Persons under the age of 18 may also be involved with a children and youth agency if they require care and supervision. Mental health treatment in Pennsylvania may be accessed by person 14 years of age and older without parental consent, however efforts are made to engage responsible adults in all aspects of treatment. Person under 18 years requiring inpatient psychiatric or medical care will require the involvement of Children & Youth and the Courts, as needed.

The JEREMY Project (NOT PATH FUNDED) is designed to assist young adults ages 16-22 in transitioning from adolescence to adulthood by focusing on the transitional needs in the domains of education, employment, independent living skills, socialization and community involvement. At the same time, JEREMY attempts to engage/re-engage participants in other mental health treatment, rehabilitation and support. The Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews.– The JEREMY Project is in its 12th year of operation.

Dauphin County studied in FY 16-17 the TAY (16-22 years of age) population discharged from The JEREMY Project over the past three years. The purpose of the review was to determine if the persons being referred, served and discharged were individuals with TAY risks: exploitation/victimization, homelessness, criminal activity, not maintaining MH recovery and lacking family or natural support. The data compilation has just ended and analysis is beginning. This is a transformation priority in the Block Grant and may lead to strategic changes in the system of care of the TAY population.

LIMITED ENGLISH PROFICIENCY

The Crisis Intervention Program utilizes the Language Line to meet linguistic needs and they have one bilingual/bicultural Hispanic staff. All Dauphin County contracted providers make individual arrangement for interpreter services for languages other than English if they do not

have staff that are bilingual/bicultural. All PATH services are provided on an individualized basis and contracted providers respect and are sensitive to the linguistic needs of the homeless population. Dauphin County MH/ID and several providers use The International Service Center to assist with various language translations and interpreting to best serve those who are not proficient in English. This agency has a list of interpreters for many frequently spoken languages that we may experience in the region. Providers continue to tailor services based on individual needs as well as accommodating individual linguistic needs in order to benefit from services provided. Many agencies seek to hire multi-lingual staff that can accommodate and further address the linguistic needs of the population they serve.

DAUPHIN COUNTY COMPREHENSIVE PATH BUDGET NARRATIVE:

Personnel ($ 62,362): $22,362 approximates one-half the salary of the Full-Time Equivalent (FTE) position with the Dauphin County Crisis Intervention Program. The salary amount is 50% of the actual costs for the Crisis Intervention Program's Lead PATH Worker's position. $40,000 is the full-time salary of the Downtown Daily Bread Outreach Specialist position.

Fringe Benefits ($25,566): $ 12,326 or 55.12% references the benefits for one position within the Crisis Intervention Program. $16,240 or 40.6 % are the fringe benefit costs for the Outreach Specialist position at Downtown Daily Bread.

Travel ($2,000): Local Travel at $.54 cents per mile X 52 miles/month X 12 months for the DDB Outreach Specialist position and parking.

Supplies ($4,000): Costs of supplies to be applied to this PATH grant are solely those related to the basic and rehabilitative needs of PATH eligible consumers. Among supplies anticipated are small stocks of non-perishable food items, clothing and blankets, as well as for accessories important to improve prospects for safe and conventional independent living. Costs for bus passes to assist clients to get to housing related services such as supported employment programs, county assistance offices, benefits counseling.

Other ($ 10,098): Staff Training (3,478): This budget line represents costs of speakers, room arrangements, presentation aids, and dining for the PATH training sponsored for the personnel of emergency shelters and other agencies that serve PATH eligible people. Staff conference costs for specialized training. **One-time Rental Assistance ($ 3,310):** This budget line represents costs incurred on behalf of PATH eligible people for whom one-time expenditures can relieve the risk of possible eviction and homelessness. **Security Deposits ($3,310):** This budget line represents a special cost in securing stable housing to prevent or resolve conditions of homelessness. **Assistance in obtaining housing –client travel expenses ($0):** No costs. **Maintenance of Equipment ($0):** No costs related to maintaining equipment.

Indirect Costs/Administrative Cost 4% @ ($ 4,281): Four (4) percent of the PATH grant is allocated to cover administrative expenses at MH/ID Crisis, Downtown Daily Bread and CMU.

Total PATH Request (Federal $83,480 /State $27,827)**…….$ 111,307**

Dauphin County MH/ID Program
FY 2017-18 PATH Comprehensive Intended Use Plan Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Personnel Position				
Crisis Caseworker	44,723	50%	22,362	22,362
DDB Outreach Specialist	40,000	100%	40,000	40,000
Salary sub-total			62,362	**62,362**
Fringe Benefits (55.12% & 40.6%)				
Crisis (55.12%)				
FICA, Health, Ret, Life			12,326	12,326
DDB Outreach Spec (40.6%)				
FICA, Health, Ret			16,240	16,240
Fringe sub-total			28,566	**28,566**
Travel				
DDB Local Travel & parking			2,000	2,000
Travel sub-total			2,000	**2,000**
Equipment				
(list individually)			0	0
sub-total			0	**0**
Supplies				
Consumer-related items			4,000	4,000
Supplies sub-total			4,000	**4,000**
Other				
Staff training			3,478	3,478
One-time rental assistance			3,310	3,310
Security deposits			3,310	3,310
Other sub-total			10,098	**10,098**
Indirect Administration @ 4%				**$ 4,281**
Total PATH Budget (Federal $83,480 /State $27,827)				**$ 111,307**

17. Dauphin County - Case Management Unit

100 Chestnut Street, 1st Floor

Harrisburg, PA 17101

Contact: Frank Magel

Contact Phone #: 717-780-7045

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID:

State Provider ID: PA

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Dauphin County's Case Management Unit will receive a total of $7059 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 20

Estimated Number of Persons to be Enrolled: 20

Estimated Number of Persons to be Contacted who are Literally Homeless: 10

Number staff trained in SOAR in grant year ending in 2017: 1

Number of PATH-funded consumers assisted through SOAR: 5

Dauphin County MH/ID Program
CMU (Case Management Unit)
FY 17-18 PATH Intended Use Plan

LOCAL PROVIDER DESCRIPTION

The Dauphin County MH/ID Program has the legal responsibility to provide administration, fiscal management, and assure the provision of treatment and support services to adults and children with and at-risk of a serious mental illness and co-occurring disorders (MH and drug & alcohol) under the Mental Health/Mental Retardation Act of 1966. The Dauphin County Mental Health/ Intellectual Disabilities Program is a department within the County of Dauphin and is the local recipient of the Commonwealth's allocation of PATH funds. The Dauphin County MH/ID Program oversees the operations of the PATH services and is the responsible fiscal entity. The contact persons for PATH at the Dauphin County MH/ID Program are:

Rose M. Schultz MSW rschultz@dauphinc.org	Deputy MH Administrator	717/780-7054
Frank Magel fmagel@dauphinc.org	MH Program Specialist 2	717/780-7045
Greg McCutcheon gmccutcheon@cmu.cc	CMU Executive Director	717/232-8761

Address: CMU
1100 South Cameron Street
Harrisburg, PA 17104

With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the County MH/ID Program office as OMHSAS does not have a contract directly with the Counties' PATH providers.

Dauphin County MH/ID Program added CMU (Case Management Unit) as a provider of PATH funds Housing Support services, specifically to screen and enroll individuals for PATH eligibility and use PATH funds to support the need for security deposits or first/last month rents. This service can provide quicker access to more permanent housing options for individuals.

The CMU will also use PATH funds to assist PATH eligible/enrolled individuals and families with rental application fees, furnishings, moving expenses and establishing good credit/reducing or eliminating bad debts. One-time Rental Payments to Prevent Eviction are provided for PATH enrolled individuals so as to receive a one-time rental assistance to prevent eviction. The CMU has access to limited PATH funds for preventing eviction on a one-time basis.

The CMU will also serve as a fiduciary in arranging the annual Dauphin County PATH Training.

The amount of PATH funds allocated to Dauphin County MH/ID Program by the Department of Human Services (DHS) , Office of Mental Health and Substance Abuse Services (OMHSAS) in FY 2017-18 is $111,307 of which $27,827 consists of State Funds and $83,480 are Federal

Funds. Dauphin County will contract with the CMU for $ 7,059 of PATH funds for these services and 25% will be State Funds and 75% will be Federal funds.

Based on data collected in the PATH Annual Report for FY2015-16 , it is projected that outreach efforts will be made to approximately 400 individuals and approximately 300 individuals will be enrolled in PATH services. Table 1 illustrates the projected enrollment and service goals in FY17-18 by provider.

Table 1 – Projected PATH Services FY 2017-18

Provider	MH/ID Crisis Intervention Program	Downtown Daily Bread	CMU	TOTAL
Estimated Number Outreach	150	250	Persons are enrolled with CMU	400
Estimated Number Enrolled	125	155	Referrals from Crisis/DDB or new enrollees/ 20	300
Estimated Number Literally Homeless	70	85	10	165 (55%)

COLLABORATION WITH HUD CONTINUUM OF CARE

CMU actively participates directly in various committees and activities of the Capital Area Coalition on Homelessness CACH, and is actively involved in serving the homeless community. CMU actively participates in the planning of the local Project Homeless CONNECT events held in Dauphin County. CMU has extensive knowledge and expertise and collaborates effectively with traditional and non-tradition MH services.

COLLABORATION WITH LOCAL COMMUNIY ORGANIZATIONS

Dauphin County MH/ID Program contracts with a network of private non-profit agencies and private agencies in collaboration with the CIP staff and the homeless provider network for uninsured individuals or services that are not eligible for Medicaid funding. There are also additional community services and supports available that are not contracted by MH/ID or PATH funded through Dauphin County MH/ID. Dauphin County's Medicaid behavioral health managed care organization is PerformCare, a company of AmeriHealth *Caritas.* All of the resources will be available to individuals served as needed and eligible within the limitations of available funding.

The County Department of Drugs & Alcohol Services functions as the Single County Authority (SCA) for the County and is responsible for the provision of prevention, screening, assessment,

treatment, case management and recovery support services in Dauphin County for the uninsured. Most services are available and can accessed directly from private-non-profit contracted agencies. PerformCare (BH-MCO) is also responsible for maintaining a network of drug & alcohol services for Medicaid recipients. Collaboration occurs frequently between mental health and drug & alcohol service providers.

The CMU (Case Management Unit) is the MH/ID contracted agency responsible to perform the duties of the Base Service Unit and registers all individuals for county-funded mental health services. By conducting walk-in intake interviews four-days per week, mental health assessments and financial liability assessments determine eligibility and the individual's ability to participate in the cost of services, if any, according to PA regulations. The CMU also provides targeted case management services called Blended Case Management for eligible adults and children. Administrative case management and peer support are also provided by the CMU. CMU has an administrative case manager specifically to serve the homeless adult population and serves as the SSI/SSDI Outreach, Access, Recovery (SOAR) Coordinator position in Dauphin County. SOAR offers quicker access and approval of Social Security benefits and income for persons who are homeless. SOAR is not funded with any PATH dollars. Intensive case management services for eligible individuals in Dauphin County are also available from Keystone Mental Health Services.

CMU, Philhaven, and Keystone offer Certified Peer Specialist services that are approved by OMHSAS and credentialed by PerformCare (BH-MCO). Certified Peer Specialists are also imbedded in Dauphin County's local psychiatric inpatient unit Pennsylvania Psychiatric Institute (PPI), psychiatric rehabilitation, employment and social rehabilitation services.

Some outpatient providers have unique characteristics or serve specific populations of Dauphin County residents. There are also several licensed psychiatric outpatient clinics that have a Medicaid HealthChoices BH-MCO contracts but not a county contract. Two of the clinic also have a D&A outpatient clinic license for the same clinic site, and two COD clinics using the Hazelden model are currently offering integrated MH and D&A treatment. There are clinics that are specialized for the following populations: LGBTQI, HIV/AIDS, homeless, Evidenced based outpatient interventions, sex offenders, open access, older adults, Hispanic, dual MH/ID, and school-based. The FQHC, Hamilton Health Center also provides some outpatient services.

Northwestern Human Services (NHS) of PA Capital Region provides Assertive Community Treatment Team (ACT) services. NHS of PA, PPI, and Philhaven also offer partial hospitalization services. Pennsylvania Psychiatric Institute (PPI) operates an acute rapid access adult partial program developed in effort to reduce high MH inpatient re-hospitalization rates in Dauphin County.

Dauphin County has two (2) social rehabilitation programs: Aurora Social Rehabilitation and a consumer-run drop-in center, Patch-N-Match. Keystone Service Systems operates a licensed Psychiatric Rehabilitation program for site-based and mobile services that opened in 2014. In FY17-18 Keystone's program will also be MA funded.

Community Residential Rehabilitation (CRR) services offer many choices to individuals to gain independence in their recovery journey. Licensed residential programs offer varying

degrees of support and are in a group setting, as well as, in scattered apartment settings. The Dauphin County contracted residential providers are NHS of PA, Elwyn, (KMHS) Keystone Mental Health Services. Supportive living services are provided by Volunteers of America (VOA), Keystone and Central Pennsylvania Supportive Services (CPSS).

CAPSTONE, a first episode psychosis program, for person ages 16-26 began services in March 2017. CMU, YWCA and Pennsylvania Psychiatric Institute are the three (3) collaborating agencies. Case management, peer support, clinical services and supported employment/supported education are all offered.

Short-term temporary residential services are available to PATH eligible individuals until a more permanent housing solution is identified. There are two providers contracted with Dauphin County MH/ID Program for specialized CRR services: NHS of PA's Windows Program in Harrisburg, and Community Services Group (CSG), Crisis and Diversion Program in the Steelton community. Both programs provide short-term 45-day residential support with a capacity of 24 persons and two (2) 5-day crisis beds with 24-hour, 7-day per week staff oversight.

Dauphin County MH/ID Program has developed a strong collaborative working relationship with the Housing Authority of the County of Dauphin (HACD) and jointly link individuals to approved landlords that accept HUD funded Shelter + Care and Project Access vouchers. Keystone Service Systems Supportive Living Program has a designated staff that acts as a housing locator for individuals that secure HUD vouchers. Dauphin County MH/ID implemented a Bridge Rental Subsidy program with that currently serves 15 individuals who have a serious mental illness. Through ongoing collaboration and support the landlord/tenant relationships have been strengthened, and there is stability in permanent housing options.

Employment services in Dauphin County are comprised of varying degrees of support and independence. Employment is viewed as a measure of personal success and recovery. The YWCA's Supported Employment program is funded through Dauphin County to assist individuals in securing and maintaining competitive employment. Most programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

A Safe Haven (men only) program is operated by Christian Churches United and offers transitional and " housing first" living for up to 25 men. The YWCA transitioned the women's "housing first" program in 2015 to a Permanent Supportive Housing Program. This transition has significantly improved the housing services available to eight chronically homeless women by providing permanent housing to women who have struggled with maintaining self-sufficiency in our community.

HUD 811 projects in Dauphin County for potential PATH enrolled persons include Creekside Village and New Song Village ; both are operated by Volunteers of America (VOA). The programs are permanent affordable housing projects for individuals with serious mental illness.

The HUD 811 project-based vouchers are a demonstration project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) and have available safe and affordable permanent housing for individuals with disabilities. These

vouchers will serve a varied group such as individuals with a physical disability, mental illness, intellectual disabilities, Autism and transition age youth with disabilities, with the priorities given to those in institutions, living in congregate living situations and those at risk of being institutionalized.

Sunflower Fields is a capital investment LIHTC housing project in Dauphin County using FY 2013-14 HealthChoices reinvestment funds. Availability of housing contingency funds and completion of PREP were positive aspects of assisting persons and families in this application/approval process.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals. The employment component is called Paxton Cleaning Solutions and has competitive contracts with local companies.

Mission of Mercy provides mobile medical outreach and care to homeless individuals and those who are uninsured or underinsured to obtain appropriate medical care. Catholic Charities continues to provide outpatient therapy services to individuals served by Mission of Mercy.

The HELP Office is the primary program for assistance with basic needs and emergency housing and is operated by Christian Churches United. Emergency shelters include: Bethesda Mission, Salvation Army, Shalom House, Interfaith Shelter and the YWCA Domestic Violence services. Several local church organizations run soup kitchens and food pantries to assist individuals in obtaining needed food.

All MH case management entities and the Crisis Intervention Program have access to consumer support and emergency housing funds available to assist individuals with first month's rent and security deposits or back rent and utilities as needed. Dauphin County continues its commitment to improving the wellness of individuals served in the MH system: ongoing information sharing on effective strategies among provider agencies to promote healthy lifestyle choices, team building on how to make lifestyle changes in group living arrangements, in addition to improved communication between primary care physicians and psychiatrists facilitated by outpatient clinics and case managers.

SERVICE PROVISION

A description of the PATH funded services provided by the CMU are listed below:

Staff Training

PATH training is selected each year by identifying the needs of PATH providers and the homeless provider network. The training may also address cross-system co-occurring training needs. Training in scheduled in 2017 with the topic Choices in Healing: "Approaches and Methods that Support Recovery" conducted by Drexel University. In FY 2017-18 CMU will receive funds for yearly training to support PATH providers and the homeless provider network to expedite contracting processes.

Case Management

The CMU's case management services are not funded with PATH dollars. The Outreach Specialist at Downtown Daily Bread and Crisis Intervention Program staffs work with the CMU to assure a connection is made with the mental health system for treatment and supports for individuals enrolled in PATH. Person may be referred and homeless or become homeless while involved with the CMU. Case management services at the CMU will not be paid with PATH funds. However, case managers will use PATH funds to prevent homelessness or remove persons and families from a homeless circumstance.

Housing Services

- Security Deposits: The CMU is contracted to provide PATH funds to assist individuals in securing permanent housing. CIP and case management entities have additional but limited funds to provide this assistance, other than PATH funding. This service can provide quicker access to more permanent housing options for individuals, rather than relying on limited shelter space. The funding assists PATH eligible individuals with securing safe, affordable and permanent housing.
- Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: When individuals secure appropriate housing, there are additional costs associated with that housing other than security deposit or first/last month rent. Some costs may involve rental application fees, furnishings, moving expenses and establishing good credit/reducing or eliminating bad debts. CMU is contracted to provide a this assistance to prevent eviction and homelessness and assist individuals in securing permanent housing. CIP and all case management entities have access to additional, but limited funds other than PATH funds for transition purposes that result in more stable housing.
- One-time Rental Payments to Prevent Eviction: PATH enrolled individuals can receive a one-time rental assistance to prevent eviction. CMU is contracted to provide a this assistance to prevent eviction and homelessness. CIP and all case management entities have access to additional, but limited funds , other than PATH for preventing eviction on a one-time basis.

Dauphin County MH/ID Program is a department also in the Block Grant and our office also manages MATP, HAP (Homeless Assistance Program) funds and ESG (Emergency Solutions Grant) funds. Dauphin County MH/ID administrator is also an officer in CACH (Capital Area Coalition on Homelessness) which also functions as the Local lead Agency (LLA) The mental health funds managed through the Block grant constitute 71.5% of the Block Grant funding. Administrative costs are only 4.5% of the MH funding in Dauphin County. The MH program is positioned to understand a wider range of funding than a typical mental health program and persons that may be PATH eligible need to access funds through other components of the homeless network funding prior to using PATH funds. For example, individuals must seek HELP Office resources for assistance with utility bills and though the LIHEAP program before seeking help from PATH providers. Another example is sharing costs of assisting a PATH eligible person in housing by agencies sharing the costs of a security deposit or providing some basic household items to establish housing.

Service Gaps

PATH-funded services continue to be flexible and address the unique needs of the homeless individuals served in Dauphin County. However, there are service gaps where capacity does not meet demand. The needs of homeless individuals for psychiatric services are prioritized along with several additional target groups such as persons with forensic involvement and acute inpatient discharges in order to prevent readmissions. Additional service gaps identified include:

- Limited availability of emergency shelter space.
- Limited number of safe and affordable housing units, due in part to rental costs that have risen tremendously in Dauphin County, which makes it very difficult for low income and very low income individuals to afford rent.
- Programs continue to be challenged with complex mental health needs and chronic medical conditions among persons with a serious mental illness or co-occurring disorder.
- Individuals being released from the criminal justice settings are not a good fit in shelter settings or are not eligible for subsidized housing due to past criminal charges. Dauphin County has a disproportionate number of persons sent to community correctional centers and halfway houses under early release that are not Dauphin County residents.

Needs of the Co-Occurring Population

Dauphin County mental health system is charged with assuring there are established services to meet the needs of the serious mental illness and individuals who also have substance use disorders. While the regulatory authority of services lies with both the Department of Human Services (mental health) and the Department of Drugs and Alcohol, County administered programs face challenges to implement integrated treatment model services to meet the needs of individuals with co-occurring disorders. Among individuals who are medical assistance eligible, services are administered through the same behavioral health managed care organization PerformCare.

Individuals with co-occurring disorders have access to the following array of mental health services and supports: outpatient services, partial day programs, residential services, and support services such as targeted case management, supportive living, social rehabilitation, peer support and inpatient care through county /state funding streams and Medicaid managed care. The Drug & Alcohol system is disproportionately funded at the community level and the lack of integrated treatment adds additional barriers to recovery.

Evidenced Based and Promising Practices

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) (a function of the CMU) is an essential first step in providing the individual access to the array of services that are available. Once registered with the BSU through walk-in access , an individual will have access to evidence based and promising practices that operate with fidelity throughout the MH system. These services can benefit

literally homeless, including chronically homeless individuals and those at imminent risk of homelessness who are seeking to engage in mental health and co-occurring services.

Table 2 represents evidence based and promising practices that are available in Dauphin County currently.

Table 2 – Evidenced Based and Promising Practices in Dauphin County

Evidenced Based and Promising Practices	Service Available in County	Staff Trained in EBP/PP	Comments
Assertive Community Treatment	Yes	Yes	Urban Team
Supported Housing	Yes	No	
Supported Employment	Yes	Yes	
Integrated Treatment Co-Occurring (MH/SA)	Yes	Yes	Located with Two (2) OPT D & A Providers
Dialectical Behavioral Therapy	Yes	Yes	Adult and Teen models; two (2) certified providers
Mobile Psychiatric Nursing	Yes	Yes	
Shared Decision Making	Yes	Yes	CAPSTONE (FEP)
Psychiatric Rehabilitation	Yes	Yes	Site and Mobile
Cognitive Behavior Therapy	Yes	Yes	
Trauma-Focused CBT	Yes	Yes	
Consumer-operated Services	Yes	Yes	Drop-in Center
MHFA Adults and Children	Yes	Yes	
Illness Management Recovery	Yes	Yes	Four (4) providers
Certified Peer Specialist	Yes	Yes	Free-standing and Embedded
Parent-Child Interaction Therapy	Yes	Yes	Two (2) certified providers
Guiding Good Choices	Yes	Yes	Parents are facilitators
First Episode Psychosis	Yes	Yes	CAPSTONE
WRAP & WRAP Facilitator	Yes	Yes	
Family Psycho-education	Yes	Yes	NAMI Family-to-Family

Dauphin County relies upon State and County Base MH funds to support the use of evidenced based and promising practices, as well as Medicaid managed care under HealthChoices.

PATH services are available for non-service connected veterans who may also be homeless and their families by accessing the same array of services available to any individual that is PATH eligible. In some cases, due to gaps in services, veterans and their families are served by both the MH and VA systems based on their need and eligibility for services. The County's Veteran Affairs Office annually coordinates a Stand Down program, and veterans and their families take

part in the Project CONNECT events. Following these events, further outreach and follow-up is provided to individuals to assist in linking them to needed services.

Dauphin County embraces the Principles of Recovery and Resilience. Most activities include all stakeholders and all individualized teams supporting persons have a common message to be recovery/resiliency oriented, work with a person's strengths, consumer-driven, and emphasize the use of natural, peer, and family support. As a Block Grant County, Dauphin MH/ID Program documents their recovery and resilience priorities and activities.

Dauphin County MH/ID and its contracted PATH providers are not required to follow 42 CFR Part 2 regulations since they do not provide any direct drug & alcohol services, diagnosis or treatment to PATH funded individuals. Referral are made as needed with the assistance of PATH providers to drug & alcohol treatment as needed, however they are not involved in providing any direct treatment services.

Dauphin County is implementing a STEPPING UP initiative. The goal of this initiative is to reduce the number of individuals with mental illness and co-occurring disorders in prison. Currently Dauphin County is currently collecting data and will develop an action plan to address issues. Dauphin County is also actively involved with re-entry of persons in local jails and State prisons.

DATA

The Dauphin County Mental Health administration will be responsible for training CMU on the use of the Federal Homeless Management Information System (HMIS). The Capital Area Coalition on Homelessness (CACH) is the local planning group in Dauphin County and the CACH funds the HMIS training and activities around data collection. Bowman is the selected HMIS contractor. The CMU will be trained to use HMIS.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH provider agency staff will be supported on a day-to-day basis by Dauphin County MH administrative staff and the HMIS program administrator. There are ongoing data entry and reporting issues with HMIS that continue to be addressed with HMIS Administrator in Dauphin County. Ongoing technical support is being used to further develop the data quality and integrity of the PATH data entered into HMIS.

ALIGNMENT WITH PATH GOALS

CMU is committed to PATH goals for literally homeless persons and devotes PATH funds and other funds to this end. CMU staff focus on conducting service by face-to-face contact in any setting, CMU staff work closely and collaboratively with traditional mental health providers and the local homeless provider network as well as other local church and volunteer organizations to assist these individuals. It is clear that the most effective approach in assisting homeless individuals is ongoing and persistent contact along with building rapport and trust with individuals will has the greatest impact and success in reducing homelessness.

ALIGNMENT WITH STATE MENTAL HEALTH SERVICES PLAN

Dauphin County MH/ID PATH providers focus and prioritize the needs of the most vulnerable individuals, especially those who experience chronic homelessness with a serious mental illness and/or co-occurring substance abuse disorder.

ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS

With the adoption of HOME RUN by the County of Dauphin and the City of Harrisburg, and the continued leadership of CACH as the Blueprint Manager, the stage has been set to make homelessness *rare, brief and non-recurring in our community*.

The 2017 Blueprint presents six (6) Primary Objectives with several strategies and action steps to achieve the U.S. Department of Housing and Urban Development's definition of "ending homelessness", where *homelessness is rare, brief, and non-recurring:*

1) Strengthen Leadership to End Homelessness;
2) Achieve a Continuum or County-Wide Coordinated Entry, Assessment and Referral System;
3) Preserve Existing, and Increase Affordable Housing Supply;
4) Ensure Access to and Availability of Supportive Services;
5) Increase Public Awareness and Education about Homelessness, the Coalition, and its resources; and
6) Prevention of Homelessness. Each Primary Objective has outcome measures based on "System Performance Measures" by the US Department of Housing and Urban Development (HUD) on how a continuum or catchment is progressing towards ending homelessness.

The Dauphin County MH/ID Program has maintained a collaborative relationship with Dauphin County Emergency Management Agency (EMA) and provides a Mental Health Response Team when an incident occurs which requires mental health disaster intervention. Under a collaborative agreement, the EMA will support the efforts of the MHRT and will provide whatever appropriate resources it may have at its disposal to intervene in a disaster incident (including activating ancillary agreements the EMA may have with other resources such as the Red Cross). The County Emergency Management Agency and local EMAs in municipalities will notify the county program by telephone or by fax if any incident has occurred that may, in their opinion, require the mental health response. The County MH/ID Administrator may also direct activation to an incident which smaller EMAs have not yet communicated. The MH/ID Administrator will however inform the county EMA's that the County MH/ID Program is indeed responding. This agreement pertains to incidents in Dauphin County as well as to any incident outside the county in which the Dauphin County Emergency Management Agency would respond to according to their own mutual assistance pacts with other County EMAs.

Crisis Intervention Program staff also participates in the County-wide TMI disaster preparedness drill, which occurs every other year. The Program staff's role is "rumor control" to the general public and support to the State and local EMA staff. Further, on a daily basis, suicide callers to the EMA 911 Center are routinely patched through to the Dauphin County Crisis Intervention Program. The Program also maintains a mutual aid agreement with the local Red Cross that will be updated in the coming fiscal year. All homeless providers have developed individual emergency preparedness plans to address the

needs of the individual they serve. CACH is in the process of developing a committee to address the need to have a comprehensive disaster preparedness plan to address individuals identified as homeless and chronically homeless that reside on the streets and places unfit for habitation.

OTHER DESIGNATED FUNDS

Dauphin County has an Emergency Solutions Grant (ESG) Program authorized by subtitle B of title IV of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11371–11378). This program authorizes the Department of Housing and Urban Development (HUD) to make grants to states, units of general purpose local government, and territories for the rehabilitation or conversion of buildings for use as emergency shelters for the homeless, for the payment of certain expenses related to operating emergency shelters, for essential services related to emergency shelters and street outreach for the homeless, and for homelessness prevention and rapid re-housing assistance. Dauphin County uses this funding for emergency shelters, rapid rehousing, rental assistance, homeless prevention and HMIS.

Dauphin County's Homeless Assistance Services (HAP) Program serves individuals and families whose income is below 200% of Federal Poverty level and who are homeless, near homeless, and who meet the specific HAP program component requirements. HAP services include; bridge housing, case management, rental assistance, emergency shelter.

Dauphin County uses MH Block Grant funds to support many homeless positions in the provider network not funded by PATH dollars. Medicaid expansion has facilitated the use of HC funds to support the provision of treatment for the homeless population, including families.

Any of the above mentioned funds could intersect and support a person who is also PATH eligible. This would primarily occur in the area of rental assistance or supports to establish housing to end homelessness and may be configured on an individual basis.

SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)

SOAR training was provided by OMHSAS in coordination with a SOAR Implementation Team. SOAR activities are not PATH funded in Dauphin County. The Dauphin County SOAR coordinator also manages a homeless caseload in the CMU agency. The position continues to work collaboratively with improving ongoing communication with Central Pennsylvania Legal Services, the Social Security Administration (SSA) and the Bureau of Disability Determination (BDD). All potential SOAR applicants are screened and the process has been used to secure benefits for 28 persons since SOAR was introduced to Dauphin County in 2012. The process is very time-consuming, detail oriented and comprehensive. During FY 16-17 five (5) persons were approved through SOAR. Dauphin County designated the homeless outreach worker at CMU for the coordination and processing of all SOAR applications in Dauphin County in part due to the detailed and technical process involved.

PROGRAMATIC AND FINANCIAL OVERSIGHT

Dauphin County MH/ID receives state and federal funds PATH directly from the Office of Mental Health and Substance Abuse services OMHSAS. These PATH funds are allocated to the subcontracted PATH providers; DDB, CMU, Crisis Intervention Services. Quarterly reviews are conducted by MH program specialist staff of HMIS data. Internal audits are conducted by Dauphin County MH/ID Fiscal Officer and PATH Financial quarterly reports are provided to the OMHSAS for review reflecting all contracted PATH funds in Dauphin County. At a minimum monthly programmatic meetings are held with the CMU staff regarding service delivery and reporting issues.

HOUSING

PATH funds continue to assist individuals who are literally homeless, chronically homeless, and at imminent risk of homelessness in securing permanent housing. PATH services continue to remain flexible and sensitive to the unique needs of individuals. CMU provides services to build rapport and engage individuals in accessing appropriate mental health treatment and support services and available housing. Several temporary options are considered first in addressing immediate housing needs and once established can lead to a permanent housing situation.

Housing Partnerships: The Dauphin County MH/ID Program has been working collaboratively with the following partners in developing affordable housing options for individuals with serious mental illness: CACH, Housing Authority of the County of Dauphin, Volunteers of America, and Paxton Ministries as well as new developers being established in the County. CACH is the designated Local lead Agency for Dauphin County with key responsibilities including coordination with area service providers and building owners regarding new HUD 811 projects and tax credit housing projects funded through PHFA in assuring there are eligible individuals ready to move into available units when they become available.

Volunteers of America is a longstanding provider of mental health services and a housing provider. The organization has developed two HUD 202s for low- income elderly and two HUD 811s for low-income individuals with mental health diagnoses. VOA's projects are located in Dauphin County provide safe and affordable housing and are fully occupied.

Paxton Ministries developed two (2) Community Lodges for up to eight (8) individuals. The business component is a cleaning company called Paxton Cleaning Solutions with contracts in the surrounding area.

COORDINATED ENTRY

CACH is the PA-501 Harrisburg/Dauphin County Continuum of Care and therefore, the PA-501 coordinated entry process is the same as CACH's process. CACH has the following Coordinated System of Entry and Referral for persons seeking homeless services and housing programs in the City of Harrisburg Dauphin County. CACH has developed a Coordinated Entry Referral Tool (CERT) and is used universally by any agency or person in initial contact with a homeless person

or family for referral to the first proper and appropriate housing option. Once an homeless individual is identified a CEAR assessment is completed by the provider that is in contact with the individual and a priority number is assigned based on the outcome of the assessment and data entered in HMIS by name list which ranks the individual's priority for the housing. Individuals who are chronically homeless or unsheltered and especially the Transition Age Youth (TAY) population are prioritized and entered into the Bowman HMIS system by name list that is monitored by CACH CEER committee and remain on the list until individual has secured permanent housing.

JUSTICE INVOLVED

Dauphin County was selected as a STEPPING UP Initiative County in Pennsylvania to undertake a planned effort to assess cross-system data and develop a six-step action plan to reduce the number of person with mental illness that the Court/law enforcement has put in jail. Resources and supports are available to the local steering group through NACo, BJA, The Council of State Governments and the American Psychiatric Foundation. Dauphin County is currently in the data collection phase of the project.

Dauphin County has many programs that address the needs of justice involved individuals. CMU operates a Forensic Blended Case Management Unit and works closely with law enforcement, Courts and probation/parole services. In 2008 Dauphin County MH/ID opened a full-care Community Residential Rehabilitation (CRR) program for 16 individuals managed by Gaudenzia Inc. to serve those released from Dauphin County Prison and those who are actively involved in the criminal justice system. Dauphin County operates a Drug Court that has been very successful in improving treatment participation and outcomes that promote recovery.

Dauphin County has a Jail Diversion & Reentry program. The Jail Diversion program is beneficial for avoiding or radically reducing jail time by using community-based treatment as an alternative, leading individuals with mental illness or mental illness and substance use problems away from criminal incarceration or cutting it short. The Reentry program works with individuals with a serious mental illness who are court ordered or sentenced to county jail time and connects them to community mental health services prior to or shortly after release from prison.

Dauphin County opened a judicial center for centralized booking several years ago. Pre-Trial staff screen admissions and request a MH assessment from Crisis Intervention Program staff or, if active, targeted mental health case managers. Recommendations are made to Magisterial District Justices in determining bail, release or incarceration.

Dauphin County is not required to and does not collect specific PATH data on individuals that are PATH enrolled and justice involved, however based on the statistics of the general population in Dauphin County that are justice involved it is estimated the percentage of justice involved persons is relatively high.

STAFF INFORMATION

Cultural Competence is fundamental to a recovery-oriented mental health system in Dauphin County; building competence needs to be deliberate and overt. Dauphin County MH providers continue to pursue cultural competence in each of their respective agencies by utilizing their own diverse staff to conduct training as well as using outside sources to further develop the agencies overall cultural competency.

The CMU recruits staff representative of the community they service throughout dauphin County. This includes bilingual/bicultural staff. Keystone Mental Health Services and the CMU are two examples of agencies that continue to cultivate staff sensitivity to cultural and ethnic differences and have many language competencies at particular programs they operate. Mental health agencies may also use contracted interpreter services when needed. Several agencies also periodically offer staff and individuals in service training on cultural topics and skills.

A survey of the demographics of the staff hired in programs that are partially funded by PATH dollars has not been undertaken. Service providers and the County-operated Crisis Intervention Program and contracted PATH providers are encouraged to hire staff representative of the population they serve demographically by age, race/ethnicity and gender while hiring the best qualified candidate for the position. Dauphin County continues to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

CONSUMER INFORMATION

Table 1 (Section: Local Provider Description) reflects the goals for the CMU in number of adults to be referred (as CMU conducts no PATH outreach) , expected number to be enrolled and percentage to be literally homeless being served with PATH Funds. Persons identified by Crisis Intervention Program and/or Downtown Daily Bread are referred to CMU for on-going MH services and supports. An estimated 20 persons will be enrolled by the CMU as PATH eligible and among those enrolled 10 (or 50%) will be literally homeless.

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 2017-18 to be similar to the previous year's PATH annual data. The chart below illustrates the demographics of individuals served in the PATH program for FY 2015-16 (n=287).

Table 3-PATH Consumer Information Demographics for PATH Planning

Demographic Information	FY15-16 Persons Served	FY15-16 Percentage Persons Served
Age: 18-30	78	27%
31-61+	208	73%
Gender: Male	193	67%
Female	94	33%

Race: African American	106	37%
Caucasian	162	56%
Other	19	7%
Hispanic Ethnicity:	170	59%
Diagnosis: MH Only	113	38%
COD MH/DA	156	54%
Veteran Status: Yes	7	3%
No	277	97%
Housing Status: Emergency Shelter/ Not meant for Habitation	161	56%
Transitional Housing	108	38%

Following the end of FY16-17 data will be compiled and analyzed for more current information.

CONSUMER INVOLVEMENT

The Dauphin County MH/ID Program is committed to having individuals in service take on leadership roles and continue to be involved in all aspects of mental health planning process. The Dauphin County Community Support Program (CSP) Committee is very involved in evaluation as well planning for mental health services and new initiatives. The expertise of the County Quality Assurance staff is utilized to compile and analyze the data received and assists in exploring next steps or recommendations that can be pursued. The survey data outcomes and reports are shared internally with program staff, the Adult MH Committee of the MH/ID Board and the Dauphin County Community Support Program (CSP) Committee. Information is incorporated into annual Block Grant Plan and an Annual Report. The Dauphin County MH/ID Program has not taken any steps in the past to evaluate the specific PATH funded services by the persons benefiting from them. Concerns about their privacy and guardedness are perceived to interfere with service delivery. The County's Quality Assurance staff is available to investigate complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns.

Dauphin County has three (3) contracted agencies that provide certified peer specialist services that conduct their own recruiting and hiring of individuals and search for the best suited candidate. CMU operates a MA funded peer support program. Many agencies also have peer specialists positions imbedded into their program staffing in programs such as social rehabilitation, inpatient services, psychiatric rehabilitation, employment and ACT.

HEALTH DISPARITIES IMPACT STATEMENT

Health disparities are not new to the Dauphin County mental health system, including for persons who are homeless, chronically homeless, or imminently homeless. Dauphin County is highly committed to addressing disparities within the County using local, State, and federal resources available to us. For the past several years, an examination of subpopulations in the county-funded system as well as in the Medicaid managed care system has been undertaken to improve the overall wellness of persons we serve. Furthermore, the relationship between health and mental health are fully understood and prioritized. The Commonwealth of Pennsylvania

provides for a County-operated and managed mental health system for persons who are uninsured. While services exist, current budgetary cuts and prior cost of living increases not tied to real costs continue to impact the availability of services leading to waiting lists and the need to triage care.

The county behavioral health system is also the primary planner and implementer of service supports and rehabilitation services not funded by Medicaid and Medicare. These are typically services which support persons living in communities. In a recovery and resilience based system, these services are as important as treatment to the individual and their family. Many of our efforts have not been solely for the benefit of PATH eligible persons; however this population has benefited from these focused efforts.

Alder Health Services provides integrated physical and behavioral health services for individuals they serve. Agencies are encouraged to address coordination and communication with primary care physicians. Hamilton Health Center, a federally qualified health center, provides mental health counseling through staff LCSWs. Case management agencies focus on the referral of insured and uninsured persons to primary care programs and services, such as Mission of Mercy and Hamilton Health Center while attempting to secure benefits and insurance barriers.

Dauphin County MH/ID Program, as well as the Medicaid BH-MCO has in place policies and procedures to support agencies in addressing the language and linguistic support needs of persons in service. This is particularly necessary when the mental health workforce does not represent the cultural, language, and ethnic demographics of the community population. The last comparative survey of workforce demographics to the persons in mental health services occurred in the mid 1990 during a period of cultural diversity efforts across the Commonwealth, especially in children's mental health services.

Wellness activities undertaken include efforts with the BH-MCO PerformCare: Medication reconciliation Toolkits and a Natural Supports Toolkit for family, friends and other to support an individual with a serious mental illness. The Natural Supports Toolkit is still pending review with OMHSAS. Efforts to implement a Nurse navigator model are also pending locally.

Dauphin County is involved in a county based grievance and complaint process to address identified disparities related to lack of access and service use. A full time Quality Assurance Program Specialist is support by all County MH staff to track and address concerns about the system. All mental health staff also play a role in grievance and complaints from members under the Medicaid managed care program. Dauphin County MH/ID Program excels at finding solutions to access and service use issues within our budgetary limitations.

Information on the persons in County-funded mental health services, including PATH eligible persons are documented annually in State reporting. PATH reporting is not integrated to the State data system and when an individual becomes registered for the provision of County-funded service there is not currently a PATH designator to track service use even though their homeless status may have improved. The system includes annual data on race, ethnicity, gender, age, income and living arrangement. Continued homelessness has not been a barrier to treatment and support access in Dauphin County while efforts continue on addressing homeless issues/status.

Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly basis to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served in both systems.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. SAMHSA PATH includes TAY persons ranging in ages from 18-30 year old age group. Transitioning young adults have unique challenges at any chronological age since their emotional and social development may have been impacted by socio-economic and mental health factors. According to Dauphin County's PATH annual report data in FY 2015-16, 27% of the individuals served were between the ages of 18-30 years. In FY17-18 the estimate for the number of TAY individuals served through PATH is 25%, but that will be reassessed based upon the complete date for FY16-17 as well as the % of funds used for the TAY population. Year-to-date 56 person categorized as TAY have been identified but the total number served is pending. The types of services funded by PATH for the TAY population are similar to all PATH funded services: outreach, homeless case management, and housing supports.

Dauphin County takes a flexible approach to determining with a person's support system and interagency team which system (child/adolescent or adult) may fit their needs best and how to individualized the transition period to gain the most success and recovery. Persons under the age of 18 may also be involved with a children and youth agency if they require care and supervision. Mental health treatment in Pennsylvania may be accessed by person 14 years of age and older without parental consent, however efforts are made to engage responsible adults in all aspects of treatment. Person under 18 years requiring inpatient psychiatric or medical care will require the involvement of Children & Youth and the Courts, as needed.

The JEREMY Project (NOT PATH FUNDED) is designed to assist young adults ages 16-22 in transitioning from adolescence to adulthood by focusing on the transitional needs in the domains of education, employment, independent living skills, socialization and community involvement. At the same time, JEREMY attempts to engage/re-engage participants in other mental health treatment, rehabilitation and support. The Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews.– The JEREMY Project is in its 12th year of operation.

Dauphin County studied the TAY (16-22 years of age) population discharged from The JEREMY Project over the past three years. The purpose of the review was to determine if the persons being referred, served and discharged were individuals with TAY risks: exploitation/victimization, homelessness, criminal activity, not maintaining MH recovery and lacking family or natural support. The data compilation has just ended and analysis is beginning. This is a transformation priority in the Block Grant and may lead to strategic changes in the system of care of the TAY population.

LIMITED ENGLISH PROFICIENCY

All Dauphin County contracted providers make individual arrangement for interpreter services for languages other than English if they do not have staff that are bilingual/bicultural. All

PATH services are provided on an individualized basis and contracted providers respect and are sensitive to the linguistic needs of the homeless population. Dauphin County MH/ID and several providers use The International Service Center to assist with various language translations and interpreting to best serve those who are not proficient in English. This agency has a list of interpreters for many frequently spoken languages that we may experience in the region. Providers continue to tailor services based on individual needs as well as accommodating individuals linguistic needs in order to benefit from services provided. Many agencies seek to hire multi-lingual staff that can accommodate and further address the linguistic needs of the population they serve.

CMU (Case Management Unit) PATH BUDGET NARRATIVE:

Personnel: ($ 0): No CMU personnel costs are funded with PATH.

Fringe Benefits (0% and $0): No fringe benefits are funded with PATH at the CMU.

Travel ($0): No travel costs are funded by PATH at the CMU.

Equipment ($0): No PATH funds are used in this category by the CMU.

Supplies ($ 0): Other ($6,788): Homeless Provider Network Training ($3,478): The CMU will serve as the fiduciary for the Annual PSTH Training. One-time Rental Assistance ($1,655): This budget line represents costs incurred on behalf of PATH enrolled people for whom one-time expenditures can address literal homelessness through the CMU. Security Deposits ($1,655): This budget line represents cost in securing stable housing to resolve conditions of homelessness for enrolled PATH persons also active with the CMU.

Indirect Costs/Administrative Cost 4% @ $ 271): Four (4) percent of the PATH grant is allocated to cover administrative expenses at CMU.

Total CMU PATH Request ($ 1,765 State funds and $5,294 Federal funds) **…….……$,7059**

Dauphin County MH/ID Program
FY 2017-18 CMU PATH BUDGET

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Personnel Position				
No CMU Staff			0	0
Salary sub-total			**0**	0
Fringe Benefits (0%)				
No CMU Fringe			0	0
Fringe sub-total			**0**	**0**
Travel				
No CMU travel			0	0
Travel sub-total			0	**0**
Equipment				
No CMU equipment			0	0
sub-total			0	0
Supplies				
No CMU supplies			0	0
Supplies sub-total			0	**0**
Other				
Staff training			3,478	3,478
One-time rental assistance			1,655	1,655
Security deposits			1,655	1,655
Other sub-total			6,788	**6,788**
Indirect Administration @ 4%				**$ 271**
Total PATH Budget ($ 1,765 State funds and $5,294 Federal funds)				**$ 7,059**

XXX5/2017

18. Dauphin County - Downtown Daily Bread

310 N 3rd St

Harrisburg, PA 17101

Contact: Elaine Strokoff

Contact Phone #: 7172384717

Has Sub-IUPs: No

Provider Type: Shelter or other temporary housing resource

PDX ID: PA-063

State Provider ID: 4263

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Downtown Daily Bread will receive a total of $62,650 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 250

Estimated Number of Persons to be Enrolled: 155

Estimated Number of Persons to be Contacted who are Literally Homeless: 55

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Dauphin County MH/ID Program
Downtown Daily Bread
FY 17-18 PATH Intended Use Plan

LOCAL PROVIDER DESCRIPTION

The Dauphin County MH/ID Program has the legal responsibility to provide administration, fiscal management, and assure the provision of treatment and support services to adults and children with and at-risk of a serious mental illness and co-occurring disorders (MH and drug & alcohol) under the Mental Health/Mental Retardation Act of 1966. The Dauphin County Mental Health/ Intellectual Disabilities Program is a department within the County of Dauphin and is the local recipient of the Commonwealth's allocation of PATH funds. The Dauphin County MH/ID Program oversees the operations of the PATH services and is the responsible fiscal entity. The contact persons for PATH at the Dauphin County MH/ID Program are:

Rose M. Schultz MSW	Deputy MH Administrator	717/780-7054
rschultz@dauphinc.org		
Frank Magel	MH Program Specialist 2	717/780-7045
fmagel@dauphinc.org		
Anne Guenin	DDB Church Administrator	717/238-4717
aguenin@pinestreet.org		

Address: The Presbyterian Church of Harrisburg
Downtown Daily Bread
Boyd Building 310 North Third Street
Harrisburg, PA 17101

With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the County MH/ID Program office as OMHSAS does not have a contract directly with the Counties' PATH providers.

The Presbyterian Church of Harrisburg, Downtown Daily Bread (DDB) is an emergency food kitchen that has been in operation for over 30 years at the Pine Street Presbyterian Church. There is no cost to the recipient. Lunch is served daily, including weekends and holidays. Downtown Daily Bread estimates that 25% of all the individuals they serve are homeless. The DDB definition of "homeless" describes an individual who has no permanent address and no permanent place of residence. Of these persons, some live on the streets, under bridges, in cars or in abandoned buildings. Others live temporarily with a relative, friend, or at a temporary shelter until their allotted time is over.

Downtown Daily Bread assists individuals with homeless needs in accessing many services including food, clothing, health care, and mental health counseling. The DDB Lunch Plus program provides information referral services, housing support, a phone, lockers, and mail service. Individuals increase their self-esteem by presenting not as homeless when applying for jobs or looking for housing. Lunch Plus allows them to present an image of being able to maintain a clean, neat appearance even in the most difficult circumstances. No other agency in

Dauphin County provides this type of service. It is crucial for individuals who experience homelessness issues. A Drop-in center was added to their services for 25-40 persons per day.

Downtown Daily Bread collaborates with and is member of CACH (Capital Area Coalition on Homelessness). Downtown Daily Bread is a central location for collaboration with other human service agencies. Some of their partners include: MH/ID, YWCA, and the Veterans Administration. There is a partnership also with the Dauphin County Bar Association for Homeless Outreach Services. Attorneys volunteer their time once a week to answer legal questions and assist individuals frequenting DDB with concerns related to their homeless experience oftentimes related to the causes of homelessness. The contact persons for PATH for DDB are:

Dauphin County MH/ID Program will contract with Downtown Daily Bread in FY 2017-18 using a total of $ $62,650 which consists of $15,662 in State Funds and $46,988 in Federal Funds of PATH funds for the Homeless Outreach Specialist position and related costs.

Based on data collected in the PATH Annual Report for FY2015-16, it is projected that outreach efforts will be made to approximately 400 individuals and approximately 300 individuals will be enrolled in PATH services. Table 1 illustrates the projected enrollment and service goals in FY17-18 by provider.

Table 1 – Projected PATH Services FY 2017-18

Provider	MH/ID Crisis Intervention Program	Downtown Daily Bread	CMU	TOTAL
Estimated Number Outreach	150	250	Persons are enrolled with CMU	400
Estimated Number Enrolled	125	155	Referrals from Crisis/DDB or new enrollees/ 20	300
Estimated Number Literally Homeless	70	85	10	165 (55%)

COLLABORATION WITH HUD CONTINUUM OF CARE

Downtown Daily Bread participates actively in the local HUD Continuum of Care. The Capital Area Coalition on Homelessness (CACH) is the lead agency for the planning and development of Continuum of Care for the County of Dauphin and routinely has over 40 agencies actively participating in this leadership group. Downtown Daily Bread participates directly in several CACH committees. DDB collaborates in many CACH activities such as the point in time

surveys, trainings, networking as well as the Project Connect events that occur yearly basis. Two projects implemented successfully in the past few years are a Safe Haven for men operated by Christian Churches United and the move to transitional housing instead of a safe haven for women. Persons in those services may also use services offered at DDB.

COLLABORATION WITH LOCAL COMMUNITY ORGANIZATIONS

Dauphin County MH/ID Program contracts with a network of private non-profit agencies and for-profit agencies in collaboration with the CIP staff and the homeless provider network including Downtown Daily Bread for uninsured individuals or services that are not eligible for Medicaid funding. There are also additional community services and supports available that are not contracted by MH/ID or PATH funded through Dauphin County MH/ID.

The County Department of Drugs & Alcohol Services functions as the Single County Authority (SCA) for the County and is responsible for the provision of prevention, screening, assessment, treatment, case management and recovery support services in Dauphin County for the uninsured. Most services are available and can accessed directly from private-non-profit contracted agencies. PerformCare (BH-MCO) is also responsible for maintaining a network of drug & alcohol services for Medicaid recipients. Collaboration occurs frequently between mental health and drug & alcohol service providers as MH case managers make many referrals for D&A services for individuals with co-occurring issues.

The CMU (Case Management Unit) is the MH/ID contracted agency responsible to perform the duties of the Base Service Unit and registers all individuals for county-funded mental health services. By conducting walk-in intake interviews four-days per week, mental health assessments and financial liability assessments determine eligibility and the individual's ability to participate in the cost of services, if any, according to PA regulations. Downtown Daily Bread is a referral source for CMU and CMU may see enrolled persons at the DDB site.

The CMU also provides targeted case management services called Blended Case Management for eligible adults and children. Administrative case management is also provided by the CMU. CMU has an administrative case manager specifically to serve the homeless adult population and serves as the SSI/SSDI Outreach, Access, Recovery (SOAR) Coordinator position in Dauphin County. Intensive case management services for eligible individuals in Dauphin County are also available from Keystone Service System.

CMU, Philhaven, and Keystone offer Certified Peer Specialist services that are approved by OMHSAS and credentialed by PerformCare (BH-MCO). Certified Peer Specialists are imbedded in Dauphin County's local psychiatric inpatient unit Pennsylvania Psychiatric Institute (PPI), psychiatric rehabilitation, employment and social rehabilitation services. There are eighteen (18) employed Certified Peer Specialist.

Dauphin County has nine (9) contracted licensed outpatient psychiatric clinic providers that offer medication management, outpatient therapies and psychiatric evaluations to adults, older adults, transition-age youth and children with serious mental illness or serious emotional

disturbance and/or adults and children with co-occurring disorders. Two clinics offer tele-psychiatry.

Some outpatient providers have unique characteristics or serve specific populations of Dauphin County residents. There are also several licensed psychiatric outpatient clinics that have a Medicaid HealthChoices BH-MCO contracts but not a county contract. Two of the clinic also have a D&A outpatient clinic license for the same clinic site, and two COD clinics using the Hazelden model are currently offering integrated MH and D&A treatment. There are clinics that are specialized for the following populations: LGBTQI, HIV/AIDS, homeless, Evidenced based outpatient interventions, sex offenders, open access, older adults, Hispanic, dual MH/ID, and school-based. The FQHC, Hamilton Health Center also provides some outpatient services.

Northwestern Human Services (NHS) of PA Capital Region provides Assertive Community Treatment Team (ACT) services. NHS of PA, PPI, and Philhaven also offer partial hospitalization services. Pennsylvania Psychiatric Institute (PPI) operates an acute rapid access adult partial program developed in effort to reduce high MH inpatient re-hospitalization rates in Dauphin County.

Dauphin County has two (2) social rehabilitation programs: Aurora Social Rehabilitation and a consumer-run drop-in center, Patch-N-Match. Keystone Service Systems operates a licensed Psyhciatric Rehabilitation site and mobile services that opened in 2014. IN FY17-18 keystone's program will also be MA funded. Community Residential Rehabilitation (CRR) services offer many choices to individuals to gain independence in their recovery journey. Licensed residential programs offer varying degrees of support and are in a group setting, as well as, in scattered apartment settings. The Dauphin County contracted residential providers are NHS of PA, Elwyn, (KMHS) Keystone Mental Health Services. Supportive living services are provided by Volunteers of America (VOA), Keystone and Central Pennsylvania Supportive Services (CPSS).

CAPSTONE, a first episode psychosis program, for person ages 16-26 began services in March 2017. CMU, YWCA and Pennsylvania Psychiatric Institute are the three (3) collaborating agencies. Case management, peer support, clinical services and supported employment/supported education are all offered.

Short-term temporary residential services are available to PATH eligible individuals until a more permanent housing solution is identified. There are two providers contracted with Dauphin County MH/ID Program for specialized CRR services: NHS of PA's Windows Program in Harrisburg, and Community Services Group (CSG), Crisis and Diversion Program in the Steelton community. Both programs provide short-term 45-day residential support with a capacity of 24 persons and two (2) 5-day crisis beds with 24-hour, 7-day per week staff oversight.

Dauphin County PATH agencies have developed a strong collaborative working relationship with the Housing Authority of the County of Dauphin (HACD) and jointly link individuals to approved landlords that accept HUD funded Shelter + Care and Project Access vouchers. Keystone Service Systems Supportive Living Program has a designated staff that acts as a housing locator for individuals that secure HUD vouchers. Dauphin County MH/ID

implemented a Bridge Rental Subsidy program with that currently serves 15 individuals who have a serious mental illness. Through ongoing collaboration and support the landlord/tenant relationships have been strengthened, and there is stability in permanent housing options.

Employment services in Dauphin County are comprised of varying degrees of support and independence. Employment is viewed as a measure of personal success and recovery. The YWCA's Supported Employment program is funded through Dauphin County to assist individuals in securing and maintaining competitive employment. Most programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

A Safe Haven (men only) program is operated by Christian Churches United and offers transitional and" housing first" living for up to 25 men. The YWCA transitioned the women's "housing first" program in 2015 to a Permanent Supportive Housing Program. This transition has significantly improved the housing services available to eight chronically homeless women by providing permanent housing to women who have struggled with maintaining self-sufficiency in our community.

HUD 811 projects in Dauphin County for potential PATH enrolled persons include Creekside Village and New Song Village; both are operated by Volunteers of America (VOA). These programs are permanent affordable housing projects for individuals with serious mental illness.

The HUD 811 project-based vouchers are a project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) and have available safe and affordable permanent housing for individuals with disabilities. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH).

Sunflower Fields is capital investment LIHTC housing project in Dauphin County using FY 2013-14 HealthChoices reinvestment funds. There are a total of 35 single family homes of which Dauphin County MH has preference for 5 of the homes. Availability of housing contingency funds and completion of PREP were positive aspects of assisting persons and families in this application/approval process.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals. The employment component is called Paxton Cleaning Solutions with competitive contracts in the surrounding area.

Mission of Mercy provides mobile medical outreach and care to homeless individuals and those who are uninsured or underinsured to obtain appropriate medical care. Catholic Charities continues to provide outpatient therapy services to individuals served by Mission of Mercy.

The HELP Office is the primary program for assistance with basic needs and emergency housing and is operated by Christian Churches United. Emergency shelters include: Bethesda Mission, Salvation Army, Shalom House, Interfaith Shelter and the YWCA Domestic Violence services. Several local church organizations run soup kitchens and food pantries to assist individuals in obtaining needed food.

All MH case management entities have access to consumer support and emergency housing funds available to assist individuals with first month's rent and security deposits or back rent and utilities as needed. Dauphin County continues its commitment to improving the wellness of individuals served in the MH system: ongoing information sharing on effective strategies among provider agencies to promote healthy lifestyle choices, team building on how to make lifestyle changes in group living arrangements, in addition to improved communication between primary care physicians and psychiatrists facilitated by outpatient clinics and case managers.

SERVICE PROVISION

Description of Downtown Daily Bread PATH Programs:

Outreach services, including in-reach at existing lunch and lunch plus programs, free meal sites, churches, shopping centers, food pantries, public government buildings and other sites yet to be identified where homeless person frequent for basic needs including weather related issues will be a PATH funded service. The goal will be to engage literally homeless individuals into treatment and supports by using engagement and relationship building strategies to identify persons in need of mental health and/or co-occurring treatment and supports, support for meeting immediate needs and referrals to appropriate housing resources. Direct face to face interactions in locations persons are comfortable with allows for sustained contact for rapport and trust building –key factors in working with a populations of individuals who often experience or have experienced fear and distrust of formal community institutions and services.

Screening and Assessment for Treatment at Downtown Daily Bread the Outreach Specialist is trained to screen and identify individuals that have mental health and/or co-occurring drug & alcohol needs and assist the individual with enrolling in case management services and linking them to needed MH and D&A services. The goal is to engage literally homeless individuals in treatment and supports by using engagement and relationship building strategies to identify individuals in need of mental health and/or co-occurring treatment and supports. Supports for meeting immediate needs and referrals to appropriate housing resources are made as needed. Direct face to face interactions in locations that homeless individuals frequent and are comfortable with allows for sustained contacts in order to build rapport and trust. These are key factors in working with a population of individuals who often experience or have experienced fear and distrust of formal community institutions and services. Downtown Daily Bread staff addresses an individual's basic and immediate needs first and then works toward assisting individuals in accessing additional services.

Case management services are intended to sustain the relationship built through in reach and outreach efforts and include assessment, planning and implementation of services and treatment in coordination with the behavioral health system and use of housing resources. Case management would be located at the areas where homeless persons frequent. Activities will be provided to assist the individual with meeting basic needs including access to showers, mail service, clothing, applications for entitlements and housing, and representative payee services.

Case management will also incrementally address steps toward full use of mental health and drug & alcohol treatment and supports with extended time for processing fears and anxieties in using formal services, stigma associated with mental illness, recovery, and illness management. Additional case management services are needed to support individuals who may drop out of contact or services when scheduled appointments are the norm.

The DDB homeless outreach position will address the volume of requests for planned outreaches. Aspects of the service address problems and gaps such as: 1) the location of in reach and case management services at sites where homeless persons frequent, including outreaches to unsheltered individuals, 2) increased opportunities for rapport and relationship building important factors in post-crisis interventions, and 3) additional staff resources for case management services to conduct the needed follow-up and follow along as individuals use housing, mental health and co-occurring resources.

The DDB is positioned to understand a wider range of funding than a typical mental health program because they have been a provider in the homeless network for more than 30 years. Persons that may be PATH eligible need to access funds through other components of the homeless network funding prior to using PATH funds. For example, individuals must seek HELP Office resources for assistance with utility bills and though the LIHEAP program before seeking help from PATH providers. Another example is sharing costs of assisting a PATH eligible person in housing by agencies sharing the costs of a security deposit or providing some basic household items to establish housing.

Service Gaps

PATH-funded services continue to be flexible and address the unique needs of the homeless individuals served in Dauphin County. However, there are service gaps where capacity does not meet demand. The needs of homeless individuals for psychiatric services are prioritized along with several additional target groups such as persons with forensic involvement and acute inpatient discharges in order to prevent readmissions. Additional service gaps identified include:

- Limited availability of emergency shelter space.
- Limited number of safe and affordable housing units, due in part to rental costs that have risen tremendously in Dauphin County, which makes it very difficult for low income and very low income individuals to afford rent.
- Programs continue to be challenged with complex mental health needs and chronic medical conditions among persons with a serious mental illness or co-occurring disorder.
- Individuals being released from the criminal justice settings are not a good fit in shelter settings or are not eligible for subsidized housing due to past criminal charges. Dauphin County has a disproportionate number of persons sent to community correctional centers and halfway houses under early release that are not Dauphin County residents.

Needs of the Co-Occurring Population

Addressing the needs of the co-occurring population has been very challenging and complex in Pennsylvania, including Dauphin County, since the most effective treatment is to offer integrated approaches. Co-occurring training for professionals is essential for staff. The proposed consolidation of State departments under one administrative and licensing entity should help establish co-occurring services without the burden of separate administrative and licensing entities.
Among individuals who are medical assistance eligible, services are administered through the same behavioral health managed care organization PerformCare.

Individuals with co-occurring disorders have access to the following array of mental health services and supports: outpatient services, partial day programs, residential services, and support services such as targeted case management, supportive living, social rehabilitation, peer support and inpatient care through county /state funding streams and Medicaid managed care. The Drug & Alcohol system is disproportionately funded at the community level and the lack of integrated treatment adds additional barriers to recovery.

Evidenced Based and Promising Practices

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) (a function of the CMU) is an essential first step in providing the individual access to the array of services that are available. Once registered with the BSU through walk-in access, an individual will have access to evidence based and promising practices that operate with fidelity throughout the MH system. These services can benefit literally homeless, including chronically homeless individuals and those at imminent risk of homelessness who we are seeking to engage in mental health and co-occurring services. Table 2 represents evidence based and promising practices that are available in Dauphin County currently.

Table 2 – Evidenced Based and Promising Practices in Dauphin County

Evidenced Based and Promising Practices	**Service Available in County**	**Staff Trained in EBP/PP**	**Comments**
Assertive Community Treatment	Yes	Yes	Urban Team
Supported Housing	Yes	No	
Supported Employment	Yes	Yes	
Integrated Treatment Co-Occurring (MH/SA)	Yes	Yes	Located with Two (2) OPT D & A Providers
Dialectical Behavioral Therapy	Yes	Yes	Adult and Teen models; two (2) certified providers
Mobile Psychiatric Nursing	Yes	Yes	
Shared Decision Making	Yes	Yes	CAPSTONE (FEP)
Psychiatric Rehabilitation	Yes	Yes	Site and Mobile
Cognitive Behavior Therapy	Yes	Yes	

Trauma-Focused CBT	Yes	Yes	
Consumer-operated Services	Yes	Yes	Drop-in Center
MHFA Adults and Children	Yes	Yes	
Illness Management Recovery	Yes	Yes	Four (4) providers
Certified Peer Specialist	Yes	Yes	Free-standing and Embedded
Parent-Child Interaction Therapy	Yes	Yes	Two (2) certified providers
Guiding Good Choices	Yes	Yes	Parents are facilitators
First Episode Psychosis	Yes	Yes	CAPSTONE
WRAP & WRAP Facilitator	Yes	Yes	
Family Psycho-education	Yes	Yes	NAMI Family-to-Family

Dauphin County relies upon State and County Base MH funds to support the use of evidenced based and promising practices, as well as Medicaid managed care under HealthChoices.

Downtown Daily Bread has the opportunity to learn more about the formal mental health and substance abuse service system and participates in training or information sessions about evidenced based practices, recovery and resiliency and promising practices which support recovery.

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) is an essential first step in providing the individual access to the array of services that are available. Once open with the BSU, an individual will have access to evidence based and promising practices that have a proven track record of success. These services which may be utilized and can benefit literally homeless individuals and those at imminent risk of homelessness who we are seeking to engage in mental health and co-occurring services.

Downtown Daily Bread is devoted to working with anyone seeking assistance and PATH services are available for non-service connected veterans who may also be homeless and their families by accessing the same array of services available to any individual that seeks services and meet PATH eligibility. For persons and their families who are service connected veterans assistance is provided through information and referral in applying for and accessing benefits and services that individuals and their families are entitled to receive through the Office of Veterans Affairs administrative office. In some cases, due to gaps in services, veterans are served by both the MH and VA systems based on their need and eligibility for services. The County's Veteran Affairs Office annually coordinates a Stand Down program, and veterans and their families are part of the Project CONNECT outreach and follow-up.

Dauphin County MH/ID and its contracted PATH providers are not required to follow 42 CFR Part 2 regulations since they do not provide any direct drug & alcohol services, diagnosis or treatment to PATH funded individuals. Referral are made as needed with the assistance of PATH providers to drug & alcohol treatment as needed, however they are not involved in providing any direct treatment services.

Dauphin County is implementing a STEPPING UP initiative. The goal of this initiative is to reduce the number of individuals with mental illness and co-occurring disorders in prison. Currently Dauphin County is currently collecting data and will develop an action plan to address issues. Dauphin County is also actively involved with re-entry of persons in local jails and State prisons.

DATA

Downtown Daily Bread is already using HMIS to collect data under the CACH umbrella. The Capital Area Coalition on Homelessness (CACH) is the local planning group in Dauphin County and the CACH funds the HMIS training and activities around data collection. Bowman is the selected HMIS contractor. Dauphin County MH/ID Program and its PATH contracted providers have worked diligently in conjunction with the HMIS Program Director to assure PATH data is successfully entered into the HMIS system.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH provider agency staff will be supported on a day-to-day basis by Dauphin County MH administrative staff and the HMIS program administrator. There are ongoing data entry and reporting issues with HMIS that continue to be addressed with HMIS Administrator in Dauphin County. Ongoing technical support is being used to further develop the data quality and integrity of the PATH data entered into HMIS.

ALIGNMENT WITH PATH GOALS

The Downtown Daily Bread is committed to PATH goals for literally homeless persons and devotes PATH funds and other funds to this end. The DDB homeless outreach specialist focuses on conducting ongoing weekly street outreach as well as in-reach to this this most vulnerable population.. The homeless outreach specialist works closely and collaboratively with traditional mental health providers and the local homeless provider network as well as other local church and volunteer organizations to assist these individuals. It is clear that the most effective approach in assisting homeless individuals is ongoing and persistent outreach along with building rapport and trust with individuals will has the greatest impact and success in reducing homelessness.

ALIGNMENT WITH STATE MENTAL HEALTH SERVICES PLAN

Dauphin County MH/ID PATH providers focus and prioritize the needs of the most vulnerable individuals, especially those who experience chronic homelessness. Street outreach is provided primarily by the Downtown Daily Bread Outreach Specialist and Crisis Intervention Program. Unfortunately, this population is one of the most challenging groups to serve due to the lack of trust with formal services that may be government-sponsored/funded and or religiously based. Dauphin County PATH providers are engaged with the ongoing efforts spearheaded by CACH to increase available resources for the homeless community.

ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS

As outlined in various sections of the comprehensive Intended Use Plan (IUP) including the individual IUPs for Downtown Daily Bread provides street outreach and focus on the most vulnerable population of homeless and chronically homeless persons in Dauphin County. This is consistent with the State's Plan to End Homelessness.

With the adoption of HOME RUN by the County of Dauphin and the City of Harrisburg, and the continued leadership of CACH as the Blueprint Manager, the stage has been set to make homelessness *rare, brief and non-recurring in our community*.

The 2017 Blueprint presents six (6) Primary Objectives with several strategies and action steps to achieve the U.S. Department of Housing and Urban Development's definition of "ending homelessness", where *homelessness is rare, brief, and non-recurring:*
1) Strengthen Leadership to End Homelessness;
2) Achieve a Continuum or County-Wide Coordinated Entry, Assessment and Referral System;
3) Preserve Existing, and Increase Affordable Housing Supply;
4) Ensure Access to and Availability of Supportive Services;
5) Increase Public Awareness and Education about Homelessness, the Coalition, and its resources; and
6) Prevention of Homelessness. Each Primary Objective has outcome measures based on "System Performance Measures" by the US Department of Housing and Urban Development (HUD) on how a continuum or catchment is progressing towards ending homelessness.

Downtown Daily Bread is well linked to supports for persons experiencing homelessness and open to serving person affect by disasters and emergencies. The Dauphin County MH/ID Program has maintained a collaborative relationship with Dauphin County Emergency Management Agency (EMA) and provides a Mental Health Response Team when an incident occurs which requires mental health disaster intervention. Under a collaborative agreement, the EMA will support the efforts of the MHRT and will provide whatever appropriate resources it may have at its disposal to intervene in a disaster incident (including activating ancillary agreements the EMA may have with other resources such as the Red Cross). The County Emergency Management Agency and local EMAs in municipalities will notify the county program by telephone or by fax if any incident has occurred that may, in their opinion, require the mental health response. The County MH/ID Administrator may also direct activation to an incident which smaller EMAs have not yet communicated. The MH/ID Administrator will however inform the county EMA's that the County MH/ID Program is indeed responding. This agreement pertains to incidents in Dauphin County as well as to any incident outside the county in which the Dauphin County Emergency Management Agency would respond to according to their own mutual assistance pacts with other County EMAs.

Crisis Intervention Program staff also participates in the County-wide TMI disaster preparedness drill, which occurs every other year. The Program staff's role is "rumor control" to the general public and support to the State and local EMA staff. Further, on a daily basis, suicide callers to the EMA 911 Center are routinely patched through to the Dauphin County Crisis Intervention Program. The Program also maintains a mutual aid agreement with the local Red Cross that will be updated in the coming fiscal year. All homeless providers have developed individual emergency preparedness plans to address the

needs of the individual they serve. CACH is in the process of developing a committee to address the need to have a comprehensive disaster preparedness plan to address individuals identified as homeless and chronically homeless that reside on the streets and places unfit for habitation.

OTHER DESIGNATED FUNDS

Dauphin County has an Emergency Solutions Grant (ESG) Program authorized by subtitle B of title IV of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11371–11378). This program authorizes the Department of Housing and Urban Development (HUD) to make grants to states, units of general purpose local government, and territories for the rehabilitation or conversion of buildings for use as emergency shelters for the homeless, for the payment of certain expenses related to operating emergency shelters, for essential services related to emergency shelters and street outreach for the homeless, and for homelessness prevention and rapid re-housing assistance. Dauphin County uses this funding for emergency shelters, rapid rehousing, rental assistance, homeless prevention and HMIS.

Dauphin County's Homeless Assistance Services (HAP) Program serves individuals and families whose income is below 200% of Federal Poverty level and who are homeless, near homeless, and who meet the specific HAP program component requirements. The use of data through HMIS continues to be refined. HAP providers also collaborate with CACH for the annual CACH Project Homeless Connect.

Any of the above mentioned funds could intersect and support a person who is also PATH eligible. This would primarily occur in the area of rental assistance or supports to establish housing to end homelessness and may be configured on an individual basis.

SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)

A SOAR Coordinator is a direct service employee of the CMU also manages homeless cases. The position continues to work collaboratively with improving ongoing communication with the Social Security Administration (SSA) and the Bureau of Disability Determination (BDD). The DDB homeless outreach worker maintains ongoing contact with the CMU Homeless Outreach/SOAR worker, they have the ability to identify individuals that may need assistance in obtaining SS disability benefits in addition to MH case management services and supports.

PROGRAMATIC AND FINANCIAL OVERSIGHT

Dauphin County MH/ID receives state and federal funds PATH directly from the Office of Mental Health and Substance Abuse services OMHSAS. These PATH funds are allocated to the subcontracted PATH providers; DDB, CMU, Crisis Intervention Services. Quarterly reviews are conducted by MH program specialist staff of HMIS data. Internal audits are conducted by Dauphin County MH/ID Fiscal Officer and PATH Financial quarterly reports are provided to the OMHSAS for review reflecting all contracted PATH funds in Dauphin County. At a minimum

quarterly programmatic meetings are held with the Downtown Daily Bread staff regarding service delivery and reporting issues.

HOUSING

PATH funds continue to assist individuals who are literally homeless, chronically homeless, and at imminent risk of homelessness in securing permanent housing. PATH services continue to remain flexible and sensitive to the unique needs of individuals. Downtown Daily Bread continues to provide outreach to build rapport and engage individuals in accessing appropriate mental health treatment and support services and available housing. Several temporary options are considered first in addressing immediate housing needs and once established can lead to a permanent housing situation, which include the following options:

General shelter/housing programs:

- Bethesda Mission, supplying emergency shelter services for men in some extended stay options, in the city.
- Shalom House, a shelter site available to single women and to women with children in the city.
- YWCA, providing transitional housing services for women, in the city. Provides overnight shelter for homeless women during the winter months
- Delta Housing, operated by Gaudenzia, provides transitional services in small apartment settings for women and women with children.
- Interfaith Shelter, a facility for intact families operated by Catholic Charities in the Colonial Park suburb area of Harrisburg.

Private and public resources outside the conventional human service agency framework:

- Harrisburg Housing Authority, in Harrisburg city.
- Housing Authority of the County of Dauphin, with units outside the boundaries of Harrisburg city and the balance of Dauphin County.
- Hotel and motel proprietorships, allowing short-term stays with sponsorship for people, both in the city and in the suburbs.
- YMCA Single Room Occupancy for men not limited to city residents.
- Susquehanna Safe Haven, a housing first program for 25 homeless men with serious mental illness.

Housing Partnerships: The Dauphin County MH/ID Program has been working collaboratively with the following partners in developing affordable housing options for individuals with serious mental illness: CACH, Housing Authority of the County of Dauphin, Volunteers of America, and Paxton Ministries as well as new developers being established in the County. CACH is the designated Local lead Agency for Dauphin County with key responsibilities including coordination with area service providers and building owners regarding new HUD 811 projects and tax credit housing projects funded through PHFA in assuring there are eligible individuals ready to move into available units when they become available.

Three permanent housing projects in Dauphin County include: Bridge Rental Assistance program, HUD 811 rental vouchers, and Sunflower Fields, a capital investment project.

Paxton Ministries operates two (2) Community Lodges for eight (8) individuals. The business component is a cleaning company, Paxton Cleaning Solutions, with contracts in the surrounding area.

COORDINATED ENTRY

CACH is the PA-501 Harrisburg/Dauphin County Continuum of Care and therefore, the PA-501 coordinated entry process is the same as CACH's process. CACH has responsibility for the Coordinated System of Entry and Referral for persons seeking homeless services and housing programs in the City of Harrisburg Dauphin County. CACH has developed a Coordinated Entry Referral Tool (CERT) and is used universally by any agency or person in initial contact with a homeless person or family for referral to the first proper and appropriate housing option. Once a homeless individual is identified, a CEAR assessment is completed by the provider that is in contact with the individual and a priority number is assigned based on the outcome of the assessment and data entered in HMIS by name list which ranks the individual's priority for the housing. Individuals who are chronically homeless or unsheltered and especially the Transition Age Youth (TAY) population are prioritized and entered into the Bowman HMIS system by name list that is monitored by CACH CEER committee and remain on the list until individual has secured permanent housing. Several priorities are identified as Emergency shelter, chronically homeless, rural homeless, homeless veterans and those experiencing domestic violence.

JUSTICE INVOLVED

Downtown Daily Bread provides PATH funded services to criminal justice involved individuals. Additionally, DDB has a number of contact in the legal system and serves as an advocate for persons to have legal representation and receive legal advice through the Dauphin County Bar Association.

Dauphin County was selected as a STEPPING UP Initiative County in Pennsylvania to undertake a planned effort to assess cross-system data and develop a six-step action plan to reduce the number of person with mental illness that the Court/law enforcement has put in jail. Resources and supports are available to the local steering group through NACo, BJA, The Council of State Governments and the American Psychiatric Foundation. Dauphin County is currently in the data collection phase of the project.

Dauphin County MH/ID PATH programs do not collect specific PATH data on individuals that are PATH enrolled and justice involved, however based on the statistics of the general population in Dauphin County that are justice involved would be relatively high.

STAFF INFORMATION

Cultural Competence is fundamental to a recovery-oriented mental health system in Dauphin County; building competence needs to be deliberate and overt. Dauphin County MH Providers continue to pursue cultural competence in each of their respective agencies by utilizing their own diverse staff to conduct training as well as using outside sources to further develop the agencies overall cultural competency.

Downtown Daily Bread (DDB) has a diverse staff working in their soup kitchen and support program. The newly hired individual for the DDB Outreach Specialist position has experience working with a diverse population of individuals in assisting individuals in mental health treatment and obtaining public housing. Sensitivity to age, gender, and cultural differences is highly valued in the Downtown Daily Bread environment because the ability to successfully engaged individuals is a foremost goal of the program. Training needs in the area of cultural diversity/competence will be assessed and addressed through monthly meetings and periodic administrative reviews.

Dauphin County will continue to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

CONSUMER INFORMATION

Table 1 (Section: Local Provider Description) reflects the goals for the DDB in number of adults to be outreached, expected number to be enrolled and percentage to be literally homeless being served with PATH Funds. DDB projected PATH services are 250 outreached, 155 enrolled and 85 person to be literally homeless (or 55%).

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 2017-18 to be similar to the previous year's PATH annual data. The chart below illustrates the demographics of individuals served in the PATH program for FY 2015-16 (n=287):

Table 3-PATH Consumer Information Demographics for PATH Planning

Demographic Information	FY15-16 Persons Served	FY15-16 Percentage Persons Served
Age: 18-30	78	27%
31-61+	208	73%
Gender: Male	193	67%
Female	94	33%
Race: African American	106	37%
Caucasian	162	56%
Other	19	7%
Hispanic Ethnicity:	170	59%

Diagnosis: MH Only	113	38%
COD MH/DA	156	54%
Veteran Status: Yes	7	3%
No	277	97%
Housing Status: Emergency Shelter/ Not meant for Habitation	161	56%
Transitional Housing	108	38%

The Capital Area Coalition on Homelessness conducted a 2017 Point in Time Survey of individuals and families who experience homelessness. The final report is not completed. The tentative data below is shared in Table 4. There were a total of 355 households with a total of 460 individuals. The chart below illustrates the raw data collected (n=460):

Table 4- Dauphin County Point in Time (PIT) Survey Data (Preliminary)

Demographic Information	**2017 Persons Identified**	**Percentage Persons Identified**
Housing Status: Safe Haven	22	5%
Unsheltered or ER Shelters	308	67%
Transitional Housing	130	28%
Homeless (Chronic)	45	10%
Gender: Male	298	65%
Female	162	35%
Race: African American	238	52%
Caucasian	170	37%
Other	52	11%
Hispanic Ethnicity:	73	16%
Veteran Status: Yes	39	9%
Diagnosis: Serious Mental Illness	92	20%
Substance use (chronic)	96	21%

CONSUMER INVOLVEMENT

Downtown Daily Bread has homeless and formerly homeless volunteers that assist with various operations of the homeless services offered, such as with the drop in center operations and with the homeless outreach specialist to provide assistance and to identify locations typically not known by the outreach worker. In allowing volunteers to assist with services has proved beneficial in providing feedback from individuals that receive services offered by the program.

HEALTH DISPARITIES IMPACT STATEMENT

Health disparities are not new to the Dauphin County mental health system, including for persons who are homeless, chronically homeless, or imminently homeless. Dauphin County is highly committed to addressing disparities within the County using local, State, and federal resources available to us. For the past several years, an examination of subpopulations in the county-funded system as well as in the Medicaid managed care system has been undertaken to

improve the overall wellness of persons we serve. Furthermore, the relationship between health and mental health are fully understood and prioritized. The Commonwealth of Pennsylvania provides for a County-operated and managed mental health system for persons who are uninsured. While services exist, current budgetary cuts and prior cost of living increases not tied to real costs continue to impact the availability of services leading to waiting lists and the need to triage care.

The county behavioral health system is also the primary planner and implementer of service supports and rehabilitation services not funded by Medicaid and Medicare. These are typically services which support persons living in communities. In a recovery and resilience based system, these services are as important as treatment to the individual and their family. Many of our efforts have not been solely for the benefit of PATH eligible persons; however this population has benefited from these focused efforts.

The Outreach Specialist position at Downtown Daily Bread specifically was established because we found that persons needed a community-based agency for outreach, including in reach. The County's Crisis Intervention Program was too much associated with inpatient psychiatric assessments to function as the sole outreach program for PATH. A specialty psychiatric clinic for persons who are homeless is monitored for access and the consistent issue has been follow-up appointments and locating unsheltered persons for subsequent appointments.

Wellness activities undertaken include efforts with the BH-MCO PerformCare: Medication reconciliation Toolkits and a Natural Supports Toolkit for family, friends and other to support an individual with a serious mental illness. The Natural Supports Toolkit is still pending review with OMHSAS. Efforts to implement a Nurse navigator model are also pending locally.

Dauphin County is involved in a county based grievance and complaint process to address identified disparities related to lack of access and service use. A full time Quality Assurance Program Specialist is support by all County MH staff to track and address concerns about the system. All mental health staff also play a role in grievance and complaints from members under the Medicaid managed care program. Dauphin County MH/ID Program excels at finding solutions to access and service use issues within our budgetary limitations.

Information on the persons in County-funded mental health services, including PATH eligible persons are documented annually in State reporting. PATH reporting is not integrated to the State data system and when an individual becomes registered for the provision of County-funded service there is not currently a PATH designator to track service use even though their homeless status may have improved. The system includes annual data on race, ethnicity, gender, age, income and living arrangement. Continued homelessness has not been a barrier to treatment and support access in Dauphin County while efforts continue on addressing homeless issues/status.

Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly basis to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served in both systems.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. SAMHSA PATH includes TAY persons ranging in ages from 18-30 year old age group. Transitioning young adults have unique challenges at any chronological age since their emotional and social development may have been impacted by socio-economic and mental health factors. According to Dauphin County's PATH annual report data in FY 2015-16, 27% of the individuals served were between the ages of 18-30 years. In FY17-18 the estimate for the number of TAY individuals served through PATH is 25%, but that will be reassessed based upon the complete date for FY16-17 as well as, the % of funds used for the TAY population. Year-to-date 56 person categorized as TAY have been identified but the total number served is pending. The types of services funded by PATH for the TAY population are similar to all PATH funded services: outreach, homeless case management, and housing supports.

Dauphin County takes a flexible approach to determining with a person's support system and interagency team which system (child/adolescent or adult) may fit their needs best and how to individualized the transition period to gain the most success and recovery. Persons under the age of 18 may also be involved with a children and youth agency if they require care and supervision. Mental health treatment in Pennsylvania may be accessed by person 14 years of age and older without parental consent, however efforts are made to engage responsible adults in all aspects of treatment. Person under 18 years requiring inpatient psychiatric or medical care will require the involvement of Children & Youth and the Courts, as needed.

The JEREMY Project (NOT PATH FUNDED) is designed to assist young adults ages 16-22 in transitioning from adolescence to adulthood by focusing on the transitional needs in the domains of education, employment, independent living skills, socialization and community involvement. At the same time, JEREMY attempts to engage/re-engage participants in other mental health treatment, rehabilitation and support. The Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews.– The JEREMY Project is in its 12th year of operation.

Dauphin County in FY16-17 studied the TAY (16-22 years of age) population discharged from The JEREMY Project over the past three years. The purpose of the review was to determine if the persons being referred, served and discharged were individuals with TAY risks: exploitation/victimization, homelessness, criminal activity, not maintaining MH recovery and lacking family or natural support. The data compilation has just ended and analysis is beginning. This is a transformation priority in the Block Grant and may lead to strategic changes in the system of care of the TAY population.

LIMITED ENGLISH PROFICIENCY

All Dauphin County contracted providers make individual arrangement for interpreter services for languages other than English if they do not have staff that are bilingual/bicultural. All PATH services are provided on an individualized basis and contracted providers respect and are sensitive to the linguistic needs of the homeless population. Dauphin County MH/ID and several providers use The International Service Center to assist with various language translations and interpreting to best serve those who are not proficient in English. Providers continue to tailor

services based on individual needs as well as accommodating individual linguistic needs in order to benefit from services provided.

DOWNTOWN DAILY BREAD PATH BUDGET NARRATIVE:

Personnel: ($ 40,000): Salary of the Full-Time Equivalent (FTE) position as an Outreach Specialist for a twelve month period.

Fringe Benefits (40.6%% percent of salary or $16,240): FICA tax, Health insurance, retirement/pension costs are included in the fringe benefit costs for the Downtown daily Bread position.

Travel ($2,000): Travel costs for the Outreach Specialist are factored at 51 cents per mile for 52 miles per month for a total of three hundred and twenty dollars and parking costs.

Equipment ($0): Equipment totals include the purchase of a laptop computer, notebook and software. Office furniture and a locked file cabinet. Office furniture will be all located in a setting where literally homeless persons frequent.

Supplies ($ 2,000): Costs of supplies to be applied to this PATH grant are solely those related to the basic and re(habilitative) needs of PATH eligible consumers. Among supplies anticipated are small stocks of non-perishable food items, clothing and blankets, as well as public transportation bus passes.

Other ($0): Staff Training and Homeless Provider Network Training ($0): This proposal is a dramatic change in the way we are providing outreach and case management to the target population. As such, certified peer specialist training and co-occurring training may be needed for the Outreach Specialist. The Homeless Provider Network will also benefit from understanding new approaches and methods of engagement and case management for the population. One-time Rental Assistance ($0): This budget line represents costs incurred on behalf of PATH eligible people for whom one-time expenditures can address literal homelessness. Security Deposits ($0): This budget line represents a special cost in securing stable housing to resolve conditions of homelessness.

Indirect Costs/Administrative Cost 4% @ $2,410: Four (4) percent of the PATH grant is allocated to cover administrative expenses at Downtown Daily Bread.

Total Downtown Daily Bread PATH Request……$ 62,650

($ 15,662 State funds and $46,988 Federal funds)

Dauphin County MH/ID Program
FY 2016-17 PATH Downtown Daily Bread IUP Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Personnel Position				
DDB Outreach Specialist	40,000	100%	40,000	40,000
Salary sub-total			***40,000***	**40,000**
Fringe Benefits (45.8%)				
DDB Outreach Spec (40.6%)				
FICA, Health, Ret/pens			16,240	16,240
Fringe sub-total			16,240	**16,240**
Travel				
Local Travel for Outreach DDB and parking			2,000	2,000
Travel sub-total			2,000	**2,000**
Equipment				
(list individually)			0	0
sub-total			0	0
Supplies				
Consumer-related items			2,000	2,000
Supplies sub-total			2,000	**2,000**
Other				
Staff training			0	0
One-time rental assistance			0	0
Security deposits			0	0
Independent Living Resource			0	0
Other sub-total			0	**0**
Indirect Administration @ 4%				**2,410**
Total PATH Budget ($ 15,662 State funds and $46,988 Federal funds)				**$ 62, 650**

19. Dauphin County Mental Health and Intellectual Disabilities Program

100 Chestnut Street

Harrisburg, PA 17101

Contact: Frank Magel

Contact Phone #: 7177807045

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-006

State Provider ID: 4206

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Dauphin County's Crisis Intervention Program will receive a total of $41,598 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 150

Estimated Number of Persons to be Enrolled: 125

Estimated Number of Persons to be Contacted who are Literally Homeless: 84

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Dauphin County MH/ID Program
Crisis Intervention Program
FY 17-18 PATH Intended Use Plan

LOCAL PROVIDER DESCRIPTION

The Dauphin County MH/ID Program has the legal responsibility to provide administration, fiscal management, and assure the provision of treatment and support services to adults and children with and at-risk of a serious mental illness and co-occurring disorders (MH and drug & alcohol) under the Mental Health/Mental Retardation Act of 1966. The Dauphin County Mental Health/ Intellectual Disabilities Program is a department within the County of Dauphin and is the local recipient of the Commonwealth's allocation of PATH funds. The Dauphin County MH/ID Program oversees the operations of the PATH services and is the responsible fiscal entity. The contact persons for PATH at the Dauphin County MH/ID Program are:

Rose M. Schultz MSW rschultz@dauphinc.org	Deputy MH Administrator	717/780-7054
Frank Magel fmagel@dauphinc.org	MH Program Specialist 2	717/780-7045
David DeSanto ddesanto@dauphinc.org	Crisis Intervention Director	717/780-7070

Address: Dauphin County MH/ID Program
100 Chestnut Street, First Floor
Harrisburg, PA 17101

With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the County MH/ID Program office as OMHSAS does not have a contract directly with the Counties' PATH providers.

The Dauphin County Crisis Intervention Program (CIP), is a direct service under the supervision of the Dauphin County MH/ID Program and is an important provider of PATH services. The CIP program is most frequent point of first contact for PATH funded services to individuals with a serious mental illness and/or a co-occurring disorder and homelessness. Services include but are not limited to 24-hour, 7 day per week availability via telephone, walk in or mobile outreach to individuals experiencing a crisis. The CIP provides MH assessments, brief counseling, service planning and referral information as well as MH stabilization. Agreements are in place with our local case management entities establishing roles and responsibilities in response to emergencies for individuals currently enrolled in services with the Base Service Unit. For individuals in which a language is a barrier to services, the CIP utilizes the Language Line to meet linguistic needs and they have one bilingual/bicultural Hispanic staff.

The amount of PATH funds allocated to Dauphin County MH/ID Program by the Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) in FY 2017-18 is $111,307 of which $27,827 consists of State Funds and $83,480 are Federal Funds. The amount of PATH funds designated for Dauphin County MH/ID Crisis Intervention

Program for FY 2017-18 is $41,958 of which $10,399 is State Funds and $31,199 are Federal Funds.

Based on data collected in the PATH Annual Report for FY2015-16, it is projected that outreach efforts will be made to approximately 400 individuals and approximately 300 individuals will be enrolled in PATH services. Table 1 illustrates the projected enrollment and service goals in FY17-18 by provider.

Table 1 – Projected PATH Services FY 2017-18

Provider	MH/ID Crisis Intervention Program	Downtown Daily Bread	CMU	TOTAL
Estimated Number Outreach	150	250	Doesn't conduct outreach	400
Estimated Number Enrolled	125	155	Referrals from Crisis/DDB or new enrollees/ 20	300
Estimated Number Literally Homeless	70	85	10	165 (55%)

COLLABORATION WITH HUD CONTINUUM OF CARE

The Dauphin County MH/ID Program and its provider network participates actively in the local HUD Continuum of Care. The Capital Area Coalition on Homelessness (CACH) is the lead agency for the planning and development of Continuum of Care for the County of Dauphin and routinely has over 40 agencies actively participating in this leadership group. CACH resources are leveraged and coordinated to maximize the efficient and effective use of HAP funds, HUD Emergency Solutions Grant funds managed by both the County of Dauphin and the City of Harrisburg, HUD Continuum of Care funds and local and private funds such as The Foundation for Enhancing Communities and the United Way of the Capital Region.

Dauphin County MH/ID Program's Crisis Intervention Program participates directly in several CACH committees. Dauphin County MH/ID Program collaborates in many CACH activities such as the point in time surveys, trainings, networking as well as the Project Connect events that occur yearly basis. CACH has been designated the Local Lead Agency (LLA) for Dauphin County by DHS and PHFA (PA Housing Finance Agency) to assist with the development and monitoring of the HUD 811 PRA demonstration project awarded in 2015.

COLLABORATION WITH LOCAL COMMUNITY ORGANIZATIONS

Dauphin County MH/ID Program contracts with a network of private non-profit agencies and for-profit agencies in collaboration with the CIP staff and the homeless provider network for uninsured individuals or services that are not eligible for Medicaid funding. There are also additional community services and supports available that are not contracted by MH/ID or PATH funded through Dauphin County MH/ID.

Dauphin County's Medicaid behavioral health managed care organization is PerformCare, a company of AmeriHealth *Caritas.* All of the resources will be available to individuals served as needed and eligible within the limitations of available funding. Dauphin County's Crisis Intervention program is a PerformCare network provider and is fully licensed by OMHSAS.

The County Department of Drugs & Alcohol Services functions as the Single County Authority (SCA) for the County and is responsible for the provision of prevention, screening, assessment, treatment, case management and recovery support services in Dauphin County for the uninsured. Most services are available and can accessed directly from private-non-profit contracted agencies. PerformCare (BH-MCO) is also responsible for maintaining a network of drug & alcohol services for Medicaid recipients. Collaboration occurs frequently between mental health and drug & alcohol service providers as MH case managers make many referrals for D&A services for individuals with co-occurring issues.

The CMU (Case Management Unit) is the MH/ID contracted agency responsible to perform the duties of the Base Service Unit and registers all individuals for county-funded mental health services. By conducting walk-in intake interviews four-days per week, mental health assessments and financial liability assessments determine eligibility and the individual's ability to participate in the cost of services, if any, according to PA regulations.

The CMU also provides targeted case management services called Blended Case Management for eligible adults and children. Administrative case management is also provided by the CMU. CMU has an administrative case manager specifically to serve the homeless adult population and serves as the SSI/SSDI Outreach, Access, Recovery (SOAR) Coordinator position in Dauphin County. No PATH funded staff were trained in SOAR and there is no plan to do so at this time. SOAR is not funded with PATH dollars. The current Homeless MH case manager has adequately met this demand. Intensive case management services for eligible individuals in Dauphin County are also available from Keystone Service System.

CMU, Philhaven, and Keystone offer Certified Peer Specialist services that are approved by OMHSAS and credentialed by PerformCare (BH-MCO). Certified Peer Specialists are imbedded in Dauphin County's local psychiatric inpatient unit Pennsylvania Psychiatric Institute (PPI), psychiatric rehabilitation, employment and social rehabilitation services. There are eighteen (18) employed Certified Peer Specialist.

Dauphin County has nine (9) contracted licensed outpatient psychiatric clinic providers that offer medication management, outpatient therapies and psychiatric evaluations to adults, older adults, transition-age youth and children with serious mental illness or serious emotional disturbance and/or adults and children with co-occurring disorders. Two clinics offer tele-psychiatry.

Some outpatient providers have unique characteristics or serve specific populations of Dauphin County residents. There are also several licensed psychiatric outpatient clinics that have a Medicaid HealthChoices BH-MCO contracts but not a county contract. Two of the clinic also have a D&A outpatient clinic license for the same clinic site, and two COD clinics using the Hazelden model are currently offering integrated MH and D&A treatment. There are clinics that are specialized for the following populations: LGBTQI, HIV/AIDS, homeless, Evidenced based outpatient interventions, sex offenders, open access, older adults, Hispanic, dual MH/ID, and school-based. The FQHC, Hamilton Health Center also provides some outpatient services.

Northwestern Human Services (NHS) of PA Capital Region provides Assertive Community Treatment Team (ACT) services. NHS of PA, PPI, and Philhaven also offer partial hospitalization services. Pennsylvania Psychiatric Institute (PPI) operates an acute rapid access adult partial program developed in effort to reduce high MH inpatient re-hospitalization rates in Dauphin County.

Dauphin County has two (2) social rehabilitation programs: Aurora Social Rehabilitation and a consumer-run drop-in center, Patch-N-Match. Keystone Service Systems operates a licensed Psychiatric Rehabilitation Program that is site and mobile services. FY17-18 Keystone's program will also be MA funded.

Community Residential Rehabilitation (CRR) services offer many choices to individuals to gain independence in their recovery journey. Licensed residential programs offer varying degrees of support and are in a group setting, as well as, in scattered apartment settings. The Dauphin County contracted residential providers are NHS of PA, Elwyn, (KMHS) Keystone Mental Health Services. Supportive living services are provided by Volunteers of America (VOA), Keystone and Central Pennsylvania Supportive Services (CPSS).

CAPSTONE, a first episode psychosis program, for person ages 16-26 began services in March 2017. CMU, YWCA and Pennsylvania Psychiatric Institute are the three (3) collaborating agencies. Case management, peer support, clinical services and supported employment/supported education are all offered.

Short-term temporary residential services are available to PATH eligible individuals until a more permanent housing solution is identified. There are two providers contracted with Dauphin County MH/ID Program for specialized CRR services: NHS of PA's Windows Program in Harrisburg, and Community Services Group (CSG), Crisis and Diversion Program in the Steelton community. Both programs provide short-term 45-day residential support with a capacity of 24 persons and two (2) 5-day crisis beds with 24-hour, 7-day per week staff oversight.
Dauphin County's Crisis Intervention Program and the CMU have 24/7 access to these services.

Dauphin County MH/ID Program has developed a strong collaborative working relationship with the Housing Authority of the County of Dauphin (HACD) and jointly link individuals to approved landlords that accept HUD funded Shelter + Care and Project Access vouchers. Keystone Service Systems Supportive Living Program has a designated staff that acts as a housing locator for individuals that secure HUD vouchers. Dauphin County MH/ID

implemented a Bridge Rental Subsidy program with that currently serves 15 individuals who have a serious mental illness. The FY16-17 goal is 18 individuals and families. Through ongoing collaboration and support the landlord/tenant relationships have been strengthened, and there is stability in permanent housing options.

Employment services in Dauphin County are comprised of varying degrees of support and independence. Employment is viewed as a measure of personal success and recovery. The YWCA's Supported Employment program is funded through Dauphin County to assist individuals in securing and maintaining competitive employment. Most programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

A Safe Haven (men only) program is operated by Christian Churches United and offers transitional and " housing first" living for up to 25 men. The YWCA transitioned the women's safe haven program in 2015 to a Permanent Supportive Housing Program. This transition has significantly improved the housing services available to eight chronically homeless women by providing permanent housing to women who have struggled with maintaining self-sufficiency in our community.

HUD 811 projects in Dauphin County for potential PATH enrolled persons include Creekside Village is located in Lower Paxton Township and New Song Village is located in Swatara Township; both are operated by Volunteers of America (VOA). These programs are permanent affordable housing projects for individuals with serious mental illness.

The HUD 811 project-based vouchers are a project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) and have available safe and affordable permanent housing for individuals with disabilities. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH).

Sunflower Fields is a capital investment LIHTC housing project in Dauphin County using FY 2013-14 HealthChoices reinvestment funds. There are a total of 35 single family homes of which Dauphin County MH has preference for 5 of the homes. Three families are currently approved for move into these permanent homes. Availability of housing contingency funds and completion of PREP were positive aspects of assisting persons and families in this application/approval process.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals. The employment component is called Paxton Cleaning Solutions with competitive contracts in the surrounding area.

Mission of Mercy provides mobile medical outreach and care to homeless individuals and those who are uninsured or underinsured to obtain appropriate medical care. Catholic Charities continues to provide outpatient therapy services to individuals served by Mission of Mercy.

The HELP Office is the primary program for assistance with basic needs and emergency housing and is operated by Christian Churches United. Emergency shelters include: Bethesda Mission,

Salvation Army, Shalom House, Interfaith Shelter and the YWCA Domestic Violence services. Several local church organizations run soup kitchens and food pantries to assist individuals in obtaining needed food. Dauphin County's Crisis Intervention Program is the link to the emergency resources after hours for the homeless network in Dauphin County.

All MH case management entities and the Crisis Intervention Program have access to consumer support and emergency housing funds available to assist individuals with first month's rent and security deposits or back rent and utilities as needed. Dauphin County continues its commitment to improving the wellness of individuals served in the MH system: ongoing information sharing on effective strategies among provider agencies to promote healthy lifestyle choices, team building on how to make lifestyle changes in group living arrangements, in addition to improved communication between primary care physicians and psychiatrists facilitated by outpatient clinics and case managers.

SERVICE PROVISION

A detailed description of the PATH funded services are listed below specific to Dauphin County Crisis Intervention Program:

Outreach Services

The Crisis Intervention Program (CIP) continues to provide outreach to the targeted population of persons experiencing homelessness with a serious mental illness and/or co-occurring disorders. PATH eligible individuals may be identified by providers, community hospitals, businesses or residents. Individuals may be self-referred or referred by others, including law enforcement, healthcare personnel, and concerned individuals. CIP determines PATH eligibility and provides outreach, initial screening, service planning, information and referrals.

Screening and Assessment for treatment services

Crisis Intervention Program (CIP) performs initial assessments of individuals when conducting an outreach. The information provided to CIP is documented in a case progress note, and the PATH Eligibility and Support Plan form for individuals in need of and willing to accept mental health services and supports. Following an outreach and enrollment, many individuals are referred to the CMU to be registered in the MH system and referred for additional supportive services as needed. Individuals needing emergency psychiatric treatment will be assessed by CIP and referred to appropriate settings as needed.

Case Management

Case management services provided by Crisis Intervention Program staff are intended to sustain the relationship built through outreach/in reach efforts through the assessment, planning and implementation of services and treatment and housing resources. Services are provided to assist individuals in meeting their basic needs including; meals, access to showers, mail service, clothing, applications for entitlements, housing, and other requested services. Case management will develop rapport and build relationships with individuals and demonstrate sensitivity to the

fears and anxieties in using formal services, stigma associated with mental illness, trauma, recovery, and illness management. The goal of case management at Crisis is to engage persons in meeting their basic needs, as well as addressing mental health and/or drug& alcohol concerns through referrals for treatment and recovery supports The Crisis Intervention Program staff and work with the CMU to assure a connection is made with the mental health system for treatment and supports for individuals enrolled in PATH.

Housing Services

Dauphin County continues to offer a way to individualize our responses to the housing challenges faced by PATH eligible persons.

- Technical Assistance in Applying for Housing Services: Knowledge and understanding of the complex application process and the documents required to apply for subsidized housing, can be difficult for individuals. Assistance is available to PATH eligible individuals in identifying available housing resources, completing applications and accessing the documentation necessary to successfully secure affordable housing subsidies. Case managers and supportive living staff are well-informed about housing resources both public and private, short term and long-term. Their technical knowledge is used with individuals to develop housing plans and put those plans into action. Crisis Intervention Program, Downtown Daily Bread, CMU and other mental health agencies continue to participate in Project CONNECT events.
  Dauphin County MH staff have been instrumental in improving technical assistance on applying for Housing as well as the Dauphin County LLA.
- Improving the Coordination of Housing Services: Ongoing coordination and collaboration within the homeless service network, CACH and mental health providers for PATH enrolled individuals continue to be developed. Dauphin County Crisis Intervention program is involved with Housing/Homeless network and CACH. Relationships with landlords, shelters, other housing programs, churches and community agencies are essential in meeting the needs of individuals or families who are literally homeless, chronically homeless, or at imminent risk of homelessness. Dauphin County utilizes the revised landlord-tenant protocol developed by the Dauphin County Local Housing Options Team (LHOT). Crisis Intervention program is the primarily contact 24/7 for landlords and property managers looking for assistance to prevent homelessness or eviction. CACH, the designated Local Lead Agency, provides ongoing information regarding newly developed housing projects in the area and alerts providers and individuals they serve in the system on location of the properties and the application process to apply for these available units and maintains MOU's with referring provider agencies.
- Security Deposits: The CMU is contracted to provide PATH funds to assist individuals in securing permanent housing. CIP and case management entities have additional but limited funds to provide this assistance with PATH funding. This service can provide quicker access to more permanent housing options for individuals, rather than relying on limited shelter space. The funding assists PATH eligible individuals with securing safe, affordable and permanent housing.

- Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: When individuals secure appropriate housing, there are additional costs associated with that housing other than security deposit or first/last month rent. Some costs may involve rental application fees, furnishings, moving expenses and establishing good credit/reducing or eliminating bad debts. CMU is contracted to provide this assistance to prevent eviction and homelessness and assist individuals in securing permanent housing. CIP and all case management entities have access to PATH funds for transition purposes that result in more stable housing.
- One-time Rental Payments to Prevent Eviction: PATH enrolled individuals can receive a one-time rental assistance to prevent eviction. CMU is contracted to provide this assistance to prevent eviction and homelessness. CIP and all case management entities have access to PATH for preventing eviction on a one-time basis.

Dauphin County MH/ID Program is a department also in the Block Grant and our office also manages MATP, HAP (Homeless Assistance Program) funds and ESG (Emergency Solutions Grant) funds. Dauphin County MH/ID administrator is also an officer in CACH (Capital Area Coalition on Homelessness) which also functions as the Local lead Agency (LLA). The mental health funds managed through the Block grant constitute 71.5% of the Block Grant funding. Administrative costs are only 4.5% of the MH funding in Dauphin County. The MH program is positioned to understand a wider range of funding than a typical mental health program and persons that may be PATH eligible need to access funds through other components of the homeless network funding prior to using PATH funds. For example, individuals must seek HELP Office resources for assistance with utility bills and though the LIHEAP program before seeking help from PATH providers. Another example is sharing costs of assisting a PATH eligible person in housing by agencies sharing the costs of a security deposit or providing some basic household items to establish housing.

Service Gaps

PATH-funded services continue to be flexible and address the unique needs of the homeless individuals served in Dauphin County. However, there are service gaps where capacity does not meet demand. The needs of homeless individuals for psychiatric services are prioritized along with several additional target groups such as persons with forensic involvement and acute inpatient discharges in order to prevent readmissions. Additional service gaps identified include:

- Limited availability of emergency shelter space.
- Limited number of safe and affordable housing units, due in part to rental costs that have risen tremendously in Dauphin County, which makes it very difficult for low income and very low income individuals to afford rent.
- Programs continue to be challenged with complex mental health needs and chronic medical conditions among persons with a serious mental illness or co-occurring disorder.
- Individuals being released from the criminal justice settings are not a good fit in shelter settings or are not eligible for subsidized housing due to past criminal

charges. Dauphin County has a disproportionate number of persons sent to community correctional centers and halfway houses under early release that are not Dauphin County residents. The DOC also discharges persons to shelters when the person is not cooperating with discharge planning or really comes from or was convicted in other Counties.

Needs of the Co-Occurring Population

Addressing the needs of the co-occurring population has been very challenging and complex in Pennsylvania, including Dauphin County, since the most effective treatment is to offer integrated approaches. Co-occurring training for professionals is essential for staff. The proposed consolidation of State departments under one administrative and licensing entity should help establish co-occurring services without the burden of separate administrative and licensing entities.

Dauphin County mental health system is charged with assuring there are established services to meet the needs of the serious mental illness and individuals who also have substance use disorders. While the regulatory authority of services lies with both the Department of Human Services (mental health) and the Department of Drugs and Alcohol, County administered programs face challenges to implement integrated treatment model services to meet the needs of individuals with co-occurring disorders. Among individuals who are medical assistance eligible, services are administered through the same behavioral health managed care organization PerformCare.

Individuals with co-occurring disorders have access to the following array of mental health services and supports: outpatient services, partial day programs, residential services, and support services such as targeted case management, supportive living, social rehabilitation, peer support and inpatient care through county /state funding streams and Medicaid managed care. The Drug & Alcohol system is disproportionately funded at the community level and the lack of integrated treatment adds additional barriers to recovery.

Evidenced Based and Promising Practices

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) (a function of the CMU) is an essential first step in providing the individual access to the array of services that are available. Once registered with the BSU through walk-in access, an individual will have access to evidence based and promising practices that operate with fidelity throughout the MH system. These services can benefit literally homeless, including chronically homeless individuals and those at imminent risk of homelessness who we are seeking to engage in mental health and co-occurring services. Table 2 represents evidence based and promising practices that are available in Dauphin County currently.

Table 2 – Evidenced Based and Promising Practices in Dauphin County

Evidenced Based and	Service	Staff	Comments

Promising Practices	Available in County	Trained in EBP/PP	
Assertive Community Treatment	Yes	Yes	Urban Team
Supported Housing	Yes	No	
Supported Employment	Yes	Yes	
Integrated Treatment Co-Occurring (MH/SA)	Yes	Yes	Located with Two (2) OPT D & A Providers
Dialectical Behavioral Therapy	Yes	Yes	Adult and Teen models; two (2) certified providers
Mobile Psychiatric Nursing	Yes	Yes	
Shared Decision Making	Yes	Yes	CAPSTONE (FEP)
Psychiatric Rehabilitation	Yes	Yes	Site and Mobile
Cognitive Behavior Therapy	Yes	Yes	
Trauma-Focused CBT	Yes	Yes	
Consumer-operated Services	Yes	Yes	Drop-in Center
MHFA Adults and Children	Yes	Yes	
Illness Management Recovery	Yes	Yes	Four (4) providers
Certified Peer Specialist	Yes	Yes	Free-standing and Embedded
Parent-Child Interaction Therapy	Yes	Yes	Two (2) certified providers
Guiding Good Choices	Yes	Yes	Parents are facilitators
First Episode Psychosis	Yes	Yes	CAPSTONE
WRAP & WRAP Facilitator	Yes	Yes	
Family Psycho-education	Yes	Yes	NAMI Family-to-Family

Dauphin County relies upon State and County Base MH funds to support the use of evidenced based and promising practices, as well as Medicaid managed care under HealthChoices.

PATH services are available for non-service connected veterans who may also be homeless and their families by accessing the same array of services available to any individual that is PATH eligible. For persons and their families who are service connected veterans assistance is provided through information and referral in applying for and accessing benefits and services that individuals and their families are entitled to receive through the Office of Veterans Affairs administrative office. In some cases, due to gaps in services, veterans and their families are served by both the MH and VA systems based on their need and eligibility for services. The County's Veteran Affairs Office annually coordinates a Stand Down program, and veterans and their families take part in the Project CONNECT events. Following these events, further outreach and follow-up is provided to individuals to assist in linking them to needed services.

Dauphin County embraces the Principles of Recovery and Resilience. Most activities include all stakeholders and all individualized teams supporting persons have a common message to be recovery/resiliency oriented, work with a person's strengths, consumer-driven, and emphasize the use of natural, peer, and family support. In Dauphin County, a Community Support Program

(CSP) Committee is actively involved in the system planning as well as improving person involvement in leadership roles and evaluation activities. As a Block Grant County, Dauphin MH/ID Program documents their recovery and resilience priorities and activities.

Dauphin County MH/ID and its contracted PATH providers are not required to follow 42 CFR Part 2 regulations since they do not provide any direct drug & alcohol services, diagnosis or treatment to PATH funded individuals. Referral are made as needed with the assistance of PATH providers to drug & alcohol treatment as needed, however they are not involved in providing any direct treatment services.

Dauphin County is implementing a STEPPING UP initiative. The goal of this initiative is to reduce the number of individuals with mental illness and co-occurring disorders in prison. Currently Dauphin County is currently collecting data and will develop an action plan to address issues. Dauphin County is also actively involved with re-entry of persons in local jails and State prisons.

DATA

The Dauphin County Mental Health administration and CIP staff have completed training on the use of the Federal Homeless Management Information System (HMIS). Downtown Daily Bread is already using HMIS to collect data under the CACH umbrella. The Capital Area Coalition on Homelessness (CACH) is the local planning group in Dauphin County and the CACH funds the HMIS training and activities around data collection. Bowman is the selected HMIS contractor. Dauphin County MH/ID Program and its PATH contracted providers have worked diligently in conjunction with the HMIS Program Director to assure PATH data is successfully entered into the HMIS system.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH provider agency staff will be supported on a day-to-day basis by Dauphin County MH administrative staff and the HMIS program administrator. There are ongoing data entry and reporting issues with HMIS that continue to be addressed with HMIS Administrator in Dauphin County. Ongoing technical support is being used to further develop the data quality and integrity of the PATH data entered into HMIS.

ALIGNMENT WITH PATH GOALS

The Dauphin County MH/ID Program is commitment to PATH goals for literally homeless persons and we have devoted PATH funds and other funds to this end. Dauphin County Crisis Intervention Program (CIP) has a homeless outreach worker who conducts street outreach. Crisis Intervention program staff on all three shifts work with persons and families experiencing homelessness. Ongoing efforts by Case Management entities and the homeless outreach specialist at the CMU (not funded by PATH) provide ongoing support and assistance to individuals they serve that are homeless or at risk of homelessness. The Crisis Intervention Program staff and supervisors work closely and collaboratively with traditional mental health providers and the local homeless provider network as well as other local church, law enforcement, and volunteer organizations to assist these individuals. It is clear that the most

effective approach in assisting homeless individuals is ongoing and persistent outreach along with building rapport and trust with individuals will has the greatest impact and success in reducing homelessness.

ALIGNMENT WITH STATE MENTAL HEALTH SERVICES PLAN

Dauphin County MH/ID PATH providers focus and prioritize the needs of the most vulnerable individuals, especially those who experience chronic homelessness. Street outreach is provided primarily by the Crisis Intervention Program and Downtown Daily Bread outreach worker. Unfortunately, this population is one of the most challenging groups to serve due to the lack of trust with formal services that may be government-sponsored/funded and or religiously based. Dauphin County PATH providers are engaged with the ongoing efforts spearheaded by CACH to increase available resources for the homeless community.

The Dauphin County MH/ID Program has maintained a collaborative relationship with Dauphin County Emergency Management Agency (EMA) and provides a Mental Health Response Team when an incident occurs which requires mental health disaster intervention. Under a collaborative agreement, the EMA will support the efforts of the MHRT and will provide whatever appropriate resources it may have at its disposal to intervene in a disaster incident (including activating ancillary agreements the EMA may have with other resources such as the Red Cross). The County Emergency Management Agency and local EMAs in municipalities will notify the county program by telephone or by fax if any incident has occurred that may, in their opinion, require the mental health response.

Crisis Intervention Program staff also participates in the County-wide TMI disaster preparedness drill, which occurs every other year. The Program staff's role is "rumor control" to the general public and support to the State and local EMA staff. Further, on a daily basis, suicide callers to the EMA 911 Center are routinely patched through to the Dauphin County Crisis Intervention Program. The Program also maintains a mutual aid agreement with the local Red Cross that will be updated in the coming fiscal year. All homeless providers have developed individual emergency preparedness plans to address the needs of the individual they serve.

ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS

As outlined in various sections of the comprehensive Intended Use Plan (IUP), Crisis Intervention Program services provide street outreach and focus on the most vulnerable population of homeless and chronically homeless persons in Dauphin County. This is consistent with the State's Plan to End Homelessness.

With the adoption of HOME RUN by the County of Dauphin and the City of Harrisburg, and the continued leadership of CACH as the Blueprint Manager, the stage has been set to make homelessness *rare, brief and non-recurring in our community*.

The 2017 Blueprint presents six (6) Primary Objectives with several strategies and action steps to achieve the U.S. Department of Housing and Urban Development's definition of "ending homelessness", where *homelessness is rare, brief, and non-recurring:*
1) Strengthen Leadership to End Homelessness;
2) Achieve a Continuum or County-Wide Coordinated Entry, Assessment and Referral System;
3) Preserve Existing, and Increase Affordable Housing Supply;
4) Ensure Access to and Availability of Supportive Services;
5) Increase Public Awareness and Education about Homelessness, the Coalition, and its resources; and
6) Prevention of Homelessness. Each Primary Objective has outcome measures based on "System Performance Measures" by the US Department of Housing and Urban Development (HUD) on how a continuum or catchment is progressing towards ending homelessness.
As mentioned in the previous section and it will be repeated, all PATH agencies participate in disaster preparedness and emergency planning. The Dauphin County MH/ID Program has maintained a collaborative relationship with Dauphin County Emergency Management Agency (EMA) and provides a Mental Health Response Team when an incident occurs which requires mental health disaster intervention. Under a collaborative agreement, the EMA will support the efforts of the MHRT and will provide whatever appropriate resources it may have at its disposal to intervene in a disaster incident (including activating ancillary agreements the EMA may have with other resources such as the Red Cross). The County Emergency Management Agency and local EMAs in municipalities will notify the county program by telephone or by fax if any incident has occurred that may, in their opinion, require the mental health response.

Crisis Intervention Program staff also participates in the County-wide TMI disaster preparedness drill, which occurs every other year. The Program staff's role is "rumor control" to the general public and support to the State and local EMA staff. Further, on a daily basis, suicide callers to the EMA 911 Center are routinely patched through to the Dauphin County Crisis Intervention Program. The Program also maintains a mutual aid agreement with the local Red Cross that will be updated in the coming fiscal year. All homeless providers have developed individual emergency preparedness plans to address the needs of the individual they serve.

OTHER DESIGNATED FUNDS

Dauphin County has an Emergency Solutions Grant (ESG) Program authorized by subtitle B of title IV of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11371–11378). This program authorizes the Department of Housing and Urban Development (HUD) to make grants to states, units of general purpose local government, and territories for the rehabilitation or conversion of buildings for use as emergency shelters for the homeless, for the payment of certain expenses related to operating emergency shelters, for essential services related to emergency shelters and street outreach for the homeless, and for homelessness prevention and rapid re-housing assistance. Dauphin County uses this funding for emergency shelters, rapid rehousing, rental assistance, homeless prevention and HMIS.

Dauphin County's Homeless Assistance Services (HAP) Program serves individuals and families whose income is below 200% of Federal Poverty level and who are homeless, near homeless,

and who meet the specific HAP program component requirements. HAP services include; bridge housing, case management, rental assistance, emergency shelter.

Dauphin County uses MH Block Grant funds to support many homeless positions in the provider network not funded by PATH dollars. Medicaid expansion has facilitated the use of HC funds to support the provision of treatment for the homeless population, including families.

Any of the above mentioned funds could intersect and support a person who is also PATH eligible. This would primarily occur in the area of rental assistance or supports to establish housing to end homelessness and may be configured on an individual basis.

SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)

Dauphin County Crisis Intervention Program is not involved in SOAR, except to recommend SOAR and refer persons to the CMU for SOAR support. Training was provided by OMHSAS in coordination with a SOAR Implementation Team. SOAR activities are not PATH funded in Dauphin County. The Dauphin County SOAR coordinator also manages a homeless caseload in the CMU agency.

PROGRAMATIC AND FINANCIAL OVERSIGHT

Dauphin County MH/ID receives state and federal funds PATH directly from the Office of Mental Health and Substance Abuse services OMHSAS. These PATH funds are allocated to the subcontracted PATH providers; DDB, CMU, Crisis Intervention Services. Quarterly reviews are conducted by MH program specialist staff of HMIS data. Internal audits are conducted by Dauphin County MH/ID Fiscal Officer and PATH Financial quarterly reports are provided to the OMHSAS for review reflecting all contracted PATH funds in Dauphin County. At a minimum quarterly programmatic meetings are held with the Downtown Daily Bread staff regarding service delivery and reporting issues. Implementation of HMIS has increased the amount of administrative monitoring conducted by Dauphin County. The Compliance Committee of MH/ID Crisis Intervention program provides quarterly monitoring of crisis services.

HOUSING

PATH funds continue to assist individuals who are literally homeless, chronically homeless, and at imminent risk of homelessness in securing permanent housing. PATH services continue to remain flexible and sensitive to the unique needs of individuals. Downtown Daily Bread and Crisis Intervention Program continue to provide outreach to build rapport and engage individuals in accessing appropriate mental health treatment and support services and available housing. Several temporary options are considered first in addressing immediate housing needs and once established can lead to a permanent housing situation, which include the following options:

General shelter/housing programs:

- Bethesda Mission, supplying emergency shelter services for men in some extended stay options, in the city.
- Shalom House, a shelter site available to single women and to women with children in the city.
- YWCA, providing transitional housing services for women, in the city. Provides overnight shelter for homeless women during the winter months
- Delta Housing, operated by Gaudenzia, provides transitional services in small apartment settings for women and women with children.
- Interfaith Shelter, a facility for intact families operated by Catholic Charities in the Colonial Park suburb area of Harrisburg.

Private and public resources outside the conventional human service agency framework:

- Harrisburg Housing Authority, in Harrisburg city.
- Housing Authority of the County of Dauphin, with units outside the boundaries of Harrisburg city and the balance of Dauphin County.
- Hotel and motel proprietorships, allowing short-term stays with sponsorship for people, both in the city and in the suburbs.
- YMCA Single Room Occupancy for men not limited to city residents.
- Susquehanna Safe Haven, a housing first program for 25 homeless men with serious mental illness.

Housing Partnerships: The Dauphin County MH/ID Program including Crisis Intervention Program, has been working collaboratively with the following partners in developing affordable housing options for individuals with serious mental illness: CACH, Housing Authority of the County of Dauphin, Volunteers of America, and Paxton Ministries as well as new developers being established in the County. CACH is the designated Local lead Agency for Dauphin County with key responsibilities including coordination with area service providers and building owners regarding new HUD 811 projects and tax credit housing projects funded through PHFA in assuring there are eligible individuals ready to move into available units when they become available.

In FY 2016-17 Dauphin County developed a Bridge Rental Subsidy program using reinvestment dollars in collaboration with the Housing Authority of the County of Dauphin (HACD) . A total of 18 individuals have received funding through the Bridge program. All applicants were required to complete a PREP (Prepared Renters Program) curriculum and PREP classes are offered to any interested MH consumer/family.

Paxton Ministries developed two (2) Community Lodges which serve a total of eight (8) persons. The lodges are managed by the individuals living in the home. Paxton developed a cleaning company, Paxton Cleaning Solutions, and has contracts with several area businesses.

COORDINATED ENTRY

CACH is the PA-501 Harrisburg/Dauphin County Continuum of Care and therefore, the PA-501 coordinated entry process is the same as CACH's process. CACH has the following Coordinated System of Entry and Referral for persons seeking homeless services and housing programs in the City of Harrisburg Dauphin County. CACH has developed a Coordinated Entry Referral Tool (CERT) and is used universally by any agency or person in initial contact with a homeless person or family for referral to the first proper and appropriate housing option. Once a homeless individual is identified, a CEAR assessment is completed by the provider that is in contact with the individual and a priority number is assigned based on the outcome of the assessment and data entered in HMIS by name list which ranks the individual's priority for the housing. Individuals who are chronically homeless or unsheltered and especially the Transition Age Youth (TAY) population are prioritized. Monitoring is conducted by CACH CEAR Committee until persons have secured permanent housing. Dauphin County's Crisis Intervention Program staff is involved in the assessment process.

Emergency Shelter:
Women and families needing immediate emergency shelter in order to avoid becoming unsheltered are all assessed through the HELP Office and at Dauphin County Crisis during off-hours and weekends. Single (unaccompanied) men access shelter directly through the Bethesda Men's Mission.

Unsheltered Persons who are Homeless (Non-Chronically Homeless):
Those who are unsheltered but do not have a disability or who do not have a recurring history of being unsheltered or in emergency shelter defined as chronically homeless will be referred to Transitional Housing Programs. Such referral TH is often done through informed outreach workers, agency, or self-referral. Immediate referral to ES may be required in the event that TH is not available or requires more time to process.

Persons who are Chronically Homeless:
Those who are unsheltered or in an emergency shelter who have a disability and repeated history of being unsheltered or in shelters (12 months in 3 years) that meet the federal definition of chronic homeless will be referred first and foremost to Permanent Supportive Housing (PSH).

Person who are in Rural Areas and Homeless:
Persons in rural Northern Dauphin County will be assisted by the HELP Office with housing/rental assistance for up to six months, using up to 20% of HP and RRH Dauphin County funds, in coordination with the Dauphin County Human Services Office in Elizabethville.

Veterans who are Homeless:
Homeless Veterans can be assisted through any program but they should quickly be referred to Veteran specific housing and service programs offered by the YWCA, Shalom House, Volunteers of America, and Lebanon VA Medical Center i.e. VA Per Diem TH, HUD-VASH, Supportive Services for Veteran Families (SSVF), and Homeless Veterans Reintegration Program (HVRP). If a homeless Veteran moves from a non-specific homeless housing program to one dedicated for Veterans only that then releases bed vacancy for non-veterans candidates.

VAWA Victims Immediately Homeless due to Fleeing**:**
Victims who are homeless because they are immediately fleeing domestic violence, dating violence, sexual assault or stalking, or fleeing any actual or threat of violence can access any portal of housing and homeless service, but are immediately referred and transferred where possible to housing and services provided by the VAWA services agency which in Dauphin County is the YWCA of Greater Harrisburg.

JUSTICE INVOLVED

Dauphin County was selected as a STEPPING UP Initiative County in Pennsylvania to undertake a planned effort to assess cross-system data and develop a six-step action plan to reduce the number of person with mental illness that the Court/law enforcement has put in jail. Resources and supports are available to the local steering group through NACo, BJA, The

Council of State Governments and the American Psychiatric Foundation. Dauphin County is currently in the data collection phase of the project.

Dauphin County has many programs that address the needs of justice involved individuals. In 2008 Dauphin County MH/ID opened a full-care Community Residential Rehabilitation (CRR) program for 16 individuals managed by Gaudenzia Inc. to serve those released from Dauphin County Prison and those who are actively involved in the criminal justice system. Dauphin County operates a Drug Court that has been very successful in improving treatment participation and outcomes that promote recovery.

Dauphin County has a Jail Diversion & Reentry program. The Jail Diversion program is beneficial for avoiding or radically reducing jail time by using community-based treatment as an alternative, leading individuals with mental illness or mental illness and substance use problems away from criminal incarceration or cutting it short. The Reentry program works with individuals with a serious mental illness who are court ordered or sentenced to county jail time and connects them to community mental health services prior to or shortly after release from prison.

Dauphin County opened a judicial center for centralized booking several years ago. Pre-Trial staff screen admissions and request a MH assessment from Crisis Intervention Program staff or, if active, targeted mental health case managers. Recommendations are made to Magisterial District Justices in determining bail, release or incarceration.

Dauphin County is not required to and does not collect specific PATH data on individuals that are PATH enrolled and justice involved, however based on the statistics of the general population in Dauphin County that are justice involved it is estimated the percentage of justice involved persons is relatively high.

STAFF INFORMATION

Cultural Competence is fundamental to a recovery-oriented mental health system in Dauphin County; building competence needs to be deliberate and overt. Dauphin County MH providers continue to pursue cultural competence in each of their respective agencies by utilizing their own diverse staff to conduct training as well as using outside sources to further develop the agencies overall cultural competency.

The Crisis Intervention Program has one staff member that is Hispanic bilingual/bicultural. Crisis has an agreement with the Language Line service; through which providers and individuals may have telephone access to interpreter services in many languages. The Crisis Intervention Program's agency brochure is available in Spanish and in English. Crisis Intervention staff including the lead homeless caseworker, have many years of experience with understanding and responding to the sensitive to needs of individuals with diverse back rounds.

A survey of the demographics of the staff hired in programs that are partially funded by PATH dollars has not been undertaken. Service providers and the County-operated Crisis Intervention Program and contracted PATH providers are encouraged to hire staff representative of the

population they serve demographically by age, race/ethnicity and gender while hiring the best qualified candidate for the position. The Crisis Intervention Program is also part of the County's Merit Hire system and County Human Resources Department reviews and monitors staff composition and equal employment opportunity criteria. Dauphin County continues to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

CONSUMER INFORMATION

Table 1 (Section: Local Provider Description) reflects the goals for all PATH agencies in number of adults to be outreached, expected number to be enrolled, and percentage to be literally homeless being served with PATH Funds. Persons identified through outreach by Crisis Intervention Program (CIP) is 150 and an estimated 125 persons will be enrolled by the CIP as PATH eligible and among those enrolled 70 (or 56%) will be literally homeless.

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 2017-18 to be similar to the previous year's PATH annual data. The chart below illustrates the demographics of individuals served in the PATH program for FY 2015-16 (n=287):

Table 3-PATH Consumer Information Demographics for PATH Planning

Demographic Information	FY15-16 Persons Served	FY15-16 Percentage Persons Served
Age: 18-30	78	27%
31-61+	208	73%
Gender: Male	193	67%
Female	94	33%
Race: African American	106	37%
Caucasian	162	56%
Other	19	7%
Hispanic Ethnicity:	170	59%
Diagnosis: MH Only	113	38%
COD MH/DA	156	54%
Veteran Status: Yes	7	3%
No	277	97%
Housing Status: Emergency Shelter/ Not meant for Habitation	161	56%
Transitional Housing	108	38%

The Capital Area Coalition on Homelessness conducted a 2017 Point in Time Survey of individuals and families who experience homelessness. The final report is not completed. The tentative data below is shared in Table 4. There were a total of 355 households with a total of 460 individuals. The chart below illustrates the raw data collected (n=460):

Table 4- Dauphin County Point in Time (PIT) Survey Data (Preliminary)

Demographic Information		2017 Persons Identified	Percentage Persons Identified
Housing Status:	Safe Haven	22	5%
	Unsheltered or ER Shelters	308	67%
	Transitional Housing	130	28%
	Homeless (Chronic)	45	10%
Gender:	Male	298	65%
	Female	162	35%
Race:	African American	238	52%
	Caucasian	170	37%
	Other	52	11%
Hispanic Ethnicity:		73	16%
Veteran Status: Yes		39	9%
Diagnosis:	Serious Mental Illness	92	20%
	Substance use (chronic)	96	21%

CONSUMER INVOLVEMENT

The Dauphin County MH/ID Program is committed to having individuals in service take on leadership roles and continue to be involved in all aspects of mental health planning process. The Dauphin County Community Support Program (CSP) Committee is very involved in evaluation as well planning for mental health services and new initiatives. The expertise of the County Quality Assurance staff is utilized to compile and analyze the data received and assists in exploring next steps or recommendations that can be pursued. The survey data outcomes and reports are shared internally with program staff, the Adult MH Committee of the MH/ID Board and the Dauphin County Community Support Program (CSP) Committee. Information is incorporated into annual Block Grant Plan and an Annual Report. The Dauphin County MH/ID Program has not taken any steps in the past to evaluate the specific PATH funded services by the persons benefiting from them. Concerns about their privacy and guardedness are perceived to interfere with service delivery. The County's Quality Assurance staff is available to investigate complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns.

HEALTH DISPARITIES IMPACT STATEMENT

Health disparities are not new to the Dauphin County mental health system, including for persons who are homeless, chronically homeless, or imminently homeless. Dauphin County is highly committed to addressing disparities within the County using local, State, and federal resources available to us. For the past several years, an examination of subpopulations in the county-funded system as well as in the Medicaid managed care system has been undertaken to improve the overall wellness of persons we serve. Furthermore, the relationship between health and mental health are fully understood and prioritized. The Commonwealth of Pennsylvania provides for a County-operated and managed mental health system for persons who are uninsured. While services exist, current budgetary cuts and prior cost of living increases not tied

to real costs continue to impact the availability of services leading to waiting lists and the need to triage care.

The county behavioral health system is also the primary planner and implementer of service supports and rehabilitation services not funded by Medicaid and Medicare. These are typically services which support persons living in communities. In a recovery and resilience based system, these services are as important as treatment to the individual and their family. Many of our efforts have not been solely for the benefit of PATH eligible persons; however this population has benefited from these focused efforts.

Alder Health Services provides integrated physical and behavioral health services for individuals they serve. Agencies are encouraged to address coordination and communication with primary care physicians. Hamilton Health Center, a federally qualified health center, provides mental health counseling through staff LCSWs. Crisis Intervention Program and Case management agencies focus on the referral of insured and uninsured persons to primary care programs and services, such as Mission of Mercy and Hamilton Health Center while attempting to secure benefits and insurance barriers.

Dauphin County MH/ID Program, as well as the Medicaid BH-MCO has in place policies and procedures to support agencies in addressing the language and linguistic support needs of persons in service. This is particularly necessary when the mental health workforce does not represent the cultural, language, and ethnic demographics of the community population. The last comparative survey of workforce demographics to the persons in mental health services occurred in the mid 1990 during a period of cultural diversity efforts across the Commonwealth, especially in children's mental health services.

Wellness activities undertaken include efforts with the BH-MCO PerformCare: Medication reconciliation Toolkits and a Natural Supports Toolkit for family, friends and other to support an individual with a serious mental illness. The Natural Supports Toolkit is still pending review with OMHSAS. Efforts to implement a Nurse navigator model are also pending locally.

Dauphin County is involved in a county based grievance and complaint process to address identified disparities related to lack of access and service use. A full time Quality Assurance Program Specialist is support by all County MH staff to track and address concerns about the system. All mental health staff also play a role in grievance and complaints from members under the Medicaid managed care program. Dauphin County MH/ID Program excels at finding solutions to access and service use issues within our budgetary limitations.

Information on the persons in County-funded mental health services, including PATH eligible persons are documented annually in State reporting. PATH reporting is not integrated to the State data system and when an individual becomes registered for the provision of County-funded service there is not currently a PATH designator to track service use even though their homeless status may have improved. The system includes annual data on race, ethnicity, gender, age, income and living arrangement. Continued homelessness has not been a barrier to treatment and support access in Dauphin County while efforts continue on addressing homeless issues/status.

Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly basis to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served in both systems.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. SAMHSA PATH includes TAY persons ranging in ages from 18-30 year old age group. Transitioning young adults have unique challenges at any chronological age since their emotional and social development may have been impacted by socio-economic and mental health factors. According to Dauphin County's PATH annual report data in FY 2015-16, 27% of the individuals served were between the ages of 18-30 years. In FY17-18 the estimate for the number of TAY individuals served through PATH is 25%, but that will be reassessed based upon the complete date for FY16-17 as well as, the % of funds used for the TAY population. Year-to-date 56 person categorized as TAY have been identified but the total number served is pending. The types of services funded by PATH for the TAY population are similar to all PATH funded services: outreach, homeless case management, and housing supports.

Dauphin County takes a flexible approach to determining with a person's support system and interagency team which system (child/adolescent or adult) may fit their needs best and how to individualized the transition period to gain the most success and recovery. Persons under the age of 18 may also be involved with a children and youth agency if they require care and supervision. Mental health treatment in Pennsylvania may be accessed by person 14 years of age and older without parental consent, however efforts are made to engage responsible adults in all aspects of treatment. Person under 18 years requiring inpatient psychiatric or medical care will require the involvement of Children & Youth and the Courts, as needed.

The JEREMY Project (NOT PATH FUNDED) is designed to assist young adults ages 16-22 in transitioning from adolescence to adulthood by focusing on the transitional needs in the domains of education, employment, independent living skills, socialization and community involvement. At the same time, JEREMY attempts to engage/re-engage participants in other mental health treatment, rehabilitation and support. The Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews.– The JEREMY Project is in its 12th year of operation.

Dauphin County studied the TAY (16-22 years of age) population discharged from The JEREMY Project over the past three years. The purpose of the review was to determine if the persons being referred, served and discharged were individuals with TAY risks: exploitation/victimization, homelessness, criminal activity, not maintaining MH recovery and lacking family or natural support. The data compilation has just ended and analysis is beginning. This is a transformation priority in the Block Grant and may lead to strategic changes in the system of care of the TAY population.

LIMITED ENGLISH PROFICIENCY

The Crisis Intervention Program utilizes the Language Line to meet linguistic needs and they have one bilingual/bicultural Hispanic staff. All Dauphin County contracted providers make individual arrangement for interpreter services for languages other than English if they do not

have staff that are bilingual/bicultural. All PATH services are provided on an individualized basis and contracted providers respect and are sensitive to the linguistic needs of the homeless population. Dauphin County MH/ID and several providers use The International Service Center to assist with various language translations and interpreting to best serve those who are not proficient in English. This agency has a list of interpreters for many frequently spoken languages that we may experience in the region. Providers continue to tailor services based on individual needs as well as accommodating individual linguistic needs in order to benefit from services provided. Many agencies seek to hire multi-lingual staff that can accommodate and further address the linguistic needs of the population they serve.

DAUPHIN COUNTYMH/ID PROGRAM CRISIS INTERVENTION PROGRAM (CIP) PATH BUDGET NARRATIVE:

Personnel ($ 22,362): $22,362 approximates one-half the salary of the Full-Time Equivalent (FTE) position within the PATH local provider's Crisis Intervention Program. The salary amount is 50% of the actual costs for the Crisis Intervention Program's Lead PATH Worker's position.

Fringe Benefits ($ 12,326): Conforming to methodology for ascertaining personnel costs, or $ 12,326 or 55.12% references the benefits attending one position within the Crisis Intervention Program, with the amount assigned to benefits based on actual costs for the lead PATH Crisis Intervention Worker's position.

Travel ($0): No travel costs under PATH funds for MH/ID Crisis Intervention Program.

Supplies ($2,000): Costs of supplies to be applied to this PATH grant are solely those related to the basic and rehabilitative needs of PATH eligible consumers. Among supplies anticipated are small stocks of non-perishable food items, clothing and blankets, as well as for accessories important to improve prospects for safe and conventional independent living. Costs for bus passes to assist clients to get to housing related services such as supported employment programs, county assistance offices, benefits counseling.

Other ($ 3,310): **Staff Training ($0):** Crisis Intervention program has no costs related to training. **One-time Rental Assistance ($1,655):** This budget line represents costs incurred on behalf of PATH eligible people for whom one-time expenditures can relieve the risk of possible eviction and homelessness. **Security Deposits ($1,655):** This budget line represents a special cost in securing stable housing to prevent or resolve conditions of homelessness. **Assistance in obtaining housing –client travel expenses ($0):** No costs. **Maintenance of Equipment ($0):** No costs related to maintaining equipment.

Indirect Costs/Administrative Cost 4% @ $1,600): Four (4) percent of the PATH grant is allocated to cover administrative expenses at MH/ID Crisis.

Total Dauphin County MH/ID Crisis Intervention Program PATH Request……$41,598
($10,399 State Funds $31,199 Federal Funds)

Dauphin County MH/ID Program Crisis Intervention Program
FY 2016-17 PATH IUP Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Personnel Position				
Crisis Caseworker	44,723	50%	22,362	22,362
Salary sub-total			22,362	**22,362**
Fringe Benefits (55.12%)				
Crisis (55.12%)				
FICA, Health, Ret, Life			12,326	12,326
Fringe sub-total			12,326	**12,326**
Travel				
Mileage			0	0
Travel sub-total			0	**0**
Equipment				
(list individually)			0	0
sub-total			0	**0**
Supplies				
Consumer-related items			2,000	2,000
Supplies sub-total			2,000	**2,000**
Other				
Staff training			0	0
One-time rental assistance			1,655	1,655
Security deposits			1,655	1,655
Other sub-total			3,310	**3,310**
Indirect Administration @ 4%				**$ 1,600**
Total PATH Budget ($10,399 State Funds $31,199 Federal Funds)				**$ 41,598**

20. Delaware County

20 South 69th Street

Upper Darby, PA 19082

Contact: Chris Seibert

Contact Phone #: 6107132306

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-008

State Provider ID: 4208

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 131,919	$ 43,973	$ 175,892	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 131,919	$ 43,973	$ 175,892	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 131,919	$ 43,973	$ 175,892	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 131,919	$ 43,973	$ 175,892	

Source(s) of Match Dollars for State Funds:

Delaware County will receive a total of $175,892 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

Estimated Number of Persons to be Contacted who are Literally Homeless: 0

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

2017-2018 PATH IUP

Delaware County Office of Behavioral Health – Comprehensive

Local Provider Description *– Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of each provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.*

The Office of Behavioral Health (OBH) is a unit of local government under the County of Delaware, the targeted service area. The mission of OBH is to assure the provision of a comprehensive array of quality mental health, drug and alcohol, homeless and other services for eligible children and adults that will assist them to maximize their human potential. There are four divisions within OBH: Mental Health (MH), Drug and Alcohol (DA), Adult and Family Services (AFS) and Quality Improvement (QI).

The DA is the administrative office which oversees the delivery of drug and alcohol treatment and prevention services in Delaware County. DA provides funding for prevention, intervention, and treatment services to all eligible Delaware County children, adults, and families. AFS oversees services to the homeless population, emergency food assistance, Medical Assistance Transportation, HIV/AIDS, Family Center and other programs.

MH administers contracts for MH Base funds, the Human Services Block Grant, PATH and oversees the Health Choices contract for Medical Assistance behavioral health services provided by Magellan Behavioral Health of PA (Magellan), the county's long-standing Behavioral Health Managed Care Organization. OBH, Magellan and a diverse group of intra and inter-system stakeholders jointly strategically plan the development, implementation, funding and monitoring of services targeted to Delaware County (DelCo) citizens with Serious Mental Illness (SMI).

Additionally, OBH is the managing authority for PATH funding and oversees contracting, monitoring and reporting of homeless service delivery for Delaware County. OBH convenes the Homeless Services Coalition and oversees the Continuum of Care (COC) planning process and annual submission of the HEARTH Act COC application and the CoC HMIS. OBH is also responsible for contracting homeless services utilizing various funding streams including: HSBG, HOPWA, County MH Base, and Reinvestment, in addition to federal and state PATH funds.

PATH funds are allocated and contracted by OBH to two provider agencies, Horizon House and the Mental Health Partnerships. Each agency receives an annual PATH allocation and is responsible for preparation of an annual PATH Intended Use Plan (IUP) and Budget with Budget Narrative that describes how each agency will deliver PATH services to homeless persons with mental illness and Co-Occurring Disorders. For the fiscal year 17-18 Horizon House's allocation amount is $ 129,369 and Mental Health Partnerships allocated amount is $ 46,523 in federal and state funding.

PDX Provider: Delaware: Delaware County Office of Behavioral Health
20 South 69th Street
Upper Darby, PA 19082

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation in the HUD Continuum of Care program, other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum of Care (CoC), briefly explain the approaches to be taken by the agency to collaborate with the local CoC. Please specifically identify your CoC and how often your organization participates in CoC meetings.

OBH functions as the lead entity and for the Delaware County COC (PA-502) through its Adult and Family Services Division. The local Homeless Services Coalition (HSC) has been operating for 23 years and serves as the governing body for the Homeless Continuum of Care. The HSC established a Governance Charter and Governing Board in 2013 to comply with new HUD HEARTH Act legislation. Successful compliance with federal COC requirements results in over $5 million annually in homeless assistance funding, much of which supports the MH and COD homeless population.

The 18 member Governing Board, with 5 standing committees, a CoC County Advisory Team and the full member ship of the HSC allows the CoC to stay informed and on line with the needs of the homeless population in Delaware County. These activities ensure information sharing, discussion of gaps, CoC outcomes evaluation and developing gap implementation plans. Consumer participation brings their voice to the table. County Offices comprise the Continuum of Care Advisory Team (CoCAT) and functions as an advisory to the HSCGB. The CoCAT meets twice a month to continually address the ever changing CoC housing needs, gaps, funding, HMIS, and performance reviews.

Annual Countywide meetings allow all stakeholders the opportunity to discuss CoC priorities, plan for meeting identified needs and gaps and discuss our progress on reducing the number of people who become homeless.

The HSC CoC System has six components: Outreach, Prevention, Emergency Shelter, Transitional Housing, Permanent Supportive Housing and Supportive Social Services. Each component has many services available to meet the varying needs of the homeless population.

Both PATH providers, Horizon House and the Mental Health Partnership are longstanding members of the HSC and both have seats on the governing board, standing committees and HSC committees.

Collaboration with Local Community Organizations – Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

Community coordination is accomplished via the HSC as it is the cornerstone of CoC structure. The HSC has over 100 organizational members from housing, medical, faith-based, mental

health, substance abuse, businesses, landlords, consumers, housing authority and local and state government, veteran, employment and vocational providers and programs. The HSC has a shared mission and has invested their time & efforts in the HSC for the very purpose of collaboration & identifying & addressing gaps in services for the homeless and those who have behavioral healthcare needs. Dedication and volunteerism are the driving forces in our collaboration. Meeting attendance, sub-committee participation & partnerships in new programs are vital to the 23 year success. The main goal of the Governing Board is to oversee the operation of the CoC. The GB is establishing CoC policies and procedures in regards to servicing the homeless population and operating the CoC. The GB, in overseeing the CoC, guides and monitors the activities of the GB and HSC committees. The Outreach Committee is the longest standing and most active committee of the HSC structure. This committee forum is where outreach activities and teams coordinate. This team is led by the PATH liaison from OBH-AFS. Outreach training, joint street outreach events, monthly meetings, development and management of a name-by-name list and conducting an unsheltered point-in-time counts twice a year is how outreach coordination is achieved. Delaware County has collaborated and coordinated with both housing authorities for a number of years: Delaware County Housing Authority and Chester City Housing Authority regarding permanent housing for homeless individuals.

Service Provision – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including: Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless.

The PATH Program in Delaware County provides services to adults 18 years or older who are literally and chronically homeless or at an imminent risk for homelessness, who have a mental illness, including those with co-occurring substance use disorder. The PATH Services provided in Delaware County include street outreach, case management, screening and diagnostic services, referrals for medical, mental health, substance abuse treatment, primary health, job training, educational, referrals to housing, crisis Intervention, habilitation/Rehabilitation supports and residential supportive and supervisory Services. PATH services are provided via two organizations; Horizon House, Inc. and the Mental Health Partnership. Please refer to each provider agencies IUP for their detailed description of PATH service provision.

- ***Provide specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services***

  Other resources used as leverage to maximize PATH funds and additional services and supports for PATH eligible clients includes:

  - Mental Health Block Grant dollars
  - HUD funds awarded for Coordinated Entry Services
  - HUD grants received for housing subsidies and services
  - County Affordable Housing Funds for program match
  - CoC resources/services
  - Access to other Mental Health Block grant funded service
  - Access to MA funded services

- Access to other mainstream funds/services (i.e. income benefits, nutrition assistance, health benefits)

- ***Describe any gaps that exist in the current service systems***

  The gaps identified by providers in the current service system with include:

  - Insufficient numbers of CRR beds and the long time on waiting lists with which people contend.
  - Lack of Housing First slots for people who aren't ready to make a firm commitment to abstinence from drugs and alcohol.
  - Insufficient supports and lack of discharge planning for people post discharge from drug and alcohol inpatient treatment.

  - The elimination of general public cash assistance to single homeless individuals continues to create many barriers for individuals to access and maintain housing.
  - The lack of employment opportunities and limited employability for participants continues to present challenges, particularly for those who have a criminal background. The CoC has maintained this as a priority area to address.
  - Shorter life expectancy and co morbidity significantly impact chronically homeless individuals with serious mental illness and requires additional focus and services. We are seeing an increasing need for nursing home services for many consumers; however, lack of income and early age are barriers to accessing appropriate housing and services for individuals.
  - Access to housing opportunities for individuals who are literally homeless with serious mental illness and other significant needs who do not meet the chronic homeless definition, can be challenging.

- ***Provide a brief description of the current services available to clients who have both a serious mental illness and a substance use disorder***

  The County OBH and Magellan, have made a wide range of behavioral healthcare services available to PATH participants **include:**

  - Homeless: PATH/Coordinated Entry, Housing First, Life Skills Training, Out of Poverty, Housing Counseling, 3Rs of Budgeting, Parenting Classes
  - Mental Health: Psychiatry, Outpatient, Intensive Outpatient, Mobile Psychiatric Rehabilitation, ICCD Certified Clubhouse, Peer Support Services, Case Management, PACT, Compeer, Vocational Rehabilitation, Crisis Intervention, Inpatient, Residential and MISA Residential, Crisis Residential, ACT, FACT, Peer Warm Line, Delaware County Crisis Connections Team (DCCT) NHS and Holcomb Behavioral Health for dual diagnosis treatment and are beginning a relationship with Omni Services.
  - Substance Abuse: Prevention, Outpatient, MISA Intensive Outpatient, Intensive Outpatient, Detoxification, Inpatient Rehabilitation, Case Management

- ***Describe how the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and***

activities to support collection of PATH data in HMIS

The OBH takes a lead role in the county in organizing and offering training opportunities to the behavioral health care provider community inclusive of PATH-funded staff. The AFS, the HMIS lead, instructs the HMIS team in supporting both PATH providers in their collection and entry of PATH data. Training is conducted in small groups or via desk side support.

- ***Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed***.

  Refer to each provider agency for their specific answers.

Data – Describe the provider's status on the HMIS transition plan, with accompanying timeline, to collect PATH data by fiscal year 2017. If providers are fully utilizing HMIS for PATH services, please describe plans for continued training and how providers will support new staff. Indicate specific PATH HMIS Directors (those who write the code) and the organization which is in charge of HMIS for each provider.

OBH AFS is the lead agency for the HMIS and holds the contract with the HMIS system CARES - Coelho Consulting, owned by Greg Coelho. The HMIS Coordinator for PA-502 is Farea Graybill. There is an HMIS team that meets weekly to oversee all aspects of the HMIS system operations which includes data quality oversight, monitoring performance standards, system updates and upgrades to meet federal reporting requirements, ongoing HMIS system training for upgrades and new staff, HMIS usage per program and provider. Coelho Consulting recently trained all providers on the new Coordinated Entry system. The training was completed in February 2017.

Alignment with PATH goals – Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

The goal of the PATH program is to reduce or eliminate homelessness for individuals with serious mental illness or co-occurring serious mental illness and substance use disorders who experience homelessness or are at imminent risk of becoming homeless. Both MHA and Horizon House PATH services provides outreach to homeless individuals, engages and assesses individuals and provides case management and referral services to assist individuals with serious mental illness or co-occurring disorders to access and utilize mainstream behavioral health services and housing supports. Outreach has included street, homeless drop in centers, warming centers, and shelters. Increasing street outreach is a goal of the service. In addition for participants of the Horizon House program, services continue once housing has been obtained the PATH service provides case management and other supports to ensure that the person has the skills and supports to maintain the housing and successfully utilize mainstream supports.

Alignment with State Comprehensive Mental Health Services Plan – Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plan.

County PATH services are informed by The State Plan and provides recovery oriented services that are targeted to individuals who have a serious mental illness and who experience homelessness. The services directly assist individuals in moving from homelessness to housing and facilitates individual's access to mainstream services that promote successful community living and independence.

Alignment with State Plan to End Homelessness – Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

The PATH Services funded in Delaware County include street outreach, case management, screening and diagnostic services, referrals for medical, mental health, substance abuse treatment, primary health, job training, educational, referrals to housing, crisis Intervention, habilitation/Rehabilitation supports and residential supportive and supervisory Services. Services will integrate Coordinated Entry functions and target street outreach for the most vulnerable adults who are literally and chronically homeless. PATH funded services also includes case management services and referral to connect individuals with mainstream behavioral health services and benefits , providing and facilitating access to permanent supportive housing and facilitating increased collaboration across systems.

The Delaware County disaster preparedness response is two-fold:

1) As part of contractual agreements with PATH providers, the OBH has expectations that providers have developed integrated emergency response plans and Continuity of Operations Plans (COOP). These plans are reviewed during monitoring visits with providers.

2) The County of Delaware's Strategic National Stockpile (SNS) advisory board offers our providers the opportunity to become PODS (Points of Dispensing) which enables stakeholder's access to necessary medication during any medical or biological outbreak. Many behavioral healthcare providers are represented on our Disaster Crisis Outreach and Referral Team (DCORT) which provides disaster mental health services to the community after a tragic event.

Other Designated Funds – Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

Mental Health Block Grant funding is utilized to serve persons who experience homelessness and have serious mental illness. This includes funding to support outreach services, housing assistance, and master leasing bridge subsidies. There are Mental Health Block Grant funds specifically allocated for PATH clients.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR during the grant year ended in 2016 (2015- 2016), and the number of PATH-funded consumers assisted through SOAR. If the provider does not use SOAR, describe the system used to improve accurate, timely completion of mainstream benefit applications and timely determination of eligibility. Also describe efforts used to train staff on this system. Indicate the number of staff trained, the number of PATH funded consumers assisted through this process, and application eligibility results.

OBH supports and encourages provider agencies to train staff on SOAR and assist participants through the SOAR process if warranted. The PATH liaison receives SOAR updates and news and forwards to all homeless services providers. OBH has also encouraged the use of the web-based training and will continue to expand on the SOAR efforts countywide. In April of 2017, MHP and Delaware County CoC, submitted a new grant application to SAMHSA for the benefit of homeless individual (GBHI) to provide SOAR services and other critical services needed for individuals experiencing homelessness.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Delaware County made its priority to house homeless individuals and CoC has allocated 56% of Housing and Urban Development's funding to Permanent Supportive Housing. Delaware County, through its Continuum of Care, has over 240 beds of permanent housing for single adults and over 70 of those are targeted for chronic homeless persons and PATH clients. The OBH Mental Health Division manages placement of persons with severe mental illness in approximately 400 beds that offer varying levels of services and treatment. Most PATH participants will utilize the homeless funded beds, however, if they have high needs and barriers, beds in staff supported units and programs are available. Housing program type includes CoC funded permanent supportive housing and rapid re-housing programs.

Coordinated Entry – Indicate if your organization is part of a coordinated entry program. If so, explain the coordinated entry process and through whom it is governed/monitored.

The PA-502 Continuum of Care for Delaware Country consists of 10 key homeless service providers and over 50 partner organizations. The Office of Behavioral Health is the Collaborative applicant for the CoC and is the lead agency for the HMIS. The OBH is also the grantee for PATH. The CoC has completed the process of implementing phase 2 of the Coordinated Entry (CE) system. The CE system in Delaware County is a decentralized-coordinated system with four entry points located in areas of high need. The CE crisis response process developed for our CoC consists of 4 core components: ACCESS Help; ASSESS the situation, barriers and needs; ASSIGN a solution; and ENSURE stable housing

With recent funding awards, the CoC has expanded the current CE System adding additional Coordinated Entry locations and staff, providing full county coverage. The CoC has implemented a modified assessment tool and fully utilize the HMIS to permit improved assessment of needs of the homeless population and housing stability planning.

The CoC uses a phased-assessment process with a series of situational assessments tools that allow assessments to occur over time and as necessary. The goals of the CoC CE system is to ensure that everyone who has a housing crisis is comprehensively assessed to determine their housing status and intervention needs in hopes of diverting households from homelessness by developing stability plans based on their ability to divert from homelessness, the housing barriers, income potential, vulnerability and level of need, housing assistance program eligibility, mainstream resources needs and other service needs. Using up to 6 assessments, helps to uncover the needs of each person and determine the service intervention level for housing, income, education, employment, mental health, drug and alcohol, life skills, legal, children, financial, parenting and health. The assessment and other tools help to determine the best possible path and programming for all households to be permanently and stably housed as quickly as possible. Once a stability plan is developed, case management services are provided for all emergency shelter and transitional housing clients and includes the development of a service plan for each client. Referrals to mainstream resources such as PATH and the provision of appropriate supportive services for clients in emergency shelter and transitional housing is extremely important. These critical support services such as case management, life skills, money management, parenting, mental health services, D&A services, employment and training, etc. are provided, utilizing a myriad of Federal, State and local funding, to improve participant's ability to achieve self-sufficiency.

Justice Involved – Please describe your agency's efforts to minimize the challenges and foster support for PATH clients with a criminal history. Examples include jail diversion and other local, regional and state programs, policies and laws in your area. Indicate the percentage of your PATH clients with a criminal history.

The Office of Behavioral has participated in various inter-system initiatives with criminal justice partners for many years. In 2010, a Cross-System Mapping was held for 45 county stakeholders that identified a number of system gaps, produced priority action steps, and resulted in many of the newest forensic initiatives being proposed and/or developed in the county. The Cross-System Strategic Planning Committee is the entity responsible for tracking intersystem program development and training initiatives. OBH also participates in the Criminal Justice Advisory Committee (CJAC), DelCo Cares initiative, MH Court Planning Team, and also works with the Regional Forensic Liaison on DOC/SCI max-out planning, and with Forensic Liaisons at GW Hill Prison for inmate re-entry planning. All PATH clients with criminal histories can access those programs in which they are eligible. The following lists specific efforts in the County.

Forensic ACT (FACT) Team	The county is converting a CTT program to a FACT model with technical assistance from the University of Rochester Medical Center. The Rochester R-FACT model is an evidence-based forensic intervention model that collaborates with the MH Court.
MH Court	The county implemented a new specialty MH Court in FY 13-14 to address the needs of the SMI/justice-involved population. There is a strong working relationship between the criminal justice and behavioral health systems in this new venture.
Forensic Peer Support	The county developed a contract with Peerstar, LLC, to implement a forensic CPS program. This model is both a jail in-reach and community-based peer mentoring model that uses an evidence-based Yale Citizenship approach.
OBH Forensic Specialist	In FY 13-14, OBH hired a dedicated Forensic Specialist to help oversee the myriad of forensic initiatives targeted to the justice-involved population.

Behavioral Health Liaisons	OBH and Adult Probation/Parole jointly fund 4 behavioral health liaisons at the GW Hill prison to coordinate treatment in the prison and in the community at release.
DOC Max-out Tracking	OBH staff, in conjunction with the Regional Forensic Liaison, track and develop release plans for the C and D roster priority max-out cases returning to DelCo.

Staff Information - Delaware County Department of Human Services (DHS) was established in 1976 under the Home Rule Charter as an umbrella department responsible for the administration and delivery of coordinated human services. The Administrators of Children and Youth Services (CYS), Behavioral Health (Mental Health [MH], Drug and Alcohol [D&A] and **Adult/Family Services**), Intellectual Disabilities, Child Care Information Services (subsidized day care), Early Intervention, Fiscal Services, and Information Technologies report to the Director of the Department of Human Services.

The Division of Adult and Family Services has four staff. The staff demographics are as follows:

Race/Ethnicity:

- White 60%
- Black/African American 20%
- Asian 20%

Gender:

- Male 0%
- Female 100%

Adult and Family Services staff is encouraged to take various training to understand the needs of Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI). Magellan, Office of Behavioral Health and various county stakeholders jointly plan for the availability of services for these populations.

The staff of MHASP's Delaware County and Horizon House provide homeless services and are sensitive to the racial/ethnic diversity of the program participants and receives cultural sensitivity training at the time of hire and annually.

Client Information - Describe the demographics of the client population, the projected number of adult clients to be contacted, enrolled and the percentage of adult clients served using PATH funds to be literally homeless.

	Horizon House	Mental Health Association
Black/ African Americans	**55%**	**15%**
White	**44%**	**85%**
Hispanic/ Latino /mixed/native	**1%**	**0%**
Male	**53%**	**65%**
Female	**47%**	**35%**
62+	**8%**	**0 %**
51-61	**33%**	**43%**
31-50	**44%**	**43%**
18-30	**15%**	**14%**

% Literally Homeless	**100%**	**100%**
Projected number to be enrolled in 2017-18	**200**	**110**

Consumer Involvement -

Delaware County's Continuum of Care (CoC) has many opportunities for consumers/ Clients to serve in different capacities:

- Homeless Service Coalition (HSC) Annual Client Recognition Award.
- Consumer Focus Group
- CoC Program Ranking and Evaluation Committee
- Consumer Satisfaction Team
- Program Disposition Committee
- HSC Governing Board
- Housing First Advisory Committee
- Point in Time Count

Horizon House (HH) and Mental Health Partnership (MHP) are involved with the Peer Specialist Program. Both agencies have employed consumers as mentors, and at times clients' volunteers in life skills/ literacy classes. Clients are also part of program planning, program evaluation process. At MHA, to keep the consumers involved there is an idea/suggestion box and clients are encouraged to put suggestion/ ideas in the box. By having an idea box the clients feel that their voices are heard and their input is valued.

Health Disparities Impact Statement

The OBH is coordinating the development of a TAY Provider Coalition that will meet several times per year with the goal of partnering with the CoC to address TAY homelessness and service needs.

- **Unduplicated TAY individuals expected to be served: 35 Total (30 HH and 5 MHP)**
- **Total Amount of PATH funds expected to be expended on TAY population: $30,700**
- **Types of Services funded:** All services provided within the PATH project will be available to TAY individuals, including: outreach, screening and diagnostic treatment, case management, referrals for primary health, job training, educational services, relevant housing services, habilitation/rehabilitation supports, and residential supportive and supervisory services.
- **A plan that implements strategies to decrease the disparities in access, services use, and outcomes both within the TAY population and in comparison to the general population.** The PATH project intends to increase access, service use, and outcomes for the TAY population through the following activities and strategies:

  Access – We intend to expand outreach to the TAY population, increase street outreach to locations frequented by TAY individuals, triage calls/contacts of TAY individuals to

PATH workers, identify TAY individuals in shelters and homeless day programs and reach out to other agencies/systems that serve TAY individuals.

Service Use- We will increase staff training on TAY issues, increase Peer Support and have an increased focus on areas of need/preference for TAY population (i.e., employment, education income/benefit, socialization, and housing).

Outcomes – Increases in TAY individuals who are employed, receiving benefits, completing and furthering education, increase their socialization opportunities and increase those who are permanently housed.

Limited English Proficiency

Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the *HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-titleVI/index.html?language=es

Delaware County employees have access to a language line: Language Line Solutions has the ability to interpret 200 + languages through an interpreter service. The system is easy to use and paper instructions were given to all employees as part of their training. Also, Delaware County has diverse group of ethnicities employed which could be an asset if need be.

Budget Narrative – Provide a descriptive budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example: $10,000 federal allocation, $3,333 state match, $1000 PATH specific base fund match. See Appendix C for a sample detailed budget.

Delaware County
Horizon House Inc. & Mental Health Partnerships
PATH Program
FY 2017-2018 Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	PATH TOTAL
Position				
Director	$115,850	0.01	1,159	
Program Director	$70,693	0.05	3,535	
Administrative Manager	55,584	0.01	556	
Administrative Assistant	34,011	0.01	340	
QI Manager	46,925	0.01	469	
QI Specialist	39,106	0.01	391	
Team Leader	54,512	.24	13,083	
Behavioral Health Spec.	29,911	0.40	11,964	
Nurse	54,417	0.12	6,530	
Housing 1st BHS	32,754	1.11	36,357	
Clinical Specialist	52,010	.04	1,905	
CPS Outreach Worker	28,562	1.00	28,562	
sub-total				**$104,851**
Benefits				
FICA Tax			8021	
Health Insurance			$15,305	
Retirement			2,850	
Unemployment—only from			1, 157	

MHP				
Life Insurance –only from HH			877	
sub-total				**28,210**
Travel				
Local Travel for Outreach/Supportive Services			16,893	0
Travel to training and workshops			2,368	0
sub-total				**19,261**
Occupancy				
Rent			4,546	
Utilities			861	
Maintenance			1,643	
sub-total				**7,050**
Supplies				
Office Supplies			974	
Consumer-related items			2,602	
sub-total				**3,576**
Communication				
Telephone/Postage			1,539	
sub-total				**1,539**
Other				
Other: Staff Training			475	
Other			4,093	
sub-total				**4,568**
Administrative Expense			6,837	6,837
sub-total				
Total PATH Budget				**$175,892**

FY 2017-2018 Budget Narrative

Personnel/Positions: (Also see Roster listed on Budget) - PATH Team including Housing First provides outreach, screening and diagnostic treatment, case management, referrals, habilitation/rehabilitation, and residential supportive and supervisory service.

Fringe Benefits: @ 23.5% including FICA Tax, Health Insurance, Retirement, Life Insurance**,** for HH and 36 % including FICA Tax, Health Insurance, Retirement, Life Insurance for MHP.

Travel: Vehicle lease, insurance, and maintenance and gas/travel expense for client outreach and services **and** Travel to training/networking meeting and staff training.

Occupancy: Office expenses, rent, utilities, and maintenance for staff/service activities.

Supplies: General office supplies for staff/services **and** Client welfare emergency needs (food, clothing, medications).

Communication: Telephone and postage.

Administrative Expense: @ 4% HH and MHP.

21. Delaware County - Horizon House

1601 Parklane Road

Swathmore, PA 19018

Contact: Theresa Murphy

Contact Phone #: 610-328-2165

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-013

State Provider ID: 4213

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Horizon House will receive a total of $129,369 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 200

Estimated Number of Persons to be Enrolled: 100

Estimated Number of Persons to be Contacted who are Literally Homeless: 194

Number staff trained in SOAR in grant year ending in 2017: 1

Number of PATH-funded consumers assisted through SOAR: 27

Horizon House, Inc. PATH Program

PATH Intended Use Plan
Delaware County, Pennsylvania
2017-2018

Local Provider Description – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization,(e.g. community mental health center, county of local government entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of each provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

Horizon House Inc.
1601 Parklane Rd.
Swarthmore, PA 19081

PDX: Horizon House, Inc.

Horizon House, Inc. is a private, non-profit organization providing community-based services to individuals with psychiatric and substance abuse disorders, intellectual disabilities, and those who have been homeless. The Delaware County Office of Behavioral Health sub-contracts with Horizon House, Inc. to provide PATH services in Delaware County. The service area targeted for the purpose of these funds is Delaware County, Pennsylvania.

In Delaware County, the Horizon House organization provides Residential Services, Mobile Psychiatric Rehabilitation, Clubhouse, Peer Support Services, ACT, and Homeless Services to individuals with mental illness and co-occurring substance use disorders. The PATH funds and services are located within Horizon House Delaware County Behavioral Health Services Department, Homeless Services unit. This structure facilitates support to staff and access for clients to a range of mental health services, housing, and other homeless services.

The total amount of PATH funds, Federal and State, to be allocated to Horizon House is indicated at **$**129,369 ($97,027 Federal and $32,342 State). Horizon House receives PATH funding from the State of Pennsylvania through the Delaware County Office of Behavioral Health.

Collaboration with HUD Continuum of Care Program - Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care (CoC) briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the area where PATH operates.

The PA 502 Continuum of Care for Delaware County consists of 10 key homeless service providers and over 50 partner organizations. The Delaware County Office of Behavioral Health

(OBH) is the Collaborative applicant for the CoC and is the lead agency for the HMIS. OBH is also the grantee for PATH. Horizon House and the PATH staff continue to play a key role in the planning, development, and coordination of overall behavioral health and homeless services in Delaware County, including the HUD Continuum of Care program and recipients. The PATH services and staff are an essential component within a comprehensive array of homeless services, providers, and various funding sources currently available or planned within the local Continuum of Care. The PATH Program continues to be an integral part of the Delaware County Homeless Services Coalition (HSC), which represents the full range of community services and housing available to homeless individuals and families in Delaware County. Horizon House, as part of the Delaware County Homeless Services Coalition, and HUD Continuum of Care Program participates in all CoC general meetings, which occurs quarterly, as well as committees, and other Continuum of Care planning activities. Horizon House has maintained leadership positions with the CoC Governing Board, which meets quarterly.

Horizon House's current involvement in Continuum of Care Committee's include:

- Governing Board
- HSC Outreach/Crisis Response
- Family Services & Children
- Participant Focus Group
- Coordinated Entry
- Housing Accessibility

Horizon House has been actively involved in program coordination initiatives as described above and including coordinated entry. Horizon House is the recipient of a HUD CoC Coordinated Entry grant and the PATH services are integrated within the CoC coordinated entry process directly providing coordinated entry activities.

Collaboration with Local Community Organizations –Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH eligible clients, and describe coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams is achieved.

Horizon House continues to provide a number of services, in addition to PATH funded services that are available to PATH-eligible clients. These services include: Specialized Residence for the Homeless (transitional housing), HUD Permanent Supported Housing, Community Residential Rehabilitation (transitional housing), Clubhouse (site-based psychiatric rehabilitation) Mobile Psychiatric Rehabilitation Services, Peer Support Services and ACT (Assertive Community Treatment),

Horizon House provides ACT services specifically targeted for transition age youth (TAY)/young adults, which are available to PATH eligible individuals.

The PATH Program identifies and works collaboratively with an array of external supports offered by other providers to PATH-eligible clients. These external supports include: emergency

shelters, drop-in centers, MH/MR Base Service Units, mental health and/or substance abuse services, health care, education, employment, financial and medical benefits, housing subsidies, and other housing services. The PATH program includes collaboration with supports and services for families and children.

The PATH Program is designed to target homeless individuals with behavioral health needs who tend to be underserved and experience difficulties or barriers in accessing and maintaining services. Behavioral health services, housing, and finances are seen as most critical. The PATH staff works with the available behavioral health service providers to improve client's access to and coordination of treatment. PATH staff performing and others performing coordinated entry activities use a standardized process for assessment and referral to housing and other supports.

Horizon House maintains coordination agreements with the County's primary behavioral health services.

Horizon House is actively involved in the planning and coordination of activities and services through the Homeless Services Coalition/CoC as well as through the Delaware County Office of Behavioral Health and provider network. Horizon House is actively involved in the development of policies through the CoC Board.

Horizon House coordinates directly with other outreach teams/staff through the CoC meeting and committees and through joint outreach efforts. During this past year, the CoC and OBH has fully implemented the coordinated entry process.

Service Provision – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

- **How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless**

PATH services are provided through two program components: the PATH/Coordinated Entry team (including outreach) and the PATH Housing First team. The CoC strategically moved forward in developing Coordinated Entry and the PATH outreach services are integrated within the coordinated entry process.

The PATH/Coordinated Entry team focuses its efforts on outreach, engagement, assessment, screening and referrals for homeless services, housing and other community services. Frequency and intensity of services may vary based upon need and individual readiness. Staff engage homeless individuals through coordinated entry access points and/or outreach; assess the individual needs, barriers, resources, and preferences; and assist the individual in accessing CoC services and other community supports. In addition to initial outreach, engagement and coordinated entry services, PATH eligible individuals may receive additional case management and referral services for behavioral health and other community supports to assist in accessing

and utilizing those services, primarily targeting those individuals who are literally and chronically homeless.

Referrals and coordination of services may include areas such as health, mental health and substance abuse, job training, education, income/benefits and housing referral services. A client record is maintained for all documenting referrals and services received.

The PATH Housing First staff provide case management, habilitation/rehabilitation, and residential supportive/supervisory assistance required for clients to achieve successful, permanent housing outcomes. Almost all clients served in Housing First meet the definition for chronically homeless. Case management supports are provided to assist individuals with linkage and access to mainstream community services.

Habilitation/Rehabilitation supports are provided to assist individuals with improving functioning, a sense of well-being, and a level of independence. Staff complete individualized assessments of skill competencies and assist individuals with gaining the skills required to:

- Maintain personal hygiene
- Perform household activities, including house cleaning, cooking, grocery shopping, and laundry
- Improve money management skills
- Use public transportation
- Obtain effective medical/dental care
- Manage medications and behavioral health symptoms

Residential supportive and supervisory assistance is provided to assist individuals to maintain stability in their homes as they transition to mainstream supports. To support individuals in their homes, PATH staff:

- Assist consumers with ADL and social/interpersonal skill improvements necessary to maintain housing and successfully utilize community resources.
- Assist with budget development prior to housing placement, bill paying, and controlling spending within the limits of each consumer's budget.
- Assist consumers with managing issues that occur with landlords, other tenants, and neighbors.
- Identify a representative payee for consumers who cannot independently manage their own funds.
- Help consumers establish and maintain schedules required to keep appointments for treatment/rehabilitation, health care, social services, and other personal needs.
- Coordinate on-call emergency contacts with consumers.

Since its inception and over its several years of operation, Horizon House PATH services have had a primary focus on outreach and case management as priority services and the target populations are the most vulnerable adults who are literally and chronically homeless.

PATH/Coordinated Entry staff are regularly scheduled at the coordinated entry access point, which is co-located with the Connect homeless drop in center. Street outreach and other outreach are conducted periodically as needed.

Literally and chronically homeless individuals are identified as the priority population in the marketing of services through the countywide Homeless Services Coalition/CoC and through information materials provided to referral sources and homeless individuals.

Horizon House currently has office space at The Connect service location, which has been identified as a coordinated entry access point. This enables Horizon House to work alongside of the Connect street outreach and drop in center staff promoting collaboration of services to better reach homeless persons. Case management, the linking and coordination of services to support individual's transition to housing and self-sufficiency, continues to be a priority service for this program.

The program provides street outreach in collaboration with the Homeless Service Coalition semi-annually and responds to requests for direct street outreach whenever individuals in need are identified. The PATH program also utilizes consumers to assist in the street outreach activities.

Delaware County Homeless Services Coalition has a strong collaborative approach to ensuring a continuum of care from street outreach to permanent housing. The PATH program coordinates with all components of the CoC including street outreach to ensure individuals are engaged and connected to services and housing. This includes PATH staff's participation on the HSC Outreach/Crisis Response Committee, which develops and coordinates strategies for effective street outreach. The Horizon House PATH service works with the CoC and Delaware County Office of Behavioral Health and Connect to assess the current street outreach activities and facilitate improvements. We have begun communicating with Philadelphia County's outreach teams to implement a joint outreach in an attempt to connect more homeless persons to services, recognizing that there are many homeless persons traveling between counties.

Overall Services provided through the PATH funding include:

- Outreach
- Screening
- Case management
- Referrals for primary health, job training, educational services, and relevant housing services
- Habilitation/Rehabilitation supports
- Residential Supportive and Supervisory Services

Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services

Horizon House utilizes PATH funds in a manner that leverages other significant funds and resources for PATH client services. PATH funds are used to partially support multiple positions that are members of a Coordinated Entry (outreach) team and a Housing First team. Additional resources are leveraged to fully support the PATH teams and services as well as to leverage additional services and supports for PATH eligible clients. Specific additional resources leveraged include:

- Mental Health Block Grant dollars received to support the PATH services and other homeless services
- HUD funds for Coordinated Entry Services
- Several HUD grants received for housing subsidies and services
- Access to the full CoC resources/services
- Access to other Mental Health Block grant funded services
- Access to MA funded behavioral health and health services
- Access to other mainstream funds/services (i.e. income benefits, nutrition assistance, health benefits)

Gaps that exist in the current service systems

Lack of income due in part to the elimination of general public cash assistance to single individual several years ago, continues to present barriers for homeless individuals to access and maintain housing. It presents challenges for individuals to meet even basic needs such as personal hygiene. This also limits a person's access to transportation, medications, and other supports that may assist in their recovery process. Delaware County Office of Behavioral Health has made funds available to address some of the basic needs but longer term solutions are needed. The PATH service actively works to assist individuals to obtain income benefits. Additional resources are typically needed for the individual during the benefit application and the appeals process.

Also related to lack of income, the lack of employment opportunities and limited employability for participants continues to present challenges, particularly for those who have a criminal background. The CoC has maintained this as a priority area to address.

Shorter life expectancy and co morbidity significantly impact chronically homeless individuals with serious mental illness and requires additional focus and services. We are seeing an increased need for nursing home services for many consumers; however, lack of income and early age are barriers to accessing appropriate housing and services for individuals. The PATH service provides case management and linkages to assist with health care issues.

The program and CoC has been successful in expanding housing opportunities particularly for individuals who meet the chronic homeless definition. For literally homeless individuals with serious mental illness and other significant needs who do not meet the chronic homeless definition, access to housing can be challenging. There have been efforts through the county, OBH and CoC to improve coordination of housing with the intent to improve housing access.

Community Mental Health centers have experienced a shortage in psychiatrists resulting in longer wait times for assessments and access for behavioral health services.

The PATH Team will continue to participate in the county wide Homeless Services Coalition/Continuum of Care to actively address the services, needs, and gaps within the service system.

Brief description of the current services available to clients who have both a serious mental illness and a substance use disorder

The PATH service includes identifying, engaging, assessing, and serving homeless clients with co-occurring serious mental illness and substance use disorders. The PATH services engage clients wherever they are in their recovery. An individual is not required to be abstinent in their substance use or active in D&A/MH treatment to receive PATH services. Horizon House and the PATH service have an effective working relationship with the County Office of Behavioral Health and Magellan Behavioral Health of PA which coordinate and fund MH, D&A, and MISA services. The PATH program staff has access to a range of MH, D&A, and MISA service providers throughout the County including outpatient, inpatient, detox, crisis, rehabilitation, and residential services.

Specialized training on dual diagnosis is available to staff through Delaware County Office of Behavioral Health, Drexel University College of Medicine, Behavioral Healthcare Education, Magellan, Behavioral Health Training and Education Network (BHTEN), Holcomb Behavioral Health and the Pennsylvania Certification Board through Eagleville Hospital. PATH staff has also had the opportunity to receive training via on line trainings offered through SAMSHA and Relias Learning.

Horizon House provides supported housing, mobile psychiatric rehabilitation, ICCD Certified Clubhouse, and ACT services in Delaware County. PATH clients with co-occurring disorders have opportunities to access all agency services as well as other homeless and mainstream behavioral healthcare services. To specifically address issues of opioid overdose, Horizon House ensures that staff have access to Narcan kits and have received training.

The PATH-Housing First component provides TBRA subsidies to the co-occurring population, and there are other subsidies and housing available, which can be accessed.

Services available to all PATH clients include:

- Homeless: PATH/Coordinated Entry, Housing First, Life Skills Training, Out of Poverty, Housing Counseling, 3Rs of Budgeting, Parenting Classes
- Mental Health: Psychiatry, Outpatient, Intensive Outpatient, Mobile Psychiatric Rehabilitation, ICCD Certified Clubhouse, Peer Support Services, Case Management, PACT, Compeer, Vocational Rehabilitation, Crisis Intervention, Inpatient, Residential and MISA Residential, Crisis Residential, ACT, FACT, Peer Warm Line, Delaware County Crisis Connections Team (DCCT)

- Substance Abuse: Prevention, Outpatient, MISA Intensive Outpatient, Intensive Outpatient, Detoxification, Inpatient Rehabilitation, Case Management

Specific integrated services utilized include:

Inpatient/Rehabilitation (Eagleville Hospital, Mirmont, Fairmount Behavioral Health, Keystone, Kirkbride, Brooke Glen Behavioral Health), Outpatient Treatment (Holcomb, Northwestern Human Services, American Day, OMNI, Crozer Chester Medical Center).

How the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data in HMIS

Horizon House and the County ensure that PATH data is collected in the HMIS system. PATH staff and Horizon House IT staff have participated in ongoing county HMIS planning activities. All staff have been trained on the HMIS system. Laptops, printers, and scanners have been purchased to assist staff in utilizing the HMIS system while working in the field. Primary funding for HMIS has been through HUD and the County.

Horizon House provides evidenced based practices in many of the agency services. While the PATH program does not fully implement evidenced based practices in its services, the agency provides and supports evidenced based practices and other training for PATH funded staff.

The PATH program also refers individuals to services, which include evidence-based practices paid for by the Office of Behavioral Health or MCO.

Trainings are provided through Horizon House's training department and Drexel University College of Medicine, Behavioral Healthcare Education, and other training resources. Examples of trainings include: Motivational Interviewing, Language of Recovery, CPI crisis prevention training, ASIST (Applied Suicide Intervention Skills Training), PTSD, DBT, Psychiatric Rehabilitation, and Co-Occurring Disorders.

Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

Horizon House, as an agency, is required to follow 42 CFR Part 2 regulations for Drug and Alcohol services. . There are policies and procedures in place which address these regulations. The Horizon House PATH services do not directly provide substance abuse treatment services. Staff are trained upon hire and annually on all confidentiality requirements. QI staff monitor to ensure compliance.

Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g. jail diversion, active involvement in re-entry), OR specific efforts to minimize the

challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)

Horizon House and the PATH services actively participate in developing, coordinating and/or utilizing a range of options to support individuals with criminal justice histories.

This includes coordination with law enforcement, probation and parole, and Mental Health Court. Horizon House, PATH staff and consumers have also been actively involved in providing CIT (Crisis Intervention Team) Training for police officers throughout Delaware County.

Horizon House provides housing subsidies which are available to individuals with a criminal history. Horizon House has been successful in working with landlords who will lease to individuals with criminal histories. Where individuals are not able to obtain a lease, Master Leased apartments available through Horizon House and other County funded providers are utilized. The program also works to identify employers who will consider individuals with a criminal history. PATH staff may also assist individuals with addressing issues with their criminal record and Legal Aid provides information and assistance with expungement or other actions.

The PATH service has a high percentage of PATH clients with a criminal history and all clients are assisted with access to health, behavioral health, benefits and other community services. The PATH program also utilizes forensic resources available through the County system including Forensic ACT and Forensic Peer Support.

The Office of Behavioral has participated in various inter-system initiatives with criminal justice partners for many years. In 2010, a Cross-System Mapping was held for 45 county stakeholders that identified a number of system gaps, produced priority action steps, and resulted in many of the newest forensic initiatives being proposed and/or developed in the county. The Cross-System Strategic Planning Committee is the entity responsible for tracking intersystem program development and training initiatives. OBH also participates in the Criminal Justice Advisory Committee (CJAC), DelCo Cares initiative, MH Court Planning Team, and also works with the Regional Forensic Liaison on DOC/SCI max-out planning, and with Forensic Liaisons at GW Hill Prison for inmate re-entry planning. All PATH clients with criminal histories can access those programs for which they are eligible. The following lists specific efforts in the County.

Forensic ACT (FACT) Team	The county converted a CTT program to a FACT model with technical assistance from the University of Rochester Medical Center. The Rochester R-FACT model is an evidence-based forensic intervention model that collaborates with the MH Court.
MH Court	The county implemented a new specialty MH Court in FY 13-14 to address the needs of the SMI/justice-involved population. There is a strong working relationship between the criminal justice and behavioral health systems in this new venture.
Forensic Peer Support	The county developed a contract with Peerstar, LLC, to implement a forensic CPS program. This model is both a jail in-reach and community-based peer mentoring model that uses an evidence-based Yale Citizenship approach.
OBH Forensic Specialist	In FY 13-14, OBH hired a dedicated Forensic Specialist to help oversee the myriad of forensic initiatives targeted to the justice-involved population.
Behavioral Health Liaisons	OBH and Adult Probation/Parole jointly fund 4 behavioral health liaisons at the GW Hill prison to coordinate treatment in the prison and in the community at release.
DOC Max-out Tracking	OBH staff, in conjunction with the Regional Forensic Liaison, track and develop release plans for the C and D roster priority max-out cases returning to DelCo.

Data -Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For *providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff.*

PATH data is currently entered into the HMIS system and all staff receive HMIS training upon hire and retraining as needed. The HMIS system is utilized for collecting and recording information as well as a case management tool to coordinate within the Continuum of Care. The County provides ongoing training on the HMIS system.

There is ongoing activity to update the HMIS system to capture all PATH required data. The Delaware County Office of Behavioral Health, Adult and Family Services Division is the organization in charge of HMIS for all providers.

Alignment with PATH goals- Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

"The goal of the PATH program is to reduce or eliminate homelessness for individuals with serious mental illness or co-occurring serious mental illness and substance use disorders who experience homelessness or are at imminent risk of becoming homeless." The Horizon House PATH service provides outreach and assessment to homeless individuals, refers individuals to appropriate CoC/homeless services and provides case management and referral services to assist individuals with serious mental illness or co-occurring disorders to access and utilize mainstream behavioral health services and housing supports. Once housing has been obtained the PATH

service provides case management and other supports to ensure that the person has the skills and supports to maintain the housing and successfully utilize mainstream supports. The majority of individuals supported in housing meet the HUD definition of chronic homelessness.

The Horizon House PATH outreach includes street outreach as well as other locations where homeless individuals may be located. Increasing street outreach remains a goal of the service and overall CoC.

Alignment with State Comprehensive Mental Health Services Plan- Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

PATH services are informed by The State Plan and provide recovery oriented services that are targeted to individuals who have a serious mental illness and who experience homelessness. The services directly assist individuals in moving from homelessness to housing and facilitates individuals' access to mainstream services that promote recovery, successful community living and independence.

Alignment with State Plan to End Homelessness- Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

The Horizon House PATH services are informed by the State Plan and directly address and support the efforts to reduce and eliminate chronic homelessness in the state. The PATH services provide outreach and case management services for the most vulnerable adults who are literally and chronically homeless. The recent State report "Homelessness in Pennsylvania" (April 2016) identifies several recommendations which are addressed by the PATH program in its direct delivery of services as well as in the activities and services facilitated or leveraged through the PATH program. Some of these (from the state report) include:

- Expand cross-training of staff in the behavioral health, housing, and criminal justice systems.
- Promote housing stability as it is a key to long-term recovery.
- Expand permanent supportive housing
- Provide housing with access to treatment and recovery support services
- Facilitate access to the disability income benefit programs administered by the Social Security Administration
- Utilize certified peer specialists and other peer supports
- Increase collaboration and coordination between providers of mental health/substance abuse services, housing authorities
- At the county level, increase collaboration between county behavioral health personnel and CoCs in various areas, including the use of funds.

Through its outreach and case management, the PATH services have been integral in connecting individuals with mainstream behavioral health services and benefits, providing and facilitating access to permanent supportive housing and facilitating increased collaboration across systems.

Horizon House maintains disaster preparedness and emergency planning policies and procedures for all of its services. This includes conducting drills for the purpose of testing emergency response plans and updating as needed. Horizon House will collaborate with the CoC and County to ensure that the disaster preparedness and emergency planning incorporates the unique needs of homeless individuals with behavioral health needs.

Other Designated Funds – Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

Mental Health Block Grant and other funds are designated specifically for people who experience homelessness and have serious mental illness within several services in Horizon House. There are Mental Health Block Grant funds specifically allocated for PATH clients.

Programmatic and Financial Oversight- In cases where the state provides funds through intermediary organization (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

Delaware County OBH provides PATH funds to Horizon House through a contract which stipulates reporting and monitoring requirements. The County also meets with Horizon House on a regular basis for contract monitoring.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system.

One current staff has completed the SOAR Online Course and is available to assist consumers with SSI/SSDI application using the SOAR model. To date the project has not directly completed SOAR applications but rather have utilized trained SOAR staff from other entities. The PATH project in collaboration with the CoC will assess and determine a plan to maximize successful SSI applications including tracking and the role of SOAR.

For the grant year 2016 – 2017, include all of the following data:

The number of staff trained in SOAR

One current staff has completed the SOAR Online Course and all staff have completed the SOAR webinar.

The number of staff who provided assistance with SSI/SSDI applications using the SOAR model

No PATH project staff provided assistance directly using the SOAR model.

The number of consumers assisted through SOAR

No consumers were assisted through SOAR directly by this PATH project. (There were some individuals that were assisted through SOAR by other providers).

Application eligibility results (i.e. approval rate on initial application, average time to approve application)

N/A

The number of staff dedicated to implementing SOAR, part and full time (If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit application (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center)

There is one part time staff trained in SOAR, however, the PATH service has not been utilizing SOAR directly. Frequently, participants have applied for Social Security benefits prior to PATH contact, although they may not have SSI/SSDI benefits at time of assessment or intake. Horizon House has utilized the SOAR trained staff located with other organizations. Those who do not get approved for benefits and wish to appeal the decision are referred to attorneys in Delaware County who specialize in Social Security Disability. In those cases where needed, staff assists individuals with the application process. In 2016 -2017, 27 individuals were assisted by PATH staff in the SSI/SSDI eligibility process and 12 individuals received SSI/SSDI benefits, in addition to non-cash benefits. As indicated above, the project will be reviewing the overall SSI/SSDI application process to determine the best approach to improve assistance and tracking.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Delaware County, through its Continuum of Care, has a broad continuum of housing options available to PATH clients including shelters (individual, family, domestic violence), transitional housing, specialized transitional housing (MH, D&A, Dual Diagnosed, domestic violence, and HIV), Rapid Re-Housing, CRRs, Personal Care Homes (PCH), Specialized PCH (mental health), permanent supported subsidized housing (MH, D&A, dual diagnosed), and a variety of permanent housing resources, including one Shelter Plus Care grants managed by OBH and Horizon House and three Permanent Supported Housing grant funded through HUD and managed by Horizon House. For PATH consumers who are veterans, Delaware County has a housing resource designed specifically for veterans. There is also a resource for independent housing through CYS available to the TAY population.

Horizon House continues to provide and utilize a range of housing services and supports available to PATH-eligible individuals ranging from transitional (Specialized Residence, Community Residential Rehabilitation) to permanent levels of housing (PSH, S+C funded by HUD). The PATH service refers clients to housing services and supports provided through Horizon House and other County agencies, including Delaware County Housing Authority, Community Action Agency of Delaware County (CAADC) and Local Housing Option Team (LHOT). The CoC has also initiated a housing clearinghouse which functions in tandem with the coordinated entry process to facilitate coordinated access to CoC housing.

Once an individual is referred for housing, the PATH Housing First staff assist individuals to locate subsidized apartments using a variety of sources of TBRA funding.. The staff provides ongoing case management, habilitation and rehabilitation, and residential supports for individuals until they are assimilated into mainstream treatment, case management, and rehabilitative mental health and substance abuse services. The key sources of TBRA subsidies come from:

- Shelter Plus Care Programs
- Permanent Supported Housing Programs
- Section 8 Housing Choice Voucher Program
- MH Community Residential Services

Coordinated Entry – Indicate if/how your organization is engage with the local coordinated-entry processes of your CoC. Please also describe the roles of key partners in the CoC.

Horizon House is a provider of Coordinated Entry services and PATH services/staff are integrated within the coordinated entry process. Additionally, all Horizon House homeless services are connected with the coordinated entry process.

The coordinated entry program is governed/monitored through the CoC/Board with support through the Delaware County Division of Adult and Family Services.

The Coordinated Entry system in Delaware County is a decentralized-coordinated system with four entry points located in areas of high need. The CE crisis response process developed for our CoC consists of 4 core components: ACCESS Help; ASSESS the situation, barriers and needs; ASSIGN a solution; and ENSURE stable housing

With HUD funds awarded, the CoC expanded the coordinated entry system adding additional coordinated entry locations and staff, providing full county coverage. The CoC also implemented a modified assessment tool and which fully utilizes the HMIS to permit improved assessment of needs of the homeless population and housing stability planning.

The CoC uses a phased-assessment process with a series of situational assessments tools that allow assessments to occur over time and as necessary. The CoC CE system ensures that everyone who has a housing crisis is comprehensively assessed to determine their housing status and intervention needs in hopes of diverting households from homelessness by developing

stability plans based on their ability to divert from homelessness, the housing barriers, income potential, vulnerability and level of need, housing assistance program eligibility, mainstream resources needs and other service needs. Using up to 6 assessments, helps to uncover the needs of each person and determine the service intervention level for housing, income, education, employment, mental health, drug and alcohol, life skills, legal, children, financial, parenting and health. The assessment and other tools help to determine the best possible path and programming for all households to be permanently and stably housed as quickly as possible. Once a stability plan is developed, case management services are provided for all emergency shelter and transitional housing clients and includes the development of a service plan for each client. Referrals to mainstream resources and the provision of appropriate supportive services for clients in emergency shelter and transitional housing is extremely important. These critical support services such as case management, life skills, money management, parenting, mental health services, D&A services, employment and training, etc. are provided, utilizing a myriad of Federal, State and local funding, to improve participant's ability to achieve self-sufficiency.

Justice Involved – Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

Delaware County has a strong CIT training process and has just completed its 11th class. To date, 302 officers have been successfully trained. Horizon House is actively involved in the planning and presentation of the CIT training, including staff and formerly homeless participants. The CIT has been effective in positively influencing the relationships and interactions of law enforcement with the behavioral health and homeless service systems and individuals within these systems.

Staff Information – Describe the demographics of staff serving the clients

- Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients.
- Discuss the extent to which staff are receptive to differences of clients
- Identify the extent to which staff receive periodic training in cultural competencies and health disparities

The demographics of the PATH staff are as follows:

Race/Ethnicity	Black/African American	71%
	White	29%
Gender	Male	14%
	Female	86%

The staff receives Cultural Competency Training through Horizon House within the first 90 days of hire and annually thereafter. This training helps to sensitize staff to age, gender, disability, lesbian, gay, bisexual, transgender, and racial/ethnic differences of clients. Horizon House has also developed a Cultural Diversity Committee to assess cultural competency within the agency

and identify strategies for improvement. Additional training in cultural competency is available through Horizon House Training Department and other training resources as needed. Through the Delaware County Homeless Services Coalition, PATH also networks with a wide range of homeless service providers who represent the County's diversity. All staff also attended training to increase their skills and knowledge specifically on the LGBT population.

Horizon House, Inc. has successfully worked with individuals with mental illness throughout the local region since 1952, helping individuals to live as independently as possible within the local community. Since the 1980's, Horizon House has helped thousands of homeless individuals with behavioral health needs in Philadelphia and Delaware Counties to regain control over their lives and become contributing members of their community. Through this experience and the training provided, Horizon House has been able to develop a workforce culture and team that is extremely receptive to the differences of clients.

The Delaware County Office of Behavioral Health also addresses Cultural Competency in its planning process. As outlined in the state information: "All 47 County MH/MR Program Offices (through which all MH services are delivered to Commonwealth residents) are required to meet certain planning efforts with regard to cultural competency. These efforts must be outlined annually in their county plan, which is received and reviewed annually at the PA Department of Human Services – Office of Mental Health and Substance Abuse Services (OMHSAS). This includes counties having to demonstrate in their plan what efforts are being made to address seven steps related to cultural competency. Counties must also demonstrate how these steps are being implemented across the access, engagement, service quality, and retention domains. Because all PATH providers are in essence contracted with the county, they too must adhere to state required cultural competency expectations. Please see the state information for details on the seven steps.

Client Information – Describe the demographics of the client population

- Project the number of adult clients to be contacted
- Identify expected number of adult clients to enrolled
- Give estimated percentage of adult clients served using PATH funds to be literally homeless

Current demographic data on the PATH population served is approximately as follows:

Race/Ethnicity:	Black/African American	55%
	White	44%
	Asian	1%
	Hispanic/Latino	1%
Gender:	Male	53%
	Female	47%
Age:	62+	8%
	51-61	33%
	31-50	44%

18-30		15%

Horizon House estimates that 200 clients will be contacted. It is estimated that 100 consumers will be enrolled in PATH funded services in FY 17-18.

We anticipate that 97% of consumers served with PATH funds are projected to be "literally homeless" and 3% will be at imminent risk for homelessness.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses and family members will be *meaningfully* involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See **Appendix I "**Guidelines for Consumer and Family Participation."

Horizon House and its services, including the PATH Program, support and promote the involvement of consumers and family members at the organizational level in the planning, implementation, and evaluation of services, which is reflected in the organization's mission: "Horizon House, in partnership with individuals with disabilities and their families, advocates and provides comprehensive, community-based rehabilitation services to create opportunities for those served to manage their lives through environments emphasizing individual strength and choice."

Employment opportunities are available to consumers throughout Horizon House services and many of the services currently employ consumers. Horizon House Human Resource policies includes consumers in the employee recruitment process when staff vacancies occur, including PATH project positions. In Delaware County, Horizon House employs Certified Peer Specialists that are utilized across all services and are available to provide supports to PATH eligible individuals. All staff receives training both internally and outside of the agency on recovery and overall consumer and family related issues. Horizon House has developed a training on family inclusion, which assists staff in developing skills to improve working with families.

Outreach and assessment with individuals are completely voluntary and those seeking services are informed of the benefits and any possible risks of services as part of their intake. There is also a "Consent" that is signed if individuals are willing to receive services. Consumers receive information on their rights and responsibilities, which is informed by information from the President's Advisory Commission.

Horizon House ensures opportunities for family and consumer involvement in program planning, administration, governance, policy determination, and evaluation of services through committees, focus groups, and satisfaction surveys. The Horizon House Board of Directors actively recruits and includes mental health consumer and family representation and the Board currently includes a formerly homeless consumer. There is also a consumer representative on the Horizon House Quality Improvement and Compliance Committee. There are a number of countywide and agency opportunities for involvement of consumers and family members in the

planning, implementation, and evaluation of the range of mental health and homeless services offered in the county, including PATH funded services. These include:

- Participant Advisory Council, which includes clients of Horizon House/PATH services to provide input and advice to program management including program development, operations, and evaluation.
- The Consumer Satisfaction Team, Inc., which is comprised of consumers who visit services to solicit input from clients for evaluation purposes.
- The Community Support Program, which is an ongoing planning and advisory committee for county mental health services with membership including providers, consumers, and family members.
- The Homeless Services Coalition, which invites and includes participation of consumers in its activities and functions, including the planning and evaluation of services.
- PATH Services focus groups and consumer satisfaction surveys completed by consumer of the services.
- The Recovery Steering Committee also invites and includes participation of consumers in its activities and functions, including the planning and evaluation of services.

A PATH eligible person serves on the HSC/CoC Governing Board for Delaware County.

Also as outlined in the state information:

> "The MH/MR Act of 1966, which governs the provision of MH services in the Commonwealth, requires that County Mental Health/Mental Retardation Program Offices submit to the Department of Public Welfare an annual County Plan in which all of the services to be provided are described. Included in those plans are descriptions of the PATH activities proposed in the 15 County Programs that have been allocated PATH monies. All County MH/MR Programs are required to hold advertised and announced public hearings on their proposed annual plans and document to the Commonwealth the meetings, attendees, and comments they received. Consumers, advocates, and other interested parties attend many of these plan forums in the counties and always have sufficient notice and opportunity to comment. Finally, the PATH activities and proposed uses of PATH funds are described in the documents developed for discussion and approval by the members of the Pennsylvania State Mental Health Planning Council, which has the responsibility of assisting in the development and approval of the Mental Health Services Block Grant application annually. The protocol document for the Planning Council details the requirements that at least 51% of the membership on the planning council be mental health consumers and family members nominated by representative constituent organization".

Health Disparities Impact Statement – Please identify efforts to support the Transition Age Youth (TAY) Disparity population by providing the following:

- The unduplicated number of TAY individuals who are expected to be served using PATH funds - We anticipate providing PATH services to 30 TAY consumers.

- The total amount of PATH funds expected to be expended on services for the TAY population – The project estimates that approximately $35,000 of PATH funds are expected to be expended on services for the TAY population.

- The types of services funded by PATH that are available for TAY individuals - All services provided within the PATH project will be available to TAY individuals, including: outreach, screening, case management, referrals for primary health, job training, educational services, habilitation/rehabilitation supports, and residential supportive and supervisory services.

- A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population- The PATH project intends to increase access, service use, and outcomes for the TAY population through the following activities and strategies which will be data driven and tracked within the HMIS system:

    - **Access**
        - Expand outreach to reach TAY individuals
        - Increase street outreach to locations frequented by TAY individuals
        - Triage calls/contacts of TAY individuals to PATH workers
        - Identify TAY individuals in shelters and homeless day programs
        - Outreach/coordination with agencies serving TAY individuals (i.e., Delaware County CYS, Office of Behavioral Health, Child Guidance, Family and Community Services

    - **Service Use**
        - Increase staff training on TAY issues
        - Increase Peer Support
        - Increase focus on areas of need/preference for TAY population (i.e., employment, education income/benefit, socialization, housing)

    - **Outcomes**
        - Increased employment
        - Increased education
        - Increased benefits/income
        - Increased socialization

- Increased housing

Limited English Proficiency – Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the *HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-titleVI/index.html?language=es.

Horizon House is committed to ensuring that all persons including limited English proficient (LEP) persons have meaningful and equal access to services. In order to ensure effective communication staff will make every effort to ensure communication and understanding for those individuals who are identified as having limited English proficiency. Once an individual has been identified as needing translative or interpretive services staff will contact the corresponding appropriate agency to obtain services and where appropriate and beneficial also refer for equivalent bilingual services as needed or available. The program has access to the County's language line service for persons with limited English proficiency

The program to date has rarely experienced persons with limited English proficiency seeking PATH services. Given the expanded focus of coordinated entry services County wide, and the importance of homeless/housing services, the program will work with the County and CoC to further assess the need for language assistance services informed by the four factor analysis provided in the HHS Guidance.

Budget Narrative – Provide a *descriptive* budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example: $10,000 federal allocation, $3,333 state match, $1000 PATH specific base fund match. SEE SAMPLE Budget matrix below. Please use this table as an example to complete similar information for your organization.

See attached budget.

Horizon House Inc.
PATH Program
FY 2017-2018 Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	PATH TOTAL
PERSONNEL Position				
Director	$115,850	0.01	$1,159	
Program Director	$70,693	0.05	$3,535	
Administrative Manager	$55,584	0.01	$556	
Administrative Assistant	$34,011	0.01	$340	
QI Manager	$46,925	0.01	$469	
QI Specialist	$39,106	0.01	$391	
Team Leader	$54,512	0.24	$13,083	
Behavioral Health Spec.	$29,911	0.40	$11,964	
Nurse	$54,417	0.12	$6,530	
Housing 1st BHS	$32,754	1.11	$36,357	
Clinical Specialist	$52,010	0.04	$1,905	
sub-total				**$76,289**
Fringe Benefits Position				
Director			$272	
Program Director			$831	
Administrative Manager			$131	
Administrative Assistant			$80	
QI Manager			$110	
QI Specialist			$92	
Team Leader			$3,075	
Behavioral Health Spec.			$2,812	
Nurse			$1,535	
Housing 1st BHS			$8,544	
Clinical Specialist			$448	
sub-total				**$17,928**
TRAVEL				
Local Travel for Outreach/Supportive Services			$16,893	
Travel to training and workshops			$2,368	
sub-total				**$19,261**

Occupancy				
Rent			$4,546	
Utilities			$861	
Maintenance			$1,643	
sub-total				**$7,050**
SUPPLIES/EQUIPMENT				
Office Supplies			$974	
Consumer-related items			$1,352	
sub-total				**$2,326**
Communication				
Telephone/Postage			$1,539	
sub-total				**$1,539**
Administrative Expense @ 4%			$4,976	
sub-total				**$4,976**
Total PATH Budget				**$129,369**

Delaware County
Horizon House Inc.
PATH Program
FY 2017-2018 Budget Narrative

Personnel/Positions: (Also see Roster listed on Budget)
PATH Team including Housing First, provides outreach, screening and diagnostic treatment, case management, referrals, habilitation/rehabilitation, and residential supportive and supervisory service.

Fringe Benefits:
@ 23.5% including FICA Tax ($5,836), Health Insurance ($9,308), Retirement ($1,907), Life Insurance ($877)

Travel:
Vehicle lease, insurance, and maintenance and gas/travel expense for client outreach and services
Travel to training/networking meeting and staff training

Occupancy:
Office expenses, rent, utilities, and maintenance for staff/service activities

Supplies:
General office supplies for staff/services
Client welfare emergency needs (food, clothing, medications)

Communication:
Telephone and postage

Administrative Expense:
@ 4%

Funds Allocated for PATH Client Services:
Federal Allocation: $97,027
State Match: $32,342

The PATH program is also funded with additional $187,135 Mental Health base block grant funding.

22. Delaware County - Mental Health Partnerships

7200 Chestnut Street

Upper Darby, PA 19018

Contact: Donna Kueny

Contact Phone #: 2675073898

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID: PA-062

State Provider ID: 4262

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Mental Health Partnerships will receive a total of $46,523 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 110

Estimated Number of Persons to be Enrolled: 20

Estimated Number of Persons to be Contacted who are Literally Homeless: 110

Number staff trained in SOAR in grant year ending in 2017: 5

Number of PATH-funded consumers assisted through SOAR: 0

Mental Health Partnerships PATH Program
7200 Chestnut Street, Upper Darby, PA 19082

PATH Intended Use Plan
Delaware County, Pennsylvania
2017-2018

<u>Local Provider Description</u> - Provide a brief description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization and region served and the amount of PATH funds the organization will receive.

The Mental Health Partnerships (MHP), previously known as the Mental Health Association of Southeastern Pennsylvania, is a nonprofit corporation that creates opportunities for individuals and family members to effectively respond to the challenges of mental health conditions through work in five domains: advocacy, direct support to individuals, training and education, information and referral, and statewide as well as national technical assistance technical assistance on developing peer-run services. MHP is active in all five counties of the Southeastern Pennsylvania region: Philadelphia, Chester, Montgomery, Bucks and Delaware Counties.

MHP was initially founded in 1951 as the Mental Health Association of Southeastern Pennsylvania. For almost six decades, MHP has been organizing, educating, and advocating for the rights of people with mental health and co-occurring substance use challenges. During that time, MHP has grown to become one of the largest of Mental Health America's more than 300 affiliates. The agency manages an annual budget in excess of $17 million and operates over 40 programs supported by 270 employees. Consumers of services and family members are extensively involved in MHP operations as board members, employees, and volunteers. The involvement of consumers and family members in all operational roles gives MHP a unique perspective and authority. Since the 1980s, MHP has been a catalyst in creating behavioral health policy that supports recovery, self-determination, community inclusion and integration. MHP has the proven expertise in the field of recovery services and education to conduct the proposed project in a successful manner.

In Delaware County MHP operates the Connect and SHARE Recovery Learning Center which provides a safe place for homeless persons to access services and supports for recovery from mental illness and substance abuse disorders, while looking for appropriate housing resources. Connect and SHARE operate a twenty-four hour haven from the streets with the assistance of our night shelter program, Connect by Night. This

emergency mobile shelter program partners with Delaware County faith communities to offer shelter from the streets, up to 50 or more people every night of the year.

The primary geographic focus of the MHP PATH project is Upper Darby, Delaware County. Upper Darby is a border community of West Philadelphia that is in transition from suburban demographics to demographics that reflect the more diverse economic, social, and racial population common to an urban profile. The location of a major Southeast Pennsylvania Transportation Authority (SEPTA) transportation facility in Upper Darby, has been a magnet for people who are homeless and living on the street for over 20 years. The SEPTA facility provides a modicum of shelter and safety that attracts homeless people from Upper Darby, from other low-income communities in Eastern Delaware County, and from the bordering city of Philadelphia.

The Connect PATH Program funds a full time street outreach worker who is required to have a certified peer specialist credential. This outreach worker partners with our other staff to engage hard to reach homeless people in Upper Darby and other Delaware County communities, which includes the SEPTA Transit facility.

The total amount of PATH funds, Federal and State, to be allocated to the Connect PATH program is $46,523 ($34,892 Federal and $11,631 State). Federal and State Provider name appears as Mental Health Association of SEPA in PDX.

<u>Collaboration with HUD Continuum of Care Program</u> - Describe the organization's participation in the HUD Continuum of Care recipient(s) and other local planning activities, and program coordination initiatives such as coordinated entry and coordinated assessment activities.

Connect's low barrier to entry and progressive demand structure make the program an essential entry point and safety net for Delaware County's homeless services and the continuum of care. Connect regularly receives referrals from other service providers around the county when they are unable to respond to someone in need, including referrals from the Domestic Abuse Project when their shelter services are full.

The Delaware County Continuum of Care has undertaken a major reorganization of the Homeless Services Coalition. Connect staff people (including the PATH funded outreach specialist) are becoming active on many of the continuum's new subcommittees, including:

- Outreach & Crisis Response
- Housing Access and Stability
- Economic Stability
- Individual Services

- Information Clearinghouse

In addition to committee work undertaken by Connect staff, the Division Director serves on the Continuum of Care's Governance Board.

Our staff persons have also contributed to the county's initiative to provide Crisis Intervention Team (CIT) training to police departments across Delaware County by coordinating a sub-committee to develop a module on engagement with and services for homeless persons with mental health and substance abuse disorders. Staff also participates in the Delaware County Systems of Care training which provides a comprehensive overview of available county resources.

The PA-502 Delaware County CoC has implemented a Coordinated Entry system in January of 2017 and MHA has been partnering with the county and Horizon House Inc. to ensure coordinated entry assessments are completed on all homeless individuals entering the Connect site or engaged through street outreach.

<u>Collaboration with Local Community Organizations</u> - Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH eligible clients and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

The staff of Connect (including the PATH funded CPS certified Outreach Specialist) maintain many relationships with other community providers to offer essential services to PATH eligible program participants. ChesPenn's Healthcare for the Homeless program comes to our site once a week to provide basic medical care and referral services. We also have an affiliation with ChesPenn's primary care practice. Connect staff works closely with case management services from Northwestern Human Services, Mercy Fitzgerald Hospital and Community Hospital, to connect eligible individuals for targeted case management services. We cooperate with Horizon House's EASR-PATH team to better serve the hard to reach, as well as other Horizon House programs for housing opportunities. Our staff refer people to Holcomb Behavioral Health and other providers for substance abuse treatment. We refer to CareerLink for vocational training, resume writing and job placement. Case Managers also work closely with the Domestic Abuse Project to provide services to those fleeing from domestic abuse and assist in securing safe housing. When we encounter people in crisis we ask for assistance from Project Reach/Holcomb Behavioral Health System, a mobile crisis team that provides 24 hour response, and assists with assessment and crisis management. Veterans are immediately referred to the VA outreach for eligibility assessment and placement.

<u>Service Provision</u> - Describe the organization's plan to provide coordinated and comprehensive services to PATH eligible clients, including:

- **How the services to be provided using PATH funds with align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless**

Connect PATH services are targeted to people who are literally homeless and sleeping in the street or other places unfit for human habitation. The service is designed to build relationships with the hardest to reach homeless people and ease their reconnection to services and supports necessary to move from homelessness to housing. The CPS/Outreach Specialist is at the center of this effort.

The CPS/Outreach Specialist partners with three Connect Recovery Workers to conduct outreach and engagement services targeted to hard-to-reach individuals who are homeless in the Upper Darby area and throughout Delaware County. The CPS/Outreach Specialist works with a different Recovery Worker each day of the week to conduct eight hours of outreach and engagement services. A two-person Connect/PATH team (the CPS/Outreach Specialist and one Recovery Worker) will be on the streets three days per week – this has doubled the amount of hours that Connect devotes to outreach and engagement. The Connect/PATH team visits sites in the area where hard-to-reach individuals who are homeless are known to congregate. Examples of these sites include the SEPTA transportation facility, local coffee shops, pool halls, the local libraries and shopping centers, area parking lots, the nightly dinner program at the Life Center (permanent shelter facility), the Connect day-time service facility, and homeless camps located in wooded areas and other secluded sites in and around Upper Darby.

The role of the CPS/Outreach Specialist is to establish a consistent presence among the hard-to-reach homeless community and to build trust through nurturing a peer-to-peer relationship with each homeless individual in the target population. The role of the Recovery Worker is to support the CPS/Outreach Specialist in the outreach and engagement process and to develop their own ongoing relationships with the individuals who are homeless in the target population. The CPS/Outreach Specialist is the primary contact with the hard-to-reach individuals who are homeless during the engagement process. The ultimate goal is to connect individuals who are homeless to the ongoing services provided by the Recovery Worker. The collaborative staff relationship between the CPS/Outreach Specialist and the Recovery Worker is a key factor in achieving the final outcome.

The design of the Connect/PATH team approach is to facilitate a step-by-step process that patiently engages and wins the trust of individuals who are homeless. The

Connect/PATH program is carried out in four distinct stages: 1) Identification and contact with a hard-to-reach homeless individual; 2) Development of a trusting, peer-to-peer relationship between the CPS/Outreach Specialist and the homeless individual; 3) Facilitation of an engagement process that involves a self-directed connection of the homeless individual to services; and 4) Ongoing connection to shelter, housing, and supportive services.

- **Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services**

MHP maximizes the use of PATH funds by providing the following services:

- Outreach
- Case Management
- Referrals for medical, mental health and substance abuse treatment
- Referrals to appropriate housing
- Crisis intervention
- Providing training for local law enforcement around the issues of homelessness, mental illness and substance abuse

- **Gaps that exist in the current service system**

The gaps in the current service system include:

- Insufficient numbers of housing opportunities and the long time on waiting lists with which people contend.
- Lack of Housing First slots for people who aren't ready to make a firm commitment to abstinence from drugs and alcohol.
- Insufficient supports and lack of discharge planning for people post discharge from drug and alcohol inpatient treatment. Many who have had some inpatient treatment must return to Connect, which is not well-equipped to support the sobriety of people new to recovery from drugs and alcohol. Connect does support the individual in attending local 12 step meetings for abstinence and encourages rehabilitation in the case of relapse.

- **Brief description of current services available to clients who have both a serious mental illness and a substance abuse disorder**

PATH eligible participants in Connect's services are able to access a variety of services for co-occurring disorders in the county and the region. Through effective

working relationships with the County's Office of Behavioral Health and Magellan, our staff assist participants with accessing appropriate services and supports. Staff are familiar with an array of services providing inpatient and outpatient treatment, detox, crisis, and rehabilitation services. We have a useful referral relationship with Northwestern Human Services and Holcomb Behavioral Health for dual diagnosis treatment and a relationship with Omni Services.

- **How the local provider agency pays for providers or otherwise supports evidenced based practices, trainings for local PATH funded staff, and trainings and activities to support collection of PATH data in HMIS**

  MHP is involved in a recovery transformation at all levels of its operation. This transformation is based upon the evidence based practices of peer support and peer run services. MHP has completed a long process whereby we examined all levels of our organization with a view toward fully integrating the principles of peer support and recovery into our day to day operations. Our new vision and mission statements are to be our guide posts for all subsequent program development and operations.

  All of our staff people receive an annual cycle of trainings that include first aid, infectious disease control, suicide prevention, LGBTQ, Mandated Reporter, Fair Housing Practices and many other topics. MHP has also developed an internal workplace skills curriculum which includes training in communication, ethics, boundaries, crisis management, documentation and burnout prevention open to all staff. Our staff persons also make use of training opportunities made available by the county and other training resources around the region.

  With regard to HMIS training, we work closely with the HMIS subcommittee to see that all staff persons with database responsibilities are adequately trained on the database with periodic refreshers to familiarize them with the improvements to the database. The current HMIS system was recently reconstructed to better meet the needs of the providers and a comprehensive training was provided to all staff in February 2017.

- **Provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If so, explain your system to ensure those regulations are followed.**

  MHP is required to follow 42 CFR Part 2 regulations. The agency ensures that these regulations are followed through the oversight of the Compliance Director to ensure all information both written and electronic records are safeguarded and

meets all HIPAA requirements. The agency also completes annual releases of information for all participants receiving services. Each release of information contains the following information to ensure that the person signing understands that his/her information is protected.

I understand that my records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

I have been informed of my rights to:

1) *Revoke permission at any time. This authorization is subject to revocation at any time, except to the extent that action has been taken to reliance on the authorization;*
2) *Inspect and receive a copy of the material to be released;*
3) *Request restrictions on how my health information is used and disclosed; and*
4) *Receive a copy of this authorization and the Notice of Privacy Practices*

MHP employees receive HIPAA training annually and the Director of Compliance monitors and addresses any violations in these areas.

- **Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g. jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in re-entry)**

The CPS/Outreach Specialist works to support the challenges faced by PATH clients with criminal histories in the following ways:

- Clients often arrive from prison without any documentation which is a critical part for reintegration back into the community. The CPS/Outreach Specialist connects the individual to the appropriate agencies so that they

can secure documents such as a birth certificate, Driver's license, state ID and social security card. Without these documents it becomes extremely difficult for individuals to reestablish their identity in the world.

The CPS/Outreach Specialist also links the client to resources for employment and housing

which includes the following agencies:

- Employment: Work/Labor Ready, The Minds of Men, and Career Link
- Housing: Rapid Rehousing Program, Permanent Supportive Housing, Community Action Agency and the Office of Behavioral Health.

Data - Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For providers who are fully utilizing HMIS describe plans for continued training and how providers will support new staff.

All PATH services at Connect are tracked on the county's HMIS system. Engagement and participant outreach encounters are tracked through encounter forms which are used to collect data about each outreach encounter including location of the encounter, basic demographics, shelter placements and other services.

All PATH and Connect staff have been trained in February 2017 in the recently upgraded version of HMIS operations to learn how the HMIS network will be integrated to provide a more comprehensive system of reporting and increase the resources available to PATH participants. The PATH CPS/Outreach Specialist regularly attends the state wide PATH conference held at Penn State. This year's conference is scheduled for 6/13/17-6/15/17. Any new staff will be fully trained in the HMIS system. Greg Coelho is the HMIS Director who is responsible for changing the computer code.

Alignment with PATH goals - Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Outreach and case management are the core services provided by the Connect PATH CPS/Outreach Specialist. Participants who are less likely to access daytime services at our shelter are assigned to the Connect PATH Outreach Specialist. These assignments are made in order to maintain contact on the street, continue relationship building, and encourage the hardest to reach participants to access services with more consistency.

The Connect PATH CPS/Outreach Specialist and our other outreach staff will develop an outreach target list to identify men and women who are most resistant to services in order to facilitate consistent responses and keep track of any progress made in responding to their needs. This year the PATH Outreach Specialist was successful in engaging and successfully bringing in several participants who were living in a parking lot that was set for demolition.

During the upcoming program year the Connect PATH CPS/Outreach Specialist will make referrals from among her assigned participants to a Peer Support program affiliated with the MHP to offer additional supports available from this evidence based practice.

<u>Alignment with State Mental Health Services Plan</u> – describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

PATH services provided are consistent with the PA Mental Health State Plan to end homelessness and reduce /eliminate chronic homelessness by providing services with outreach, case management, crisis intervention and by collaborating with other providers to provide a holistic system of care. By partnering with other providers, the PATH CPS/Outreach Specialist is able to address the needs of each individual whether they have been a victim of domestic abuse, have been diagnosed with a co-occurring disorder, were formerly incarcerated or a homeless veteran. The PATH CPS/Outreach Specialist works with the client to complete all necessary application processes, while providing trauma informed care to combat the effects of trauma, which is necessary to combat recidivism. With the addition of the CoC's Coordinated Entry system, staff are able to work quickly to identify the needs of a homeless individual, and develop solutions to any barriers in place so that stable housing and any needed services can be quickly obtained. MHP also provides on-going training in many areas such as Mental Health First Aid, Suicide Prevention, and Trauma Informed Care, to both educate staff and reduce the stigma of mental illness which often prevents a person from reaching out for help.

<u>Alignment with State Plan to end Homelessness</u> – Describe how the services to be provided using PATH funds are consistent with the State Plan to end homelessness. Describe how the PATH Program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH Program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

PATH funds will allow for the program to target the most vulnerable chronically homeless people who are sleeping in the streets or residing in places not fit for human habitation. The CPS/Outreach Specialist will conduct outreach and engagement services

targeted to the most vulnerable and hard-to-reach individuals. The PATH CPS/Outreach Specialist works collaboratively with local law enforcement and SEPTA Transit Officers to identify homeless clients who are residing on the streets, in places not fit for human habitation, and in the transit terminal, to provide outreach and engagement. Law enforcement has the ability to call a dedicated outreach phone line, which results in the PATH worker being dispatched immediately to meet with the homeless individual. By engaging and building a trusting relationship with these individuals, the PATH CPS/Outreach Specialist will then seek to provide the supports necessary to reconnect the individual to the services needed to move from homelessness to a more stable housing environment.

Emergency response plans are in place for severe weather, fire safety and evacuation of the site. For severe weather, if a "code blue" is issued, every possible resource is utilized to ensure no one is on the streets. This includes collaborating with additional area shelters, utilizing an existing agreement with a back-up church shelter to serve additional people, and/or sheltering in place at the Connect site in the event roads are impassable or dangerous. Emergency food provisions are put in place prior to the event.

With respect to fire safety and evacuations, regular fire drills are conducted the Connect site and monthly fire drills are conducted at the church sites. Fire extinguishers are regulated and tested. Emergency notification flyers are posted throughout the site with the number to call in the event of an emergency. A Safety Committee has been established to oversee and assess the systems in place. The PATH program has also established an emergency outreach response line with a dedicated number that the county, police or local community can utilize to report homeless individuals in need of support.

<u>Other Designated Funds</u> – Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked For PATH services specifically.

All PATH funding received is designated solely to providing services for PATH eligible participants who are experiencing both homelessness and serious mental illness. There are no other funds earmarked for PATH services specifically.

<u>Programmatic and Financial Oversight</u> – in cases where the state provides funding through intermediary organizations (i.e. county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

MHP submits detailed monthly and quarterly reporting with appropriate backup for expenditures. Annually, MHP submits its annual financial audit to the county. The audit is performed by Tait Weller, an independent accounting firm.

<u>SSI/SSDI Outreach, Access, Recovery (SOAR)</u> – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking system (OAT) For grant year 2016-2017, include all the following data:

- **The number of staff trained in SOAR**
- **The number of staff who provided assistance with SSI/SSDI applications using the SOAR model:**
- **The number of consumer assisted through SOAR**
- **Application eligibility results (i.e., approval rate on initial application, average time to approve the application)**
- **The number of staff dedicated to implementing SOAR, part and full time. (if the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and outcomes of those applications (i.e. approval rate on initial application, average time to approve application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHA SOAR TA Center.**

Approximately 5 staff were trained in SOAR previously, but not from the online course. The PATH CPS/Outreach Specialist is not currently using SOAR but assists all PATH participants to apply for all mainstream benefits for which they are eligible, but may not be receiving.

Last year MHP was awarded a SAMSHA CABHI Enhancement grant to provide outreach to Homeless individuals with SMI and co-occurring disorders using a CPS team, supported by a SOAR Attorney, Nurse, Wellness Director and Vocational Specialist in Delaware and Bucks Counties. The program was a year-long opportunity to work towards more integrated health/recovery services to homeless people in the county.

In April of 2017, MHP in collaboration with the CoC, submitted a grant application to SAMHSA for the benefit of homeless individuals (GBHI) to provide SOAR services to provide critical services needed for individuals experiencing homelessness.

<u>Housing</u> - Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e. indicate the type of housing provided and the name of the agency.

Our staff persons work with participants to access the entire range of housing options maintained by Delaware County. Agencies within this group include the Delaware County Housing Authority, Delaware County Office of Services for the Aging (COSA), the VA in Coatesville, PA, Horizon House Inc, and local landlords within the community.

Our staff are also familiar with other housing options available with Delaware County's continuum of care which include: shelters (including specialized domestic abuse and family programs), transitional housing (including specialized housing for MH, D&A, Dual diagnosis, domestic violence and HIV), CRRs, and personal care homes.

Coordinated Entry – Indicate if/how your organization is engaged with the local coordinated entry processes of your CoC. Please also describe the roles of key partners in the CoC.

The PA-502 Delaware County CoC s has implemented a CE system and the Mental Health Association is a partner in that program. The CE Program is monitored and governed by the Delaware County CoC. The process begins with a coordinated entry assessment that gathers all relevant participant information, scores the application based on criteria, then makes recommendations to the housing placement best suited to the individual. There are 5 main components to this process which include the following:

1. Establish locations where the individual can access help
2. Conduct an assessment to assess the situation, gather general information, assess current situation, vulnerabilities and housing barriers
3. Assign a solution by developing an "Immediate Needs Plan" to identify and address what is needed for housing stability and what are the housing barriers
4. Implement a solution by connecting the individual to resources to address the barriers, complete all service plan immediate needs previously identified, gather the documentation of eligibility and connect to the appropriate housing program
5. Ensure stable housing by providing a safety net plan, proper discharge planning, assistance with budgeting and money management, follow up and provide adequate resources the individual may need once they are reintegrated back into the community.

Key partners include the CoC, and Horizon House Inc. who was appointed by the county to conduct all CE assessments for MHP. Horizon House staff works to quickly identify the needs of a homeless individual, and develop solutions to any barriers in place so that stable housing can be obtained. Information is then communicated to Connect, who

works with the client on his/her housing stability plan. Both Horizon House and MHP meet monthly with the CoC to discuss the disposition of all clients being served.

<u>Justice Involved</u> – Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please indicate approximate % of law enforcement that has been CIT trained and any feedback of effectiveness.

CIT training is provided annually in Delaware County and the PATH worker participates in the curriculum to educate law enforcement about the challenges and barriers homeless individuals face and ways to assist and support these individuals. This year in Delaware County approximately 80 law enforcement officers participated in the training. The PATH and Connect Programs have found this training to be highly effective as program staff now work collaboratively with local law enforcement to assist homeless individuals to come in off the streets into shelter and begin the process of applying for the services necessary to rebuild their lives.

<u>Staff Information</u> - Describe the demographics of staff serving the clients; explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay bisexual and transgendered, racial/ethnic, and differences of clients. Discuss the extent to which staff are receptive to clients; identify the extent to which staff receive periodic training in cultural competence and health disparities.

Demographics of all Connect Staff:

Race/Ethnicity:	Black/African American:	90%
	White:	10%
Gender:	Male:	25%
	Female:	75%
Age:	62+:	10%
	51-61:	20%
	31-50:	60%
	18-30:	10%

All our services are available to homeless men and women who are residents of Delaware County regardless of race, ethnicity, gender, LGBTQ and age. The PATH-funded fulltime CPS/Outreach Specialist is an African American female in her 40's with a Certified Peer Specialist credential.

The staff of MHP's Delaware County homeless services is sensitive to the racial/ethnic diversity of the program participants and receives cultural sensitivity training at the time of hire and annually thereafter. Although we do not have bilingual persons on our program staff, we are able to call upon other MHP staff for assistance with translation and interpreting when necessary. All staff receive training in Cultural Diversity, LGBTQ, Equal Access to Housing and Trauma Informed Care annually.

Client Information - Describe the demographics of the client population, project the number of adult clients to be contacted, identify expected number of adult clients to be served, give estimated percentage of adult clients served using PATH funds to be literally homeless.

Race/Ethnicity:	Black/African American:	15%
	White:	85%
	Hispanic/Latino	0%
	Asian:	0%
Gender:	Male:	65%
	Female:	35%
Age:	62+:	0%
	51-61:	43%
	31-50:	43%
	18-30:	14%

One hundred percent of the adult clients served using PATH funds are literally homeless.

MHP estimates that 110+ people will be engaged and 20 enrolled in PATH services in the coming program year.

Consumer Involvement - Describe how individuals who are homeless and have serious mental illnesses and family members will be meaningfully involved at the organizational level in the planning, implementation and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards

Consumer and family member involvement are central to the recovery transformation that MHP is currently undergoing. MHP has developed a new vision statement and a new mission statement

- **MHP's Vision Statement:** Individuals challenged by mental health conditions are empowered to direct their recovery journeys, and family members are prepared to play supportive roles, all as members of informed and inclusive communities.
- **MHP's Mission Statement:** To promote groundbreaking ideas and create opportunities for resilience and recovery by applying the knowledge learned from the people we support, employ, and engage in transformative partnerships.

At Connect we are putting these values into operation in our day to day services. Connect holds a monthly community check in meeting which is open to all participants and staff. The community check in meeting is the forum for discussing and processing all proposed changes in program policy or procedure. The community meeting is also the forum for problem solving for community issues that arise from many people living together under crowded circumstances. Representatives for a Participant Advisory Committee are chosen from the community meeting to meet regularly to develop programming ideas, propose revisions to policy and procedure and help to set the direction for program decisions. Consumer Satisfaction Teams also visits on a quarterly basis to ensure the quality of services and Connect also has a suggestion box on site for those who may not be comfortable participating in a large group.

MHP is at the forefront of including individuals who have lived experience as consumers of mental health services as employees, board members and volunteers. Of our 270 staff people, 60% have lived experience as a consumer of mental health services or a family member.

<u>Health Disparities Impact Statement</u> – Please identify efforts to support Transitioned Age Youth (TAY) disparity population by providing the following; unduplicated number of TAY who are expected to be served using PATH funds; total amount of funds to be expended for the TAY population; types of services funded by PATH that are available for TAY individuals; a data driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population.

This year the CPS/Outreach Specialist encountered 4 transitional aged youth who presented at the shelter for services. No funds have been expended for this population. In the past, the CPS/Outreach Specialist encountered youth on a very rare basis, and the individual was provided with immediate assistance and then referred to services with Covenant House PA, who serve runaway, homeless, and trafficked youth, throughout the Philadelphia Metropolitan area.

<u>Limited English Proficiency</u>- Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the *HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, available at*:https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.

It is our responsibility to ensure that all eligible persons with disabilities have meaningful and equal access to services. This responsibility encompasses the most basic of human needs, the need for communication and understanding.

To ensure effective communication, staff will make every effort to ensure communication and understanding for those participants or their immediate families who are identified as having Limited English Proficiency (LEP).

In addition, the public offices have been equipped with universal symbols for bathrooms, exits and water fountains.

Once participants or his/her family have been identified as needing translation of interpretive services, staff will contact the corresponding appropriate agency.

This policy is applicable to all programs of MHP, including but not limited to Philadelphia, Bucks, Montgomery, Chester and Delaware Counties, as well as services provided in the state of Delaware, and other jurisdictions.

MHP BUDGET
PA-602: Delaware County
PATH Program
FY 2017-2018 Budget

	Annual Salary	PATH-funded FTE	PATH-funded
Position			
Outreach Liaison (Certified Peer Specialists)	$28,562	1.0 FTE	$28,562
sub-total			$28,562
Fringe Benefits – 36% of salary			
Outreach Liaison (Certified Peer Specialists)			$10,282
sub-total			$10,282
Travel			
sub-total			$0
Supplies/Equipment			
Consumer-related items			$1,250
sub-total			$1,250
Other			
Staff training			$475
Other			$4,093
sub-total			$4,568
Admin – 4% of Direct			
Sub-total			$1,861
Total PATH Budget			**$46,523**

Connect PATH Program
FY 2017-2018 Budget Narrative

Personnel:
Funding of $28,562 is being requested to provide for the full-time salary, 100% time, of an Outreach Liaison (Certified Peer Specialist). This position will be located at Mental Health Partnerships, whose work concentration is to provide mental health and housing resources for homeless or at imminent risk of homelessness persons with serious mental illness. Total request for salaries is $28,562.

Fringe Benefits:
Funding of $10,282 is being requested to provide for the full-time fringe benefits of an Outreach Liaison (Certified Peer Specialist). Fringe benefits include the following costs: FICA at $2,185, unemployment insurance at $1,157, retirement at $943, life insurance, disability and health insurance at $5,997. Total request for fringe benefits is $10,282.

Travel:
Total travel request: $0.00.

Supplies:
Funding of $1,250 is being requested to provide for participant related outreach items that are an immediate need.

Total supplies/equipment request: $1250.00.

Other:
Funding of $475 is being requested to provide for staff training. Staff training costs include both live training and a seat in Relias, an online training tool.
Funding of $4,093 is being requested for other costs. Other costs include the annual PATH conference, rent, utilities and telephone.

Total request for other expenses: $4,568.00.

Administrative:
Funding of $1,861 is being requested at the allowable rate of 4.00%.

Total request for administrative expenses: $1,861.00.

Federal Allocation: $34,892
State Match: $11,631
The Connect PATH program is also funded with additional $22,856 Mental Health base block grant funding.

23. Erie County - Erie County Care Management

1601 Sassafras Street

Erie, PA 16502

Contact: Sheila Silman

Contact Phone #: 8145280727

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-066

State Provider ID: 4266

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 90,821	$ 30,274	$ 121,095	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 90,821	$ 30,274	$ 121,095	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 90,821	$ 30,274	$ 121,095	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 90,821	$ 30,274	$ 121,095	

Source(s) of Match Dollars for State Funds:

Erie Co will receive a total of $111,307 total in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 150

Estimated Number of Persons to be Enrolled: 125

Estimated Number of Persons to be Contacted who are Literally Homeless: 105

Number staff trained in SOAR in grant year ending in 2017: 2

Number of PATH-funded consumers assisted through SOAR: 0

Erie County Mental Health/Intellectual Disabilities (Erie County MH/ID)
Erie County Care Management, Inc. (ECCM)
PATH IUP 2017-2018

1. Local Provider Description:

Provider name as it appears in PDX:
Erie County Care Management, Inc.
Non-profit 501 (c) 3 Corporations
1601 Sassafras Street
Erie County, PA 16501

Erie County Care Management, Inc., a private not-for-profit organization, was established in June 2006 by an act of Erie County Council as a conflict-free care management entity, serving the behavioral health and intellectual disabilities systems in Erie County to provide for Mental Health Administrative Case Management, Intellectual Disabilities, and Early Intervention Service Coordination. A primary focus for the organization is to promote the integration of community services into a seamless system of care for any child or adult in need of services. Funding is received from Federal, State, Erie County and other sources. ECCM serves all Erie County residents by offering appropriate options for service, based on individual choice, from the Erie County Continuum of Care.

Mission Statement
Erie County Care Management, Inc. (ECCM) provides case management and other support services to Erie County's behavioral health, intellectual disabilities, and other human service consumers. By offering local support that assures access, ECCM ensures that care decisions are consumer-based and individualized, offering comprehensive, holistic care that fosters independence.

ECCM's Homeless Case Management Team is part of the Administrative Case Management Division (the Mental Health Base Service Unit) which provides intake for persons with serious mental illness into the County mental health system and works to insure availability and timely, prioritized access to resources.

While basic services are provided to all persons who have a mental health diagnosis, Administrative Case Management's most intensive activities are often conducted with persons who meet the criterion for the State Priority Groups which are defined as adults who meet the threshold for Serious Mental Illness (SMI) and children who meet the threshold for Serious Emotional Disturbance (SED). This definition is referenced directly in the Commonwealth of Pennsylvania, Department of Public Welfare's Mental Health Bulletin of March 4, 1994, Serious Mental Illness: Adult Priority Group.

Specialized focus is directed toward individuals who are self-reported, or otherwise identified, as homeless, veterans, dually diagnosed, forensic, or families with children.

Administrative Case Management activities are organized according to the following functions: Identification and engagement on-site at a variety of sites (prisons, temporary shelters, consumer centers, nursing homes, schools, etc.) with professionals and consumers in order to identify those in need of service and encourage their participation, as well as mental health holistic assessment and service planning, referral/linkage to appropriate services and consultation and community education regarding special populations as described above.

Indicate the amount of federal PATH funds the organization will receive.

- The amount of PATH funding for FY 2017-2018 Total = $121,095
- Federal Funds = $90,821
- State Funds = $30,274 *Block Grant County

2. <u>Collaboration with HUD Continuum of Care Program</u>:

Erie County Care Management is a long-standing member of the HOME Team which is part of the Erie County Continuum of Care (PA-605 Erie City-County). The mission of the HOME Team is to plan and implement housing and support services for homeless individuals and families in Erie County. In addition to the Executive Committee, the HOME Team has six (6) subcommittees which include Children and Youth, GAPS, Information, Education and Outreach, Membership and Housing. Home Team meetings are held every other month or six (6) times a year. Erie County Care Management also participates on the housing sub-committee which is held every other month or six (6) times a year. Meetings are held to discuss the work of the subcommittees and to bring forward any emerging critical needs of the homeless in our community. Erie County Care Management participates annually in the Single Point in Time (SPIT) survey which documents the housing and support needs of the homeless; including the chronic homeless. Erie County Care Management also participates in the Local Housing Option Team (LHOT) whose mission is to facilitate the development of permanent housing for persons with disabilities.

Erie County Care Management works collaboratively with other mental health care providers such as Lakeshore Community Services, Safe Harbor Behavioral Health, St. Vincent Hospital, Millcreek Community Hospital, Erie Veteran's Medical Center, Corry Counseling, Barber National Institute, and Stairways Behavioral Health to ensure that mental health care and other related services are well coordinated and provided in a timely manner.

Drug and alcohol services, both inpatient and outpatient, are provided by a number of community agencies. Erie County Care Management will assist an individual experiencing homelessness in accessing services at Millcreek Community Hospital, Crossroads/Gaudenzia, Pyramid, Deerfield Behavioral Health, Stairways Dual Diagnosis Unit, and/or Gateway through the Erie County Office of Drug and Alcohol Abuse (Single County Authority).

Coordination with the organizations referenced above occurs at a number of different levels depending on the specific circumstances. Erie County Care Management has established and maintained very strong working relationships with community agencies and their representatives to make accessing services as simple and as efficient as possible for our consumers. Other

services listed above, such as substance abuse treatment, may require a specific application and/or admission process. In such cases, the homeless case management team works closely with individuals experiencing problems with substance abuse to help them complete and submit any information necessary to secure services or resources. As much as possible, staff provides support and advocacy to consumers so that they can effectively learn to navigate the various community systems independently over time. Regardless of the service or resource needed, however, Erie County Care Management's staff is capable and competent to assist consumers with case management and service coordination activities through effective networking with community agencies. Any individual experiencing difficulty accessing services of any type is always welcome to contact ECCM staff for "whatever it takes" support.

Additionally, ECCM has a unique role in Erie County, as it serves as the enrollment and intake point for the County's Intellectual Disabilities and Early Intervention Services, as well as for any County-funded Mental Health programming. With the ability to interface internally with the service coordinators of both the Intellectual Disabilities and Early Intervention Service programs, the Mental Health Administrative Case Management Staff of ECCM are in the distinctive role of offering easy access and collaboration, for resource support and consultation, to the individuals served through these other systems. A dedicated program through the Intellectual Disabilities system, Specialized Probation Services, focuses on serving individuals with an IQ below 70 who are involved in the criminal justice system. These individuals often find homelessness an obstacle to community living. The opportunity for internal interface at ECCM between systems is a rare support, as staff brainstorm creative solutions to challenges to independent living.

ECCM provides psychiatric consultation to staff on an as needed and scheduled bi-weekly basis to offer education and support regarding consumer special needs. Such educational individualized access increases staff success in engagement and service access review for those we serve.

3. <u>Collaboration with Local Community Organizations</u>:

PATH grant eligibility determination and inclusion, as well as requests for support and service access, come through to Erie County Care Management through a variety of sources, including self-referrals, shelters, transitional living centers, community outreach centers, Mental Health Association, ECCM call center, Erie County's Managed Care partner, Community Care's call center, Erie County Drug and Alcohol Abuse Program (SCA), Department of Human Services, Office of Children and Youth, Behavioral Health service providers, Physical Health Managed Care Organizations, Community Health Net, St. Paul's Free Neighborhood Clinic, Drug and Alcohol service providers, Certified Peer Supports, Intellectual Disabilities, Early Intervention, Greater Erie Committee on Aging (GECAC), PA Probation and Parole, and other community outreach agencies. ECCM collaborates with all community organizations who serve consumers with identified service needs related to the life domains of primary health, mental health, substance abuse, employment and housing, education and training, etc. Contacts to the referenced agencies and systems are regularly completed to increase awareness regarding service support to the County's homeless population.

ECCM has a long established history of positive relationships and joint activities on behalf of consumers with local community organizations. ECCM has Business Partnership arrangements and Memorandums of Understanding (MOU), rather than strict policies that address the coordination of activities with the above systems, as well as service providers. It is the policy of ECCM to accept, at no cost to any individual or agency, all requests from any source, and offer information and referral to appropriate service (s), without discrimination. All referrals and requests for assistance for homeless individuals are addressed by the ECCM Homeless Case Management team.

4. Service Provision:

There is intentional focus on support to the local shelter to offer resource consultation and coordination to identify individual domain needs and initiate a planned response, through Homeless Case Management directly or through supporting the assigned Blended Case Manager at the provider agency, whenever needed. The utilization of ECCM's psychiatric consultant is always available for support in determining service need and appropriate access options. Erie County Care Management is well versed in all services available through all funding sources in Erie County. If a PATH client is in need of a service and meets the criteria, they will be linked, in order to maximize available funding outside of PATH. (e.g., a Veteran may receive Case Management and Homeless supports through the Erie Veterans Administration.)

A recurring gap in the existing service system involves safe, affordable housing options: more specifically, subsidized housing programs which are available for the individuals served. A significant percentage of consumers receive benefits from the Department of Human Service (DHS), formerly known as the Department of Public Welfare for themselves and their minor dependents, which is not sufficient to afford housing at fair market rates. Therefore, subsidized housing is virtually the only option for many of these consumers, whose income is only "welfare", save for a less desirable option such as a shelter. Additionally, since August 1, 2012, Pennsylvania eliminated the $205.00 monthly General Cash Assistance category of benefits, leaving many individuals without any income at all. This has resulted in more Erie County residents being identified as homeless.

Although many referred consumers receive social security benefits, primarily in the form of Supplemental Security Income (SSI), it is still challenging to find affordable housing based on the limited availability and increasing costs of rental units in Erie. Also, many individuals referred are not at a point where they can pursue, get and/or maintain a level of competitive employment where they can either supplement their entitlement benefits to afford independent housing, or to afford fair-market rental housing.

Additionally, many individuals served have experienced difficulties with the legal system as a result of their mental illness and/or substance abuse histories. Therefore, a significant number of individuals served are ineligible for many existing subsidized housing options, based on their criminal records. Unfortunately, both the number and the limitations of current subsidized housing programs do not meet the existing need of those consumers in this community.

Homeless Case Management was fortunate to have secured a One-Time-Only support through the HealthChoices reinvestment funds, through May 2016, for use in supporting individuals who are homeless in payments for security and first month's rental assistance. Unfortunately, the money is fully drawn with no expectation of future funding in subsequent fiscal years. However, the use of these funds created opportunities for access to stabile housing for many vulnerable consumers who also were diagnosed with serious mental illness and substance abuse disorders.

Erie County Care Management currently serves individuals with co-occurring mental illnesses and substance abuse disorders and will continue to do so through referrals to appropriate outpatient treatment, community-based, and residential programming. Staff also offer support to the client who is struggling with maintaining their recovery and desires to seek Drug and Alcohol services with contacting the Erie County Office Drug and Alcohol Abuse for an intake.

Erie County Care Management is proud to be a team member of the Erie County Treatment Court specifically designed to serve individuals with mental illness and/or co-occurring mental illness and substance abuse problems. Erie County Treatment Court consists of three components: Drug Court, Family Dependency Court, and Mental Health Court. They work within a combined framework referred to as "Treatment Court." Treatment Court is a setting of supportive treatment that uses graduated incentives and sanctions. It provides a supportive, comprehensive, and holistic team approach in addressing the needs of the offender. Treatment Court was developed to work with non-violent D&A and/or mentally ill cases utilizing intensive supervision, support with case management and treatment resources for parole and child welfare. Treatment Court is a method by which individuals with mental illness and/or co-occurring disorders can receive proper treatment and monitoring as an alternative to imprisonment.

ECCM has been providing homeless case management services since its inception in 1994. Staff receives a variety of training from a diverse group of providers through biweekly staff meetings: i.e. Social Security Office, Pyramid Drug Alcohol Services, Safe Harbor Behavioral Health Crisis Services, Erie County Involuntary Commitment Procedure, etc. ECCM sent the Program Director to the VI-Spat TOOL Training on November 16, 2015, as well as to HMIS training in April, 2016, along with the Homeless Case Management Team Leader. ECCM will send a representative to the next annual training or other appropriately aligned training targeted for PATH.

ECCM is not a provider of Drug and Alcohol Services, and consequently, is not required to follow 42 CFR Part 2 regulations.

However, the agency's confidentiality policy reflects the imperative importance of confidentiality for the individual who is diagnosed with a co-occurring substance abuse disorder. ECCM has a strict policy and procedural process that governs all authorizations for disclosure of any information about a consumer's treatment.

5. Data:

Currently, Erie County Care Management's Homeless Case Management staff input information into the County's designated HMIS system. The County's HMIS administrator, Erie United Methodist Alliance, (EUMA), Lisa Karle, continues to provide both group and individual training to the staff. Training will occur annually for updates, as well as ongoing support to new staff.

The outcome of the collaborative relationship that has developed between the Direction of Supportive Housing at ECCM and the HMIS Administrator has resulted in an immediate response in support to all PATH staff. At a minimum, training with ECCM PATH staff occurs quarterly. Additionally, ECCM, as a PATH Grant recipient, is always responsive to any requests and participation in any training(s) offered by the HMIS Administrator. Erie County's HMIS System is fully compliant at this point.

6. New Alignment with PATH goals:

ECCM will utilize PATH grant funds to focus on outreach, engagement and case management services, which align with the primary PATH goals of serving Erie County's most vulnerable adults who are literally and chronically homeless. The ECCM Homeless Case Management team prioritizes their time in outreach activities to individuals within the local homeless shelters, overflow shelters, churches, libraries, drop in centers, city parks, and other designated areas where homeless individuals are reported to gather.

The Erie area continues to have an increase of individuals, in the spring and autumn seasons, who are reporting homelessness while standing at various entries to the local malls and interstates. Whenever staff has noticed or been contacted by concerned citizens of an individual with a sign seeking help for housing, PATH staff have physically driven to the designated area with responses of support to secure essential resources.

In regards to our vulnerable citizens, who are also veterans, ECCM will continue to make every effort to serve military families, and will prioritize access to care on their behalf. ECCM has an established collaborative relationship with the local Veteran's Homeless Case Management Program staff, as well as their Behavioral Health program. ECCM homeless case management staff conducts the initial need assessment, so that when homeless veterans are identified, services can begin immediately. This assessment facilitates the single point of contact entry into the Veteran's system locally, which provides both access to physical health and behavioral health services.

7. Alignment with State Mental Health Services Plan:

Erie County Care Management's PATH project continues to prioritize the identification and support to individuals who are experiencing homelessness, who also have been diagnosed with mental illness and or co-existing substance abuse disorders. Referrals come to the Homeless Case Management staff through any and all doors, through a no "wrong door" policy to ensure that no person misses the opportunity to secure support and service access.

All services are designed to promote street outreach and positive engagement with individuals who are our most vulnerable adults, utilizing effective and timely supportive case management strategies in a plan to end homelessness, one empowered consumer at a time.

Erie County Emergency Preparedness Plan (erieCountypa.gov), includes the use of Shelters, Special Needs, and Emotional Support. Shelters will be opened in schools, churches or other large public use buildings. Shelters will be open based on need. Those with special medical/cognitive needs should consider registering with Safetown. Safetown is an easy-to-use suite of web-based and mobile apps that empower you to share information with local law enforcement, fire, emergency services, and other citizens to make your community a better, safer place to live. Home Profile allows for persons to register those with special needs so that if an emergency would occur the emergency responders are aware of those needs. When open, Red Cross shelters can assist in accessing special medical needs. Erie County has a Disaster Crisis Outreach Referral Team (DCORT) that assists the public in coping with the emotional impact of the events and also helps them meet their basic needs by providing referrals and information.

DCORT activities include:

Supportive Listening – one-on-one support and crisis counseling with disaster victims.

Education – help victims to learn ways to manage their reactions and find ways to take care of themselves and recover from the disaster.

Action Planning – help disaster victims to determine their priorities and develop a plan of action to reorganize their lives.

All three area hospitals have emergency management plans. One hospital has a mobile medical team. Many local providers are involved in Disaster drills in the County on a yearly basis. Erie County Care Management can access numerous services in the community to assist individuals who are homeless in the event of an emergency/disaster.

8. Alignment with State Plan to End Homelessness:

Erie County Care Management is committed, to use PATH funds to target street outreach and case management to identify our most vulnerable adults for access to needed supports across all domains.

ECCM's mission is to deliver services in accordance with the Recovery Principles that include self-direction within a holistic perspective. Staff working with the individual, families and community members understands that recovery encompasses the varied aspects of an individual's life. This includes mind, body, spirit, and community. Community services such as housing, employment, education, mental health and healthcare services, complimentary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports are options available to each person. ECCM's holistic assessment process, which includes needs-based service planning, as well as barriers to care, results in an increase in access to quality behavioral healthcare services. Identifying and addressing individual obstacles to services access, empowers PATH eligible consumers to lead, control and exercise choice over their own life. PATH funded consumers will be supported in making informed decisions about the nature, location and provider of services to encourage self-direction and strength based decision making.

ECCM's staff's extensive expertise in working with homeless individuals underlines the team's unique ability to engage PATH funded consumers in a process to access the local continuum of care for behavioral health and substance abuse services, as well as community resources, to end homelessness.

Focused energy for identification, engagement and case management activities on behalf of PATH eligible consumers will produce increased community tenure and stability, which is a basic component of the state's pan to end homelessness.

Erie County's PATH program reflects the state plan by increasing the opportunities for individuals to access a stable and safe place to live in the community with relationships and social networks that provide support, friendship, love, and hope.

9. Other Designated Funds:

The Erie County Office Department of Human Service Office of Drug and Alcohol, and Office of Mental Health/Intellectual Disabilities administers Mental Health Block Grant (MHBG), Substance Abuse Block Grant (SABG), and general revenue funds that are allocated to serve child and adult individuals in Erie County. Funds are subcontracted to a number of organizations that provide services to individuals and families who are managing a combination of needs related to mental illness, substance abuse and homelessness/near-homelessness. Specifically, MHBG, and general revenue funds, as well as PA Department of Human Services Homeless Assistance Program, are used to purchase services at Erie County Care Management in the Administrative Case Management Division for Homeless Case Management services for persons who are subject to the PATH service guidelines. These funds are used because PATH clients meet the criteria, but are not specifically designated for PATH clients.

10. Programmatic and Financial Oversight:

Erie County Department of Human Services (DHS) is the direct recipient of PATH funds for the Erie community. Erie County DHS provides the PATH funds to Erie County Care Management (ECCM), who provides direct services using the funding. Erie County DHS is responsible for the oversight of ensuring that the PATH funds are being utilized appropriately through the sub recipient, ECCM. The Fiscal monitoring of PATH funds includes, ensuring that the federal portion of the funds is correctly listed in the agency contract, Erie County DHS participation in provider budget/monitoring meetings as applicable, reviewing a Compliance Review Tool annually which ensures document, financial, and administrative compliance, ensuring that payments to ECCM for ACM services do not exceed the contract maximum, ECCM audit confirmation identifies Federal PATH funds and the CFDA number, ensuring that PATH funds are recorded properly on the HSBG Annual Expenditure Report, and confirming that PATH funds are correctly reported on the Single Audit Schedule. Erie County has biweekly meetings with ECCM to discuss and review any pertinent issues regarding any contracted services with Erie County DHS.

11. SSI/SSDI Outreach, Access, Recovery (SOAR):

Currently, there are two (2) SOAR trained staff at the Erie United Methodist Alliance. When SOAR training is available ECCM will plan to have a staff trained at that time.

Erie County presently offers training to the entire homeless delivery system in keeping with our 'no-wrong-door policy". It is the intension that no matter where a person presents for homeless services that they may be connected with appropriate services, including SOAR, in an individualized treatment/goal plan to foster greater health, economic, and housing self-sufficiency.

ECCM staff is trained in the application process for both public assistance and disability benefits through the Social Security, and utilize this skill set in supporting individuals experiencing homelessness in the application for such resources. Our continued collaborative relationship with our local County Assistance Office (CAO) has led to more accurate and timely completion of the benefit applications, which has facilitated the timely determination of eligibility, especially by the CAO.

12. Housing:

ECCM is identified by the Department of Human Services as the Local Lead Agency that acts as a consultant to secure affordable housing for people with Mental Illness in federally funded tax credit projects, 811s and 202s. ECCM sent two (2) management staff to training in April, 2016 related to the role of the Local Lead Agency (LLA) for continued education in working to reduce homelessness through specialized opportunities.

Strategies utilized to seek and secure available housing depend on the individual's circumstances. For those consumers who receive welfare benefits, locating affordable housing is a tremendous challenge. Erie County Care Management staff assists these consumers in applying for all subsidized housing programs for which they are eligible, such as through the Erie City Housing Authority, Housing and Neighborhood Development Services (H.A.N.D.S.), Community Shelter Services that operates the Lodge on Sass and Columbus Apartments, and landlords who participate in Section 8 housing. The obvious benefit is that the client only pays 30% of his/her income so that he/she can afford the other necessities of living.

For consumers who are able to afford non-subsidized housing, Erie County Care Management maintains productive relationships with community landlords so that we can at times take advantage of apartment availability as openings occur. We have been successful in assisting many consumers in establishing permanent housing with neighborhood landlords who have demonstrated understanding, and in some cases making allowances, for individuals with mental illness who are too often rejected by landlords due to stigma. Advocacy is key in these cases, and Erie County Care Management staff have been instrumental in assisting consumers to assert their rights when it comes to securing housing and other community services.

In addition to utilizing community housing resources, Erie County Care Management continuously applies for grants that fund permanent housing opportunities, such as supportive housing initiatives.

ECCM is a sponsor of five Shelter Plus Care grants, supporting over one hundred (100) individuals with Serious Mental Illness and/or Substance Abuse. Shelter provides stable housing and linkages to mainstream supportive services in the community. Once individuals are stable in the Shelter Plus Care program, all efforts are made to transition them to Section 8 or other public housing opportunities. Additionally, Shelter Plus Care focuses on enabling families to remain intact by providing stable housing and supports, reducing the cycle of homelessness.

PATH Case Managers have the opportunity to refer their consumers who are experiencing homelessness and are also considered disabled by virtue of their mental health or substance abuse issues, as a priority for the Shelter Plus Care program. The positive peer relationships between the ECCM PATH Case Managers and the ECCM Shelter Plus Care staff supports advocacy on behalf of the individual.

13. Coordinated Entry:

Erie County Department of Human Services has received HUD Continuum of Care Grant funds in the 2016 competition for the creation of a Coordinated Entry system. Erie County is currently in the planning phase of beginning a Coordinated Entry system for the community. The system is planned to begin operating on 10/1/17.

14. Justice Involved:

ECCM employs a Forensic Specialist who has direct access to individuals incarcerated in Erie Co Prison. The Forensic Specialist works with the jail's counselors and MH staff to identify individuals who are soon to be released from the Erie Co Prison who meet eligibility for PATH. Prior to release, the Forensic Specialist will coordinate with the PATH Case Managers to secure a shelter bed, meet the person as they are released from the jail, accompany the individual to the Department of Human Services and/or Social Security to activate benefits, and support the client at MH appointments.

ECCM has developed strong working relationships with the Justice Related agencies in the County. Jail staff, parole officers, Forensic Outpatient Clinic staff, and other providers will contact the PATH Case Managers, Forensic Specialist, and/or the Director of Supportive Housing and Forensic Services on behalf of an individual who becomes homeless or is at risk of homelessness.

Criminal history is an ongoing obstacle for individuals. PATH Case Managers are informed of the area housing programs and will support the person in completing housing applications to any program the person wants to apply to. The PATH Case Manager will also assist the person in appealing denials and, if requested, can accompany the person to the denial hearing as a support. ECCM is the sub-recipient of HUD Permanent Supportive Housing grants, known as shelter Plus Care (S+C) and PATH Case Managers assist the person in making referrals to the program. PATH Case Managers are able to provide firsthand information on the person's ability to live independently and helps provide valued information for the selection process. We estimate that 65% of the individuals of PATH individuals have had criminal history.

15. Staff Information:

Erie County Care Management provides a mandatory array of training opportunities to staff to enable them to effectively serve the homeless population. Training focus incorporates cultural competence, recovery and resiliency principles. Additionally, ECCM covers the cost of all interpretation service. Staff will always secure an interpreter for individuals who have a primary language which does not allow them to communicate their needs for service and supports.

The ECCM homeless case management team reflects cultural diversity and experience, as it is comprised of the following:

*Program Director	(Caucasian male, age 41)
*Team Leader	(Caucasian male, age 52)
*Homeless Case Manager	(Caucasian female, age 26)
*Homeless Case Aide	(Caucasian male, age 30)

ECCM utilizes *Administrative Case Managers, who are masters level mental health professionals, to conduct psychosocial assessments for homeless individuals, to facilitate access to the behavioral health and drug and alcohol continuum of services for Erie County, as needed.

The ECCM division of Administrative Case Management, with expertise in forensic, geriatric, intellectual disabilities, and family care, will also provide direct support, to augment the homeless case management team as requested by the Director, for expert directed response for identified individuals with special needs.

16. Client Information:

Adults Consumers Contacted 152

Adults Consumers Enrolled *127

*Number based on full homeless case management complement of 2 FTE Case Managers and 1 FTE Case Aide

Percent of Consumers Contacted Literally Homeless 71.71%

Percent of Consumers Enrolled Literally Homeless 83.55%

Demographics for the PATH-funded client population are as follows: HMIS

- Age Range Consumers

18-23	7
24-30	26
31-40	33
41-50	27
51-61	29
62 and over	5

- Race Consumers

American Indian or Alaskan Native	1
Asian	0
Black or African American	45
Native Hawaiian or Other Pacific	1
White	82
Two or more races	0

- Gender Consumers

Male	58.26%
Female	40.94%
Transgender	.80%

- Ethnicity — Consumers

Non-Hispanic/Non-Latino	95.28%
Hispanic/Latino	3.93%
Neither (per client report)	.79%

17. Consumer Involvement:

A director on the Erie County Care Management (ECCM) Board of Directors has a family member who is a consumer of services. ECCM employs a consumer advocate on a full-time basis who is a mental health consumer. ECCM is partnered with the Erie County Mental Health Association which employs at least two persons who have been homeless in the past and are currently consumers of services. The Erie County Office of MH/ID hosts monthly meetings of the HealthChoices Advisory Board which is led by current and former consumers and family members of mental health and homeless services. Further, the Behavioral Health Managed Care Organization for Erie County (Community Care Behavioral Health) convenes quarterly Family Advisory Committee and Consumer Advisory Committee meetings to promote consumer and family participation in service development and improvement efforts.

18. Behavioral Health/Health Disparities Impact Statement:

The PATH consumers are identified and Erie County MH/ID will use their names and social security numbers to track their services utilizing Health Choices and Base MH funding databases. We will search on the client specific demographic and track utilization. We will analyze the data to ascertain if there are any differences to accessing services and positive outcomes for people by race, ethnicity, gender, LGBTQ, or age. If differences are noted we will seek training for the outreach workers in order to deliver a more specific client centric quality service.

Through both Community Care Behavioral Health (CCBH), the County's managed care partner for behavioral health services, and the County's Department of Human Services, we continue to contract with four agencies to provide interpretation services for people who have limited English proficiency.

As ECCM reported last year, the agency will continue to work with agencies providing the mainstream mental health services to address the disparities, if they occur, with a corrective action plan with timelines and measurable action steps to ensure that the disparities are reduced or eliminated.

PATH will be utilized for the outreach workers to input data into the database as they always have. The measuring of outcomes, tracking and response to the disparities will fall on the County Mental Health Office (Department of Human Services). As noted above, the County strives for equal access and hopes for positive outcomes in all contracted behavioral health services. The County contracts for behavioral services for both Medical Assistance and Base funded contain provisions that prohibit discrimination by race, ethnicity, gender, LGBTQ,

limited English proficiency and age. The County enforces contract compliance through contract monitoring. If disparities exist a corrective action plan is submitted by the agency where the disparities exist and the County then monitors progress towards the elimination of such barriers. Erie County has a provider of therapy services with an expertise in the area of behavioral health support to the LGBTQ population.

TAY Disparity Population Projection Plan

Unduplicated number of TAY individuals to be served with PATH funds in the 2017-18 fiscal year is anticipated to be 37. These individuals will be in the age range of 18 to 25 years.

The total amount of PATH funds expected to be expended on services in the TAY population: $47,777.00 for the fiscal year 2017-18.

The types of services funded by PATH that are available for TAY individuals consist of outreach, engagement and case management services, which align with the primary PATH goals of serving Erie County's vulnerable transitional age youth who are literally and chronically homeless. The PATH/Homeless Case Management team will prioritize their outreach activities to all individuals, including the TAY group within the local homeless shelters, overflow shelters, churches, libraries, drop in centers, city parks, and other designated areas where homeless TAY individuals are reported to gather.

Case management supports to individuals who are PATH eligible and within the TAY population will be holistic and individualized, as for all other special populations served. Examples of past support for the TAY population include: transportation application, payment and subsequent access for vocational and/or educational opportunities, child care support through DHS application, etc., physical health service access, Food stamp application, disability application, as well as traditional housing activities.

A plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population.

In the event that PATH staff identify a disparity for the TAY population in accessing or utilizing community services, they have been instructed to report such disparity to the Director of Supportive Housing. The Director will discuss an immediate response plan with the Administrative Officer for Mental Health at ECCM and the County's Housing Specialist, to create a corrective action plan with the specific agency. The corrective action plan will be monitored for a change in outcome for TAY individuals through the County's contract monitoring process, as it would be for any other vulnerable population.

19. Limited English Proficiency:

ECCM supports the provision of effective, equitable, understandable, and respectful quality services that are responsive to diverse cultural health beliefs and preferred languages. Subsequently, as the primary goal of Administrative Case Management is to link individuals, who have or who are at risk for mental illness, with identified supports and services, it is

essential that Administrative Case Management staff ensure access to interpreter services, as needed, to create a supportive environment for the client interview.

Administrative Case Management personnel (ACMs) will make every effort to identify issues in regard to language and culture which must be addressed in the process of assisting a client.

For services to be rendered by ECCM to a client, ECCM will pay the cost of interpreter services required to complete this activity. For services to be delivered by another provider agency to an ECCM client, that agency is responsible for any interpreter costs (per the MH/ID Office). ECCM personnel may help to arrange an interpreter for meetings at other provider agencies, and they must take care to ensure that all parties understand which agency is responsible for the cost.

If a client has difficulty conversing in spoken English, then they will be offered an opportunity to have an interpreter obtained for additional services at ECCM. ACMs will not rely on written notes (in the case of a deaf or hard of hearing individual), on an individual's limited use of spoken English, or on a friend/family member as interpreter, unless it is the individual client's expressed wish to do so.

Additionally, ECCM will use only certified interpreters for individuals who are deaf or hard of hearing, unless a client signs a waiver to use a non-certified interpreter. TTY/TDD capability for those members who are hearing-impaired or speech-impaired is also available.

ACMs will consult with supervisory and administrative personnel for assistance in making accommodations which are outside the realm of routine interpreter services. Where appropriate, consultants will be employed to assist the agency in meeting the language and cultural needs of all clients.

ECCM will contract with interpreters in the community who are generally held as qualified and in good standing in the community. The list of interpreters and their rates and contact information will be provided upon request. ACMs wanting to use an interpreter who does not have a contract with ECCM must review the need with the Administrative Officer.

There is never a cost charged to a client or family member for an interpreter service for services to be rendered by ECCM. The agency will always cover this essential cost to assure that the client's needs are met in a way that is responsive to culture and language reference.

Erie County Mental Health and Intellectual Disabilities (MH/ID)
Erie County Care Management, Inc.
PATH 2016-2017 Budget Narrative

20. Budget Narrative:

Director of Supportive Housing and Forensic Services: $8,955 or 15%
A full-time position that provides supervision to the Homeless Case Management (HCM) team, the Shelter Plus Care housing program staff, and forensic services programs. The Director oversees ECCM's Shelter Plus Care staff's input into HMIS and is actively involved with various collaborative community teams to enhance the direct care of the individual with a serious mental illness and/or homeless; e.g. the Erie County Home Team, Criminal Justice Advisory Board, etc.

Homeless Case Management Team Leader: $29,271 or 62%
A full-time position, this lead person for the HCM team directs the team activities for outreach and coordination to individuals who are homeless. The Team Leader also provides direct care to assist shelters and their clients in accessing various community resources and/or benefits the individual needs help in obtaining; e.g. facilitating housing program applications, assisting in locating stable housing options, assisting with MA benefit application, etc.

Homeless Team Case Manager: $24,854 or 60%
A full-time position, this Case Manager provides direct care to shelters and their clients through daily visits to multiple shelters. This position focuses on engagement with the individual to identify needs, refer, when appropriate, for psychosocial assessment to the Housing Specialist, and help connect the individual with various resources and/or benefits the individual needs help in obtaining; e.g. facilitating housing program applications, assisting in locating stable housing options, assisting with MA benefit application, obtaining personal identification documentation, etc.

Homeless Case Management Team Case Aid: $21,462 or 60%
A full-time position, the Case Aid provides direct care by supporting individuals with transportation from the shelter to their medical or mental health clinic appointments. If the individual is in need of support and agrees, the Case Aid will escort the person to their mental health appointment to facilitate discussion with the mental health professional, go to the Department of Public Welfare and/or Social Security Office to assist the individual with filling out benefit applications and meet with their caseworker. In addition, the Case Aid can offer support in obtaining personal identification documentation, clothing or household items access from donation centers, access to county support funds, etc.

Fringe Benefits: $29,259, social security, retirement, and insurances for assigned personnel.

Travel: $4,000, $0.53.5 per mile reimbursement for assigned staff to meet with clients in the community, connect them to needed services and supports, and to assist with scheduled appointments.

Staff Development: $1,000, to provide training, and to develop strategies, methods and competence for the assigned staff to assist PATH clients to re-enter the community.

Client Funds: $2,294, Funds to support and assist PATH clients as they re-enter the community and transition to stable housing.

Erie County Mental Health and Intellectual Disabilities (MH/ID)
Erie County Care Management, Inc.
PATH Program
FY 2016-2017 Budget

	Annual Salary	PATH-Funded FTE	PATH-Funded Salary	TOTAL
Position				
Director of Supp. Housing	$59,701	.15 FTE	$8,955	$8,955
Team Leader	$47,211	.62 FTE	$29,271	$29,271
Case Manager	$41,423	.60 FTE	$24,854	$24,854
Case Aide	$35,770	.60 FTE	$21,462	$21,462
Sub-total			$84,542	$84,542
Fringe Benefits				
FICA Tax				0
Unemployment				0
Retirement				$5,072
Life Insurance				0
Insurance				$17,720
Social Security				$6,467
Sub-total				$29,259
Travel				
Local Travel for Outreach				$4,000
Travel to training and workshops				
Sub-total				$4,000
Supplies/Equipment				
Consumer-related items				$2,294
Sub-total				
				$2,294
Other				
Staff training				$1,000
One-time rental assistance				
Security deposits				
Sub-total				$1,000
Total PATH Budget				$121,095

24. Fayette County - City Mission - Living Stones, Inc.

155 N. Gallatin Ave

Uniontown, PA 15401

Contact: Dexter Smart

Contact Phone #: 7244390201

Has Sub-IUPs: No

Provider Type: Other housing agency

PDX ID: PA-034

State Provider ID: 4234

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 58,392	$ 19,464	$ 77,856	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 58,392	$ 19,464	$ 77,856	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 58,392	$ 19,464	$ 77,856	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 58,392	$ 19,464	$ 77,856	

Source(s) of Match Dollars for State Funds:

Fayette Co will receive a total of $77,856 in federal and state PATH funding.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 450

Estimated Number of Persons to be Enrolled: 55

Estimated Number of Persons to be Contacted who are Literally Homeless: 383

Number staff trained in SOAR in grant year ending in 2017: 2

Number of PATH-funded consumers assisted through SOAR: 8

Fayette County Behavioral Health Administration
PATH Intended Use Plan
2017-2018

Local Provider Description –
Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

It is Fayette County Behavioral Health Administration's continued mission to provide access to and assure choice among quality behavioral health services for Fayette County residents. Fayette County Behavioral Health Administration intends to continue sub-contracting all PATH services through the following provider:

City Mission-Living Stones, Inc., 155 North Gallatin Avenue, Uniontown Pa 15401
is a non-profit organization whose sole purpose is to provide for the comprehensive housing and service needs of Fayette County, PA's homeless population. During its 30-plus year history, City Mission has sought creative and innovative ways of addressing the problems of rural homelessness. City Mission's comprehensive housing and service programs and professional, compassionate staff help clients by supporting them step-by-step through the arduous process of moving from homelessness to self-sufficiency.

City Mission has two emergency shelters to meet the immediate needs of homeless families and individuals. Homeless individuals receive food, clothing, case management, and transportation support at these shelters. The men's shelter has beds for 21; the agency's shelter for women and children has a 12-bed capacity. A third facility, HOME AGAIN serving youth ages 12-17, opened in May 2002. This 14-bed facility provides housing and specialized support services to Fayette County's abused/neglected children, incorrigible children, youth needing respite care placed through community treatment providers, and runaway/homeless youth.

In addition to these facilities, City Mission operates the Gallatin School Living Centre, which is a 30-unit housing and service complex. Gallatin School Living Center has 11 transitional housing units, one unit for emergency shelter for families, and 18 Single Room Occupancy (SRO) units of permanent housing. All units are fully furnished. City Mission serves clients from birth to adulthood. Clients served through the PATH program can be any age provided they are PATH program-eligible.

City Mission's most recent housing program is 8-units of permanent supportive housing. During the past several years that the PATH program has been operational, the need for permanent housing linked to support services, has been a priority. Liberty Park and Sycamore Hills Apartments both comprising 4-units are all occupied by formerly homeless families/individuals. Additionally, City Mission recently completed our newest project Stone Ridge Apartments, which is a 6-unit apartment complex which opened in September 2015.

These permanent supportive housing units prioritize serving individuals with mental health disability.
In November of 2016, City Mission opened Promise House, an independent living program/facility that serves young adults ages 18-22. Promise House consists of three small two-bedroom cottages—one for young men, one for young women, and a third will function as a staff unit. Our experience is that youth with no parental involvement who age out of our HOME AGAIN program have had no options for housing other than adult shelter. Promise House will provide accountability, life skills programming, along with safe, permanent, and affordable housing to transition age youth.

Along with these housing options, a multitude of support services are offered to City Mission's clients at all sites. City Mission's 35 staff members are comprised of both Master's degree and Bachelor's degree level personnel whose education and extensive work experience uniquely qualify them to work with the homeless population, other than the small administrative staff of four, all services provided by staff focus on serving the clients of City Mission.

City Mission-Living Stones, Inc. $ **77,856**
Funds contracted with City Mission – Living Stones, Inc. will be used for salary and benefits for one (1) FTE Case Manager. Additional expenses include program supplies, consumer transportation, training and client rental assistance. Please see the attached budget for more detail.

PDX – PA-034 Fayette: City Mission-Living Stones, Inc

Collaboration with HUD Continuum of Care (CoC) Program –
Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the areas where PATH operates.

City Mission has been an active participant in the HUD Continuum of Care process since its inception. City Mission's executive director wrote the entire Continuum of Care component for the Southwest PA Region prior to the State of PA hiring a developer to complete that task; her efforts resulted in the first successful funding of the Balance of State's application. The City Mission Executive Director chaired the SW Region Homeless Advisory Board for several of its early years while policy and the process were being developed. Beyond this, members of City Mission has always actively participated in the process as a member of the (Southwest Regional Homeless Advisory Board) SWRHAB and attends all scheduled meetings of the (Regional Homeless Advisory Board) RHAB. City Mission's shelter supervisor is City Mission's representative to the SWRHAB. As a member of the RHAB she participates in both the scoring of applications for the region, is active in formulating policy, and is a member of the RHAB committee that has been set up to target the special housing needs of transition age youth. City Mission participates with the coordinated entry and assessment activities of the RHAB.

City Mission is a very active participant in the HUD Continuum of Care. City Mission's Executive Director and Shelter Supervisor are members of the Southwest Regional Homeless Advisory Board this is the leadership entity for the continuum of care. Over the past 15-plus years, City Mission has obtained numerous HUD grants through the Continuum of Care process to meet the needs of Fayette County's homeless population. This process includes assessing gaps in service, coordinating with other providers, and spearheading capital campaigns, as well as completing the rehabilitation and/or construction of major housing projects (those mentioned above), and the development of programs such as HOME AGAIN and Promise House.

Collaboration with Local Community Organizations –
Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

Fayette County has a rich array of community supports and treatment services, in addition to continued, long-standing collaboration among service providers. City Mission has worked with local providers in Fayette County to implement the entire continuum of housing and support services for homeless individuals and families. Both Fayette County Behavioral Health Administration and City Mission representatives are active on the Fayette County Partnership for Housing and Homelessness and its Local Housing Options Team (LHOT). This organization is made up of representatives from all county agencies that deal with various aspects of housing throughout the Fayette County area. This team has been involved in several affordable housing studies that point out housing needs and gaps for various subpopulations. The team has been instrumental in working with developers on the revitalization of many low-income neighborhoods.

Services available to individuals with serious mental illness and co-occurring substance abuse, including those who are homeless, are described below:

Primary Health: Primary health care is available through individual practitioners and several clinics that have as their mission providing care to low-income individuals: two Federally-Qualified Health Centers (Centerville Clinic and Cornerstone Care), Wesley United Methodist Church Medical Clinic in Connellsville, PA and Adagio Health (preventative and primary care for women). In addition, Uniontown Hospital, located in the heart of Uniontown and Highlands Hospital, located in Connellsville, provides emergency and urgent outpatient care. Also centrally located is a MedExpress Urgent Care Center. Special Needs Units of Health Maintenance Organizations are an invaluable resource in arranging for specialized assessment and treatment for individuals diagnosed with mental illness and co-morbid medical conditions. These comprehensive assessments of an individual's needs address physical health status and potential referrals for follow-up medical care.

Mental Health: Inpatient psychiatric care; phone, mobile and walk-in crisis services; outpatient services; partial hospitalization; behavioral health rehabilitation services for transition-age youth (18-21 years of age); Assertive Community Treatment (ACT); site-based

and mobile Psychiatric Rehabilitation services; and drop-in centers in two communities are available to PATH consumers, and Highlands Hospital continues to provide Mental Health inpatient services.
Fayette County has also established a Forensic Diversion and Reentry Program for persons with mental illness who have been incarcerated or are at risk of incarceration. The Fayette County Mental Health Treatment Court, The Veterans Court, and Fayette County Drug and Alcohol Court each refer their participants to treatment and rehabilitation programs. Since 2012, four classes of municipal and state police officers have been completed the Memphis Model CIT Training. These officers are trained to effectively intervene in situations regarding individuals who may be experiencing mental health symptoms. The PATH Case Manager maintains a positive working relationship with many of the county's mental health service providers. Providers such as the Mental Health Association and Chestnut Ridge Counseling Center Inc. work directly with City Mission and the PATH Case Manager. The PATH Case Manager also helps to play the role as a consumer advocate and supporter in attending appointments with individuals and helping maintain their overall treatment plan. This coordination helps to provide a more holistic approach to client services. The PATH Case Manager accesses additional guidance and funding through the Fayette County Behavioral Health Administration in order to better support client needs. Through stabilization funds provided through Fayette County Behavioral Health Administration, PATH clients are able to access funds for rental assistance and household items such as furniture, beds etc… which allow them the ability to move into their own apartments, increasing their independents in the community. Skill building for individuals with severe mental illness is supported through three providers of Psychiatric Rehabilitation services, Chestnut Ridge Counseling Services, Crosskeys, and Goodwill. These programs can assist clients within the living, working, learning, and socialization environments through skill building to increase independents.

Substance Abuse: Outpatient drug and alcohol services; residential drug and alcohol services; ambulatory detox clinic; methadone treatment services; Suboxone Treatment; and 12-Step programs are located throughout the county. The PATH Case Manger has access to a variety of treatment and care options available through both the mental health and drug and alcohol systems within the region. As well as rehabilitation facilities in Pennsylvania and nearby states. MISA (Mental Illness and Substance Abuse) services are offered at Chestnut Ridge in Uniontown PA on a weekly basis. The PATH Case Manager is familiar with both private and county run programs that offer D&A support meetings on a daily basis and is able to refer clients that are interested in attending. City Mission also provides support group sessions at their primary office in Uniontown for PATH clients. These sessions focus on the unique needs of individuals with co-occurring diagnoses.

Housing: City Mission's permanent, transitional, and emergency shelter services are described throughout this plan. In addition, Fayette County Community Action Agency and Fayette County Behavioral Health Administration have collaborated on a permanent housing initiative Fairweather Lodge in Connellsville, Pa. for individuals with mental illness and /or substance abuse (serving 8 individuals). This, along with the development of Fayette Apartments, a 10-unit permanent supportive housing complex in Uniontown for chronically homeless single adults with Mental Health diagnoses. Fayette County Community Action in collaboration with Fayette County Behavioral Health Administration is continuing its

Housing Opportunities Program (HOP) into 2018. This program provides Case management services, tenant-based and master leasing opportunities for Fayette County residents with a mental health diagnosis. Fayette County Behavioral Health Administration contracts for Community Residential Rehabilitation Services (CRR); Supported Housing programs; and a Long-Term Structured Residential (LTSR) program -- providers for these mental health services include Chestnut Ridge Counseling Services, Inc., Crosskeys Human Services, and Southwestern Pennsylvania Human Services (SPHS). Subsidized housing services continue to be available through the Fayette County Housing Authority. City Mission continues to partner with local community providers and Fayette County Behavioral Health Administration continues to help support the housing needs of individuals with mental illness in the community through increasing the availability of supportive housing and scattered sites in the area.

FACT (Fayette Area Coordinated Transportation): FACT plays a key role in contributing to the independence of PATH clients. FACT provides general transportation to designated stops as well as appointment-specific transportation to include medical appointments as well as behavioral health appointments. There is some limited transportation outside of Fayette County to the Pittsburgh and Morgantown WV areas for medical appointments.

Employment Services: Workshops, Transitional Employment, Mental Health supportive employment programs, Intensive Vocational Rehabilitation Program for individuals with substance abuse disorders, and Clubhouse Psychiatric Rehabilitation Program are available through several local employment-support providers. Literacy programs are offered by a variety of organizations. Career Link provides assistance in arranging for job training, securing employment, and GED preparation. Office of Vocational Rehabilitation maintains a local office, providing vocational assessment and assistance in arranging job training and supports.

Education Services: Penn State Fayette – Eberly Campus and Westmoreland Community College- Fayette Campus offer assistance in admission and financing of higher education. Laurel Business Institute, centrally located in Uniontown, PA offers continuing education opportunities, along with Pennsylvania Institute of Health and Technology and Fayette County Career and Technical Institute.

Community Support Services: A number of local organizations provide concrete goods, including food, clothing and household items. Among them are local churches, Society of St. Vincent DePaul, Salvation Army, Connellsville Area Community Ministries, Goodwill Industries, Fayette County Community Action Agency, and City Mission.

The PATH Case Manager understands eligibility, referral and access procedures for all of these programs and supports. The PATH Case Manager also participates in several established councils to insure coordination of care for individuals with mental illness. These include the Continuity of Care Committee (representatives from local inpatient units, outpatient, case management providers and Fayette County Behavioral Health Administration), Fayette County Human Service Council, the Fayette County Partnership for Housing and Homelessness and its Local Housing Options Team (LHOT). City Mission is one of the community's primary provider of services to Fayette County's homeless

population. The agency receives referrals from area hospitals, the local police departments, and other related housing and service organizations that come in contact with individuals who fall within the targeted PATH population. The PATH grant offers an opportunity to enhance these outreach efforts by strengthening its speaker's bureau and through the distribution of brochures and a video shown periodically on local TV outlining its services.

The PATH Case Manager has also completed the SOAR on line training certification which provided intensive step-by-step instruction on completing SSI/SSDI applications.

Service Provision –
Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

- **How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless**

  Fayette County is a rural community with few street homeless. However, the PATH Case Manager continues to provide ongoing outreach through shelter visits and partnering with other social services agencies to complete the point-in-time count. There is outreach, collaboration with Fayette County's service systems, including the local prison, Probation Office, and Children and Youth Services. PATH Case Manager also actively participates in community provider meetings, such as local housing and mental health meetings; and serves on Fayette County's St. Vincent DePaul's Board of Directors.

- **Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services.**

  Financial assistance is available and utilized thru several Fayette County Agencies on case-by-case basis. Fayette County Community Action Agency, St. Vincent de Paul, Salvation Army and our County Assistance Office as well as several local churches, are willing to provide direct financial assistance to our clients. These agencies are always our first consideration. The PATH Case Manager also accesses financial support for PATH individuals through Fayette County Behavioral Health Administration's Consumer stabilization funds. These funds assist with rental assistance and household items that help support independence.

- **Gaps that exist in the current service systems.**

  While service delivery in the current service system has shown some improvements, it continues to remain somewhat fragmented. Clients with co-occurring disorders often move between mental health and drug and alcohol service providers with little collaboration between systems and/or accessible information. Consumers who find themselves without safe, permanent, and affordable housing tend to focus on these areas rather than treatment concerns. The housing needs of PATH eligible clients continue to be addressed by City Mission through the Gallatin School program and in community-

based housing. Additionally, City Mission's Liberty Park Apartments, Sycamore Hills and Stone Ridge Apartments, are dedicated to family/individuals who need social services linked to their housing. Residents at these supportive housing facilities who experience mental health or drug and alcohol concerns are able to live independently in the community in large part due to the support services that are tied to their housing. All of these projects have help fill the housing gap by providing PATH clients with a total of 14 units of permanent supportive housing.

Transportation remains a challenge for Fayette County residents. City Mission continues to work on addressing this area of concern by upgrading City Mission vans and collaborating with the County Office of Human Services' FACT Program for those clients who have transportation needs beyond the county line. PATH case manager is able to register and document client eligibility for FACT transportation. The FACT office continues to be an important asset to the community and is working hard to meet the needs of all Fayette County residences. FACT continues to assess community needs and are working to expand its fixed routes and maintain its Medical Assistance Transportation Program.

The PATH case manager faces many obstacles when supporting PATH eligible clients in the community. One ongoing barrier to independences is employment. In spite of the ongoing community supports full-time employment in our particular area is difficult to access for this population. The majority of jobs are in the food service industry and are part-time preventing individuals from earning enough money to support themselves. This obstacle is being addressed by the PATH Case Manager through assisting PATH clients with additional training and building ongoing relationship with community business.

- **Brief description of the current services available to clients who have both a serious mental illness and a substance use disorder.**

  PATH clients who have both a serious mental illness and substance use disorder have access to the following services: case management, transportation, housing, emergency shelter (at one of City Mission's two shelter facilities), and transitional and permanent housing—both onsite at the Gallatin School Living Centre as well as community-based housing. PATH clients also have the option of City Mission's permanent housing in Liberty Park Apartments, Sycamore Hills or Stone Ridge Apartments.

  A Master's level social worker employed by City Mission facilitates weekly support group sessions at the Gallatin School Living Centre for eligible clients with co-occurring disorders. These weekly sessions' help to address the unique needs of dually diagnosed individuals. In addition, CRCSI and Family Behavioral Resources work with PATH Case Manager by setting up intake appointments quickly as well as providing access to mental health treatment and services as well as providing drug and alcohol services.

  Outreach: Fayette County Behavioral Health Administration conducts ongoing outreach activities with the Fayette County Prison through a contract with Southwestern Pennsylvania Human Services to complete assessments and design treatment and release strategies for individuals in the county jail. PATH Case Manager has access to Public

Defender office, Adult Probation and Legal Aid. PATH Case Manager also has access and is able to go into the jail to provide case management services for PATH clients who have been detained. City Mission is working with the county's Children and Youth Services and Juvenile Probation Office to identify youth who are aging out of their systems and need ongoing supportive housing services. Promise House will be a key resource for those youth needing housing and support services beyond age 18. Fayette County Behavioral Health Administration partners with City Mission to identify and assess the needs of individuals who are homeless. PATH staff stays in contact with the Veterans Affairs and local veterans support organizations. PATH staff helps veterans with accessing benefits and reaches out to larger community supports in order to find their client the most affordable and best suited housing.

Transportation: Transportation will continue to be provided on an ongoing basis with the PATH Case Manager determining the transportation schedule for those clients residing at the Gallatin School Living Centre. The PATH Case Manager continues to work with FACT to coordinate transportation for clients living in the community as well as utilizing City Mission's vans. Most homeless individuals have either no income or very low incomes, and no personal transportation. Most depend heavily upon City Mission for transportation. Due to their special needs, PATH clients are more dependent on the transportation support from City Mission. City Mission's two passenger vans are used not only to serve PATH clients who reside at City Mission's shelter facilities, but also for those PATH clients who live in the community. Clients receive assistance in accessing basic community amenities—medical facilities, shopping malls, grocery stores, and treatment services, including recovery-focused services—until they are able to successfully utilize the community's public transportation services.

Rental assistance and/or security deposit assistance: A percentage of PATH dollars are utilized as an emergency fund to assist PATH eligible individuals with one-time rental assistance/security deposits. These emergency funds are supplemented with Department of Community and Economic Development-Emergency Shelter Grant funds that can be used for utility assistance. While some PATH clients, (particularly those who are dependent upon the on-site support services) are able to reside permanently in the Gallatin School Living Centre, others utilize community-based housing. In the latter cases, case management staff coordinates and advocates on behalf of the client—working with local landlords to assist clients in finding safe, affordable, and permanent housing. Typically, by the time a PATH-eligible client is homeless, he/she has burned many bridges—with family, with the Fayette County Housing Authority, or other supportive housing programs. Often, clients also have very poor credit and do not qualify for loans, or other types of assistance. The proposed use of PATH dollars remains critical, as it provides the client with both the opportunity and the means to secure permanent housing.

Case Management: Participation in the PATH program and related services are voluntary; individuals are not coerced to receive or reject services at any time. Fayette County Behavioral Health Administration requires that PATH providers inform participants of the benefits and risks of services so that these participants make informed decisions about all aspects of the program. In addition, consumers and family members must be fully informed of their rights as behavioral health care consumers including those

outlined in the President's Advisory Commission's Healthcare Consumer Bill of Rights and Responsibilities. These rights are presented both verbally and in written format to all participants. All PATH clients work with a Case Manager—employed by City Mission—who is ultimately responsible to ensure that all of the client's needs are identified and adequately met, including acquisition of any mainstream benefits for which the client may be eligible. The PATH caseworker has completed the Mental Health targeted case management (ICM/RC) training and has increased her understanding of psychiatric disorders, treatment strategies and recovery principles. This approach has ensured appropriate mental health screening and follow-up assistance to individuals presenting at the shelter or other City Mission facility. This approach has also enhanced the awareness of mental health disorders and effective approaches to recovery throughout the agency. She has been trained in promising approaches, cultural competence, and recovery principles. The PATH Case Manager has also completed the SOAR training.

In summer of 2017, the PATH Case Manager will participate in a 2-day Aggression Replacement Training (ART). While designed primarily as an intervention to target aggression in youth, this training will provide the trainees with the tools to implement a 10-week ART course with clients in the program who would also benefit. ART covers social skills training, anger control and moral reasoning.

The PATH Case Manager has access to a variety of treatment and care options that are available through the mental health, drug and alcohol, and healthcare systems within the region. The PATH Case Manager completes a comprehensive assessment of the client's needs as well as an individualized goal plan. Consumers are offered assistance in completing a Wellness Recovery Action Plan (WRAP) if they so choose. Each client's program is designed to contain the components specific to his/her needs and include, as necessary, life skills training, budgeting, resume assistance, health care screenings, and/or literacy classes.

- **How the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data into HMIS.**

  PATH Case Manager has participated in trainings that reflect PATH requirements, housing supports, and evidenced-based practices. These trainings have helped staff to better support the rural population in Fayette County and to meet their individualized needs. Particular evidence-based practices that City Mission's PATH Case Manager continues to implement focuses on Employment Transformation, Motivational Interviewing, Case Management Practices, and Mental Health Recovery.

- **Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.**

  A person receiving services at the City Mission shall retain all civil rights and liberties, except as provided by law or stated in the following special conditions. Each client's services are confidential. This is protected by federal law. No information identifying

the client may be disclosed outside the City Mission program: (1) unless the client consents in writing, or (2) unless the disclosure is to medical personnel for medical emergency, or (3) to qualified personnel with prior written permission to conduct audits and evaluations, or (4) with or without a client's consent where a judge court orders via a subpoena and makes a ruling that the need for disclosure outweighs the risk for harm.

City Mission's policy on client confidentiality is twofold. Staff to client is one aspect and client to client is another. A successful working relationship with a client can only be built when a client knows that his/her concerns are kept confidential. Staff members at City Mission are made aware of how extremely important client confidentially is. City Mission staff understands and agree to protect the confidentiality of clients. Staff is required to sign a Statement of Confidentiality prior to employment. It is the intent of City Mission to take every step possible to ensure the confidentiality of all the clients that we serve.

During a client stay at City Mission they will become familiar with other clients and their life situations. In consideration of this we ask that each client take every precaution not to give out information on the identity or life circumstances of any other resident. Each client is also required to sign a Statement of Confidentiality upon entering the shelter.

- **Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)**

  The PATH Case Manager maintains a positive working relationship with many of the county's service providers. Providers such as the Mental Health Association and Chestnut Ridge Counseling Center Inc., County Assistance Office, Adult Probation, Legal Aid, Local magistrates and several private medical and dental service providers, work directly with City Mission and the PATH Case Manager. The PATH Case Manager also helps to play the role as advocate and supporter in attending court hearings, medical and mental health appointments with individuals who are having problems and at times don't fully understand information presented to them. This coordination helps to provide a more holistic approach to client services. Since 2012, three classes of local and private Police Officers have been trained as CIT (Crisis Intervention Team) Officers. These officers are trained to effectively intervene in identifying and assessing situations regarding individuals who may be experiencing mental health symptoms. Fayette County Behavioral Health Administration conducts ongoing outreach activities with the Fayette County Prison to complete assessments and design treatment and release strategies for individuals in the county jail. PATH Case Manager has access to Public Defender office, Adult Probation and Legal Aid as well as the District Attorney's Office and local Magistrates. PATH Case Manager also has access and is able to go into the jail to provide direct case management services for PATH clients who have been detained. Approximately 70% of PATH clients have been involved with the Criminal Justice System.

- **Jail Diversion** Fayette County has established a Forensic Diversion and Reentry Program for persons with mental illness who have been incarcerated or are at risk of incarceration. The Fayette County Mental Health Treatment Court, The Veterans Court, and Fayette County Drug and Alcohol Court each refer their participants to treatment and rehabilitation programs. The PATH Case manager has access to each of these programs and is able to refer individuals.
- **Primary health** care is available through individual practitioners and several clinics that have as their mission providing care to low-income individuals: two Federally-Qualified Health Centers (Centerville Clinic and Cornerstone Care), Wesley United Methodist Church Medical Clinic in Connellsville, PA and Adagio Health (preventative and primary care for women). Criminal histories do not restrict access to medical services.
- **Housing Programs:** Housing remains a challenge. Stability is essential for supporting a formerly incarcerated person's successful return to the community. However tenant-selection criteria in most public housing throughout the country including Fayette County have and are still preventing individuals with criminal histories access to affordable housing, or even returning to their homes or living with family members in public housing. Lacking other housing options, many of these people still lived with their families in public housing but off the lease and "in the shadows," which put their entire family at risk of eviction.

  Through the contingency/stabilization funds provided through Fayette County Behavioral Health Administration, Housing assistance thru Fayette County Community Action, PATH clients are able to access funds for rental assistance and household items such as furniture, beds etc… which allow them the ability to move into their own apartments, increasing their independents in the community. Eligibility requirements at time are still an obstacle.
- **Job Opportunities:** Workshops, Transitional Employment, Mental Health supportive employment programs, Intensive Vocational Rehabilitation Program for individuals with substance abuse disorders, and Clubhouse are available through several local employment-support providers. Literacy programs are offered by a variety of organizations. Career Link provides assistance in arranging for job training, securing employment, and GED preparation. Penn State Fayette – Eberly Campus and California University of PA offer assistance in admission and financing of higher education. Fayette County Community Action Agency offers literacy and job training programs. Office of Vocational Rehabilitation maintains a local office, providing vocational assessment and assistance in arranging job training and supports.

Data –
Describe the provider's status on the transition to collect PATH data in HMIS. If providers

are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For *providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff*.

City Mission has been utilizing the Housing Management Information System (HMIS) since its inception in 2006 - and inputs both universal and program specific data for all City Mission clients including PATH. Staff working directly with HMIS has completed the required HMIS Intake/Caseworker training and continues to complete 2-3 HMIS trainings per year. City Mission's staff also assures that any related trainings to HMIS updates and changes are completed. City Mission had already taken the necessary steps required to smoothly transition PATH data into the HMIS system. At present, all clients that are PATH eligible are currently being entered into the PATH-HMIS System. As updates to the HMIS system are launched, PATH Case Manager will stay current with all new required trainings to stay proficient in using the system.

Alignment with PATH goals.
Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Fayette County is a rural community with few street homeless. However, the PATH Case Manager continues to provide ongoing inreach through shelter visits, partnering with other social services agencies to do the point-in-time count. There is outreach, collaboration with Fayette County's service systems, including the local jail, Probation Office, and Children and Youth Services and social workers from the two area hospitals.

The PATH Case Manager has completed the Mental Health targeted case management (ICM/RC) training and has increased her understanding of psychiatric disorders, treatment strategies and recovery principles, and has access to a variety of treatment and care options that are available through the mental health, drug and alcohol, and healthcare systems within the region. All PATH clients work with the Case Manager who is responsible for ensuring that all of the client's needs are identified and adequately met, including acquisition of any mainstream benefits for which the client may be eligible. A comprehensive assessment of the client's needs as well as an individualized goal plan is developed. Each client's program is designed to contain the components specific to his/her needs and includes, as necessary, life skills training, budgeting, resume assistance, health care screenings, and/or literacy classes. PATH Case Manager has been trained in promising approaches, cultural competence, and recovery principles. The PATH Case Manager has also completed the SOAR training.

Alignment with State Comprehensive Mental Health Services Plan –
Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

City Mission's permanent, transitional, and emergency shelter services as described throughout this plan are consistent with the state's plan to end homelessness. The PATH Case Manager works with local landlords in preventing eviction by accessing assistance whenever necessary to prevent eviction. In following the Housing First model, Fayette

County Community Action Agency and Fayette County Behavioral Health Administration have collaborated on a permanent housing initiative (Fairweather Lodge) in Connellsville, Pa. for individuals with mental illness and /or substance abuse (serving 8 individuals) along with the development of Fayette Apartments, a 10-unit complex in Uniontown for single adults with Mental Health diagnoses. Fayette County Behavioral Health Administration contracts for Community Residential Rehabilitation Services (CRR); Supported Housing programs; and a Long-Term Structured Residential (LTSR) program -- providers for these mental health services include Chestnut Ridge Counseling Services, Inc., Crosskeys Human Services, and Southwestern Pennsylvania Human Services (SPHS). Subsidized housing services continue to be available through the Fayette County Housing Authority. In addition, to increase collaboration among community providers, the PATH Case Manager participates in local and state housing meetings. The PATH Case Manger continues to grow in her knowledge of local housing options and landlord relationships. She is SOAR trained and has an extensive understanding of the Medicaid and Social Security Disability processes.

Alignment with State Plan to End Homelessness –
Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

As stated previously Fayette County is a rural community with few street homeless. However, the PATH Case Manager continues to provide ongoing inreach through shelter visits, partnering with other social services agencies to do the point-in-time count. There is outreach, collaboration with Fayette County's service systems, including the local jail, Probation Office, and Children and Youth Services. The PATH Case Manager also actively participates in community provider meetings, such as local housing and mental health meetings; and serves on Fayette County's St. Vincent DePaul's Board of Directors. The PATH Case Manager works to assess each client for chronic homelessness and the needed documentation is collected in order to prioritize housing for our most vulnerable population.

Fayette County's housing programs have continued to increase efforts to prioritize our chronically homeless population. HUD funded programs continue to reach out to local and regional housing providers to first house individuals that are defined as "Chronically homeless". The PATH Case Manager assess all clients for chronic homelessness, along with working to obtain the appropriate documentation to prove chronic homelessness. Fayette County Community Action Agency along with Fayette County Behavioral Health Administration have partnered to build Fayette Apartments. These apartments focus on permanently housing our chronically homeless individuals.

PATH Case Manager as well as City Mission staff has been trained in disaster preparedness. City Mission clients for the most part live independently in their own apartment except those that are being housed in our shelter programs. Most emergency situations the main focus is on food, water and shelter. The PATH Case Manager provides direct instruction to resident that are being housed independently to gradually begin to store and rotate enough food and water to last three days in case of an emergency. Clients are also advised to obtain first aid

kits, flash lights, batteries, etc. Our men, women and youth shelters already have needed supplies and procedures in place. City Mission staff is also available 24 hours a day with the intention of providing assistant to 100% of clients in any crisis situation.

Other designated Funds-
Indicate the Mental Health Block Grant, Substance Abuse Block Grant or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

No specific funding is earmarked for PATH services in the county under the Mental Health or Substance Abuse sections of the Human Service Plan 16-17. The County Human Service Plan continues to focus on needs surrounding increase access to safe, affordable, and permanent housing along with access to community-based mental health and drug and alcohol services. City Mission works on addressing these community concerns through the activities of the PATH Case Manager. PATH works in partnership with Fayette County Community Action Agency; FCCAA receives some of its funding from the Homeless Assistance Program (a component of the County Human Service Plan). This funding helps to support the homeless population in the county along with PATH clients. The PATH Case Manager helps clients access this funding source.

Programmatic and Financial Oversight –
In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

Fayette County Behavioral Health Administration designates a Master's level Mental Health Program Specialist to oversee PATH spending and to assist the PATH case manager in completing all required State and Federal PATH trainings. The Mental Health Program Specialist actively participates in PATH trainings and HMIS trainings in order to have a better understanding of PATH goals and data collection. PATH monitoring takes place at the county level, through visits, billing review, and plan updates. The county PATH monitor and the PATH Case Manager have a positive working relationship and are open in discussing client needs, community needs, and required PATH data collection.

SSI/SSDI Outreach, Access, Recovery (SOAR) –
Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. For the grant year 2016-2017, include all of the following data:

- **The number of staff trained in SOAR**
  In addition to the PATH case manager, City Mission has one other full time staff person who has also completed the SOAR on-line certification training.

- **The number of staff who provided assistance with SI/SSDI applications using the SOAR model:**
  In addition to the PATH case manager, City Mission has one other full time staff person trained in SOAR who provided assistance with SI, SSDI applications.
- **The number of consumers assisted through SOAR**
  Eight PATH consumers have successfully received benefits (SSI/SSDI) from directly working with the SOAR trained staff at City Mission.
- **Application eligibility results (i.e., approval rate on initial application, average time to approve the application)**
  Average time for clients to be approved is still approximately 60 - 90 days from day of application and sometimes longer. Each client situation is different. Those that have been denied in the past and are reapplying a determination can take up to a year or more.
- **The number of staff dedicated to implementing SOAR, part and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]**
  In addition to the PATH case manager, City Mission has one other full time staff person who has also completed the SOAR on-line certification training.

Housing-
Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Fayette County has a continuum of housing services in place to meet the needs of Fayette County's homeless population. PATH consumers are offered housing that meets their needs and preferences. The PATH Case Manager works with the consumer to obtain safe, appropriate, and affordable housing options that meet his/her need and individual preferences. Since the PATH program became operational in Fayette County, City Mission has worked to develop relationships with private landlords within the county as a viable means of securing housing for PATH clients.

Housing services available in Fayette County:

- City Mission Living Stones, Inc.
  - Two emergency shelter facilities (a women & children's shelter and a homeless men's shelter)
  - Gallatin School Living Center (18 SRO units and 12 transitional housing apartments, eight units of permanent housing for individuals with disabilities)
  - Liberty Park Apartments - Four units of Permanent Supportive Housing
  - Sycamore Hills Apartments- Four units of Permanent Supportive Housing
  - Stone Ridge Apartments- Six units of Permanent Supportive Housing (two units dedicated to individuals with mental health concerns.)
  - HOME AGAIN (Youth shelter serving youth ages 12-17)
  - Promise House (Independent living facility serving youth ages 18-22)

- Fayette County Community Action Agency
    - Bridge Housing
    - Housing Supports Program
    - Master Leasing
    - Tenant-based rental subsidy
    - Lenox Street Apartments
    - Fairweather Lodge
    - Fayette Apartments
- Fayette County Housing Authority
    - Permanent, Supportive housing vouchers
    - Public Housing
- Chestnut Ridge Counseling Services, Inc
    - Long-term Structured Residential (LTSR)
- Crosskeys Human Services, Inc.
    - Community Residential Rehabilitation (CRR)
    - Housing Supports Program
- Southwestern Pennsylvania Human Services
    - Community Residential Rehabilitation (CRR)
    - Housing case management
- Goodwill Industries
    - Jefferson Apartments
- Fayette County also has numerous small (less than 16 resident) personal care homes that provide housing for individuals with mental illness.

Coordinated Entry-Indicate if your organization is part of a coordinated entry program. If so explain the coordinated entry process and through who it is governed/monitored.

City Mission is participating directly with the Coordinated Entry process and is working with Fayette County Community Action Agency (FCCAA) in understanding and implementing the process and requirements. Several families have entered through Coordinated Entry and are presently residing in our Gallatin School Living Center's transitional Housing Program. Clients entering emergency shelter are assisted in setting up an appointment with FCCAA to go through the coordinated intake process. A point person at FCCAA contacts City Mission's property manager to streamline the entrance process to longer term housing.

Justice Involved –
Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness. (FCBH needs to provide info)

The Memphis Model Crisis Intervention Team training is employed in Fayette County. There are many small municipal police departments with only a couple of officers. In those communities, 50-100% of the officers are CIT-trained. In larger communities and within the local State Police Barracks, 0-20% are trained. The chiefs from the departments that actively use CIT officers as their specialists when responding to persons with mental illnesses are very pleased with officer safety, consumer safety, and reduced arrests.

Staff Information –

- **Describe the demographics of staff serving the clients**

  City Mission as the PATH program provider is made up of a diverse array of staff which includes:

  - Male and female staff.
  - White, African-American and other ethnic minorities.
  - Master's level, Bachelor's level, and High-School trained staff
  - City Mission employs and uses volunteers who were formerly homeless clients.

- **Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients**

  City Mission has more than 30 years of experience serving the identified population in Fayette County. As in most rural communities, the majority of staff originate from and live in the communities where services are delivered, sharing the same language and cultural beliefs and customs unique to the area. The PATH Case Manager will continue to look for opportunities to develop her understanding of the LGBTQI2-S community. City Mission does not discriminate based on sex, gender, race, age, sexual preference, or disability.

- **Discuss the extent to which staff are receptive to differences of clients**

  City Mission has employee orientation programs that address human diversity within its individual service delivery system. Additional training programs are used to reinforce the importance of cultural sensitivity and provide opportunities for employees to examine their personal beliefs and attitudes, and develop plans for personal growth in this area.

- **Identify the extent to which staff receive periodic training in cultural competence and health disparities**

  City Mission has addressed these service barriers through program design and the utilization of a specialized Case Manager, working within City Mission with all specialized sub-populations who utilize PATH services. It is the practice of the Fayette County Behavioral Health Administration to engage local consumers and family members in all aspects of program development and evaluation.
  Fayette County Behavioral Health Administration has identified cultural sensitivity as a priority for training, and in fact, worked with the Fayette County Human Service Council and Penn State Fayette – Eberly Campus to make training available. Other trainings are offered through local universities including California University, West Virginia University and the University of Pittsburgh. The County and PATH providers seek out opportunities for cultural sensitivity training for staff involved in the PATH project and other services as well.

  Finally, in order to assure that services are being delivered in a culturally sensitive manner, consumers are advised of procedures for filing complaints with the Fayette County Behavioral Health Administration about any problems they perceive in the delivery of services, including disrespectful behavior on the part of staff. The County reviews all such complaints with providers and works with them to develop corrective

action plans.
Listed below are trainings completed by PATH Case Manager since the PATH program was implemented in Fayette County.

- Improving Practice in our African American Appalachian Community
- PA Office of Mental Health & Substance Abuse in collaboration with Drexel University—16th Pennsylvania Case Management Conference
- Suicide / Risk Assessment – Penn State Fayette
- Co-Dependency – Penn State Fayette
- Forensics and Addiction – Penn State Fayette
- Evidence-Based Practices – Employment Transformation Project
- Strategic Planning session – Employment Transformation Project
- Basic Case Management/Resource Coordination Web-Based training
- Motivational Interviewing for Mandated Treatment
- PATH National Teleconference on Recovery
- Substance Abuse & Axis II Personality Disorders Assessment & Treatment
- Wellness Planning – First Annual Recovery Conference in Fayette County
- Choices in Recovery seminar
- Motivational Interviewing Skills for Mental Health Care Workers
- Outreach to People Experiencing Homelessness & PATH National & State Perspectives
- Learning About Adult Services in Fayette County
- Working with Family Systems – Fayette County Drug & Alcohol Commission, Inc.
- Peer Employment Training
- SOAR – Stepping Stones to Recovery
- HIV & Pregnancy – Fayette Healthy Start
- Cross Systems Mapping & Taking Action for Change
- Promoting a Healthy Work Environment in Homeless Services: What Works (web training / SAMHSA)
- Supportive Housing; Speaking Landlord (OMHSAS web training)
- PREP - Prepared Renters Program I & II (coach training)
- PATH Data Reporting 2010 (SAMHSA)
- Fair Housing: Rights & Responsibilities
- Evidence Based Practices KITs: Shaping Mental Health Services Toward Recovery (SAMHSA)
- "The Mystery of the Mind and the Demystification of Psychiatric Drugs" – (CRCSI)
- SAMHSA Street Outreach Video
- Healthy Start/University of Pittsburgh School of Social Work… HIV & Pregnancy, Impact & Issues
- FCBHA/Fayette Court of Common Pleas …Cross Systems Mapping & Taking Action for Change
- SAMHSA…Promoting a Healthy Work Environment for Homeless Service Agencies

- Veterans: Return, Reintegration and Reconnecting
- SAMHSA…Homelessness Prevention
- Recovery & Resiliency-based Individualized Service Treatment Planning
- Stalking: Know it/Name It
- HMIS Training – (HMIS Intake/Caseworker and HMIS Intake/Caseworker Supp.- 11/2012; HMIS Intake/Caseworker - 10/2013; HMIS Core Training & HMIS/PATH Training - 11/2014; HMIS/PATH Programs – 2/2015)
- CPR First Aid
- SOAR Certification on-line training.

Client Information –

- **Describe the demographics of the client population**
  Based on data provided by City Mission on homeless clients served from 2000-present as well as information from Fayette County Behavioral Health Administration, a description of the demographics for clients in the PATH program is as follows:
  - The majority of the clients are single white males, between the ages of 25 and 40.
  - Have experienced homelessness 2 or more times (difficulty maintaining permanent housing).
  - Experiencing or diagnosed with severe mental health and/or co-occurring serious mental illness and substance abuse disorder.
  - Multiple episodes of psychiatric hospitalization within the last 24 months.
  - **Breakdown of clients served July 2016- June 2017**
    Total number of clients that have received services as of May 2017……

Gender	**Race/Ethnicity**
Female – 23	White 10 Black- 13 Hispanic
Male – 44	White- 24 Black -19 Hispanic 1

    41 Entered the program from the emergency shelter
    (Two of which were housed in our Emergency apartment)
    1 Residential Program
    2 Entered from the Domestic Abuse Shelter
    16 Staying with family or friend
    8 Being Evicted
    3 Referred to Shelter from Hospital
    3 Were incarcerated and entered the shelter upon release
- **Project the number of adult clients to be contacted**
  City Mission expects to provide outreach to approximately 450 homeless clients primarily at our two emergency homeless shelters. .
- **Identify expected number of adult clients to be enrolled**
  City Mission anticipates enrolling approximately 50-60 adult clients using PATH funds in FY 2017-2018
- **Give estimated percentage of adult clients served using PATH funds to be literally homeless.**
  City Mission expects that 85% of PATH clients will be literally homeless, and 15% will be at imminent risk of being homeless. For PATH clients who are literally homeless, City Mission provides an array of housing and service options including food, clothing, shelter, transportation, and case management. For those who are at risk of being

homeless City Mission uses homeless prevention funds from the PATH program. Money utilized in PATH for re-housing homeless clients can be used to leverage funds from other local providers including, Saint Vincent de Paul, Connellsville Community Ministries, Fayette County Community Action, and City Mission.
Additionally, City Mission also links persons to case management services from Southwestern Pennsylvania Human Services (SPHS) for PATH clients who are literally homeless. Initially the PATH Case Manager works to stabilize the client in housing, follow-up to assure all housing related supports are established, and then refer the client to SPHS for further behavioral health case management

Consumer Involvement - Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix I "Guidelines for Consumer and Family Participation".

Each year consumers are given the opportunity to discuss, evaluate and give feedback on the proposed intended use of PATH funds. PATH consumers meet at the Gallatin School Living Centre for the above purpose. For those consumers who cannot attend the above meeting, special arrangements are made to meet with them or their representatives individually at a location convenient to them. Documentation outlining feedback from PATH consumers is kept on file.

City Mission requires that their governing board include representatives who are either current service users or have used services in the past. City Mission employs six formally homeless individuals—several of whom are PATH clients. Fayette County Behavioral Health Administration's Advisory Board also includes consumer and family representatives.

Health Disparities Impact Statement – Please identify efforts to support the Transition Age Youth (TAY) Disparity population by providing the following:

In August, 2016, City Mission opened Promise House, an independent living program/facility that will serve young adults ages 18-22. Promise House will consist of three small two-bedroom cottages—one for young men, one, for young women, and a third will function as a staff unit. Youth with no parental involvement who age out of our HOME AGAIN program have had no options for housing other than adult shelter. Promise House will provide accountability, life skills programming, along with safe, permanent, and affordable housing to transition age youth. Promise House will be a key resource for those youth needing housing and support services beyond age 18. Fayette County Behavioral Health Administration partners with City Mission to identify and assess the needs of individuals who are homeless.

- **The unduplicated number of TAY individuals who are expected to be served using PATH funds.**
  City Mission anticipates serving 6-8 transition age youth annually. Of these, we anticipate two (2) will be PATH eligible.

- **The total amount of PATH funds expected to be expended on services for the TAY population**
  That amount is difficult to determine at this time. Each PATH client is assisted on an individual basis and needs vary. However, based on previous year's amount it is estimated that $800 will be spend on TAY PATH eligible clients.

- **The types of services funded by PATH that are available for TAY individuals**
  The types of services funded by PATH that are available for TAY individuals will include Path Case Management, as well as rental assistance used during period of transition from Promise House into the community.

- **A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population**
  Promise House will help to fill the current gap in service that exists as far as supporting the needs of transition age youth. The program will specifically target the needs of TAY in the community. Promise House will consist of a comprehensive curriculum consisting of life skills programming and other elements designed to meet the specific needs of TAY.

Limited English Proficiency –
Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?languages.

City Mission has access to faculty and student body at the University of Pennsylvania, Fayette Campus, who are willing to provide assistance when needed. A long-standing partner and friend to City Mission PSU offers instruction in well over 50 languages, and will be a definite, unlimited, benefit to clients that need this type of assistance.

Budget Narrative- Provide a *descriptive* budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example: $10,000 federal allocation, $3,333 state match, $1000 PATH specific base funds match.

When reviewing the overall budget for the Fayette County PATH program, fiscal year 2017-2018, the majority of the expenditures are prioritized for professional expenses. These include PATH case manager and benefits, totaling $54,776. City Mission will continue to absorb the cost of PATH outreach aspect of its overall budget and agency outreach. In addition, City Mission will make use of local and free training/workshops for its PATH case manager. Fayette County Community Action Agency (FCCAA),

Fayette County Drug & Alcohol, and Southwestern PA Human Services (SPHS) have several workshops and training throughout the year that will be beneficial to the PATH case manager. Expenses related travel and staff trainings, has an estimated cost of $500. Housing related expenses, including one-time rental assistance and security deposits, total $4,400. The cost of individual and group support sessions, provided by a Master's level Social Worker, will be absorbed by City Mission. This service is to help support PATH clients and staff weekly at the Gallatin School Living Centre location. Transportation expenses include bus tokens, fuel, and insurance coverage estimated at an increased amount of $9,500. Other PATH related expenses include Office Supplies, Equipment/Furnishings, internet cost, and other consumer-related items estimated at $5,685. Administration cost of monitoring the PATH program funding is 2,995. The total budgeted cost for the PATH program is $77,856.

Fayette County
City Mission – Living Stones
PATH Program
FY 2017-2018 Budget

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
Case Manager	$48,000.00	1 FTE	$48,000.00	$48,000.00
sub-total	$48,000.00		$48,000.00	$48,000.00
Fringe Benefits				
FICA Tax	$3,686.00	1 FTE	$3,686.00	$3,686.00
Retirement	$1,440.00	1 FTE	$1,440.00	$1,440.00
Life Insurance/WC	$1,650.00	1 FTE	$1,650.00	$1,650.00
sub-total	$6776.00		$6776.00.	$6776.00.
Professional Training				
Travel to training and workshops	$250.00		$250.00	$250.00
Training cost	$250.00		$250.00	$250.00
sub-total	$500.00		$500.00	$500.00
Equipment/Furnishings				
As needed furnishings	$1.000.00		$1.000.00	$1.000.00
sub-total	$1.000.00		$1.000.00	$1.000.00
Supplies				
Office Supplies	$575.00		$575.00	$575.00
Postage	$50.00		$50.00	$50.00
Telephone/internet	$3,260.00		$3,260.00	$3,260.00

Consumer-related items	$800.00		$800.00	$800.00
sub-total	$4,685.00		$4,685.00	$4,685.00
Support group Sessions				
Individual and group support sessions provided by Master's level social worker				
sub-total				
Rental Assistance				
One-time rental assistance	$2,200.00		$2,200.00	$2,200.00
Security deposits	$2,200.00		$2,200.00	$2,200.00
Sub-total	$4,400.00		$4,400.00	$4,400.00
Transportation				
Transportation	$9,500.00.		$9,500.00	$9,500.00
(includes bus tokens, fuel,				
insurance for van and to Case manager's mileage expenses.				
sub-total	$9,500.00		$9,500.00	$9,500.00
Administration				
(includes 4% allowable costs)	$2,995.00		$2995.00	$2995.00
Sub-total	$2,995.00		$2,995.00	$2,995.00
Total PATH Budget			**$77,856**	

25. Forest-Warren - Warren Forest Economic Opportunity Council

1209 Pennsylvania Ave West

Warren, PA 16365

Contact: Chad Ressler

Contact Phone #: 8147262400

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-038

State Provider ID: 4210

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 34,816	$ 11,605	$ 46,421	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 34,816	$ 11,605	$ 46,421	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 34,816	$ 11,605	$ 46,421	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 34,816	$ 11,605	$ 46,421	

Source(s) of Match Dollars for State Funds:

Forest/Warren will receive a total of $46,421 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 70

Estimated Number of Persons to be Enrolled: 56

Estimated Number of Persons to be Contacted who are Literally Homeless: 7

Number staff trained in SOAR in grant year ending in 2017: 2

Number of PATH-funded consumers assisted through SOAR: 0

Warren and Forest Counties Economic Opportunity Council
PATH Intended Use Plan for FY 2017-2018

Section C: Local-Area Provider Intended Use Plans

• Local Provider Description – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local government entity, health care provider, and private non-profit organization) region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of each provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

Forest Warren Human Services is a political sub-division that provides linkage between the county, the Forest Warren County Commissioners, and the publically funded human service system.

Forest Warren Human Services is responsible for the fiscal management of allocated federal, state, and county funds received for the specific purpose of providing identified human service programs. In conjunction with the fiscal management of these monies, Forest Warren Human Services is responsible for the management of contracts with private providers who agree to provide services in compliance with licensing, regulatory, and contractual requirements.

Forest Warren Human Services is also responsible for the planning requirements of each categorical program (MH, ODP, CYS, and ATOD). Each year a plan is developed, with consumer and community input, describing the current status and future goals for each program, utilizing the principals and advancement towards a recovery oriented approach.

Forest Warren Human Services receives PATH funding through OMHSAS and contracts with the *Forest Warren Economic Opportunity Council* (EOC) as our PATH provider in the amount of $46,421.

The Warren-Forest Counties Economic Opportunity Council (E. O. C.), Inc. is a private, non-profit Community Action Agency and part of a 43-agency network covering the 67 counties in Pennsylvania and more than 1,000 Community Action Agencies nationwide, adhering to the philosophy of the Economic Opportunity Act of 1964. The agency utilizes available funds to operate programs designed to eliminate poverty in Warren and Forest Counties. The organization was incorporated in 1965.

The Agency Board of Directors responds to the needs of the local community through its operation of targeted programs. Since its inception, The Warren-Forest E. O. C. has ventured to move individuals to a higher economic position through services provided and by instilling a self-reliant and self-sufficient attitude in each client. It provides a systematic set of programs that attacks poverty through employment training, budget and savings assistance, and Head Start. It also addresses the conditions that low-income

persons face in such areas as housing (through its homeless prevention, weatherization, housing counseling, transitional housing units and supportive housing units), and utility assistance. Some other examples of programs include: Housing Rehabilitation, Veterans Assistance, and Transitional Housing for Victims of Domestic Violence, Homelessness Prevention and Rapid Rehousing Program. The Economic Opportunity Council continues to provide exceptional services for people seeking to improve their quality of life through community, economic, personal, and family development.

The full name and address of the organization is:

Warren-Forest Counties Economic Opportunity Council
1209 Pennsylvania Avenue West
Warren, PA 16365

This provider appears in the PDX as: PA-038 Forrest/Warren: Forrest Warren Economic Opportunity Council.

Most housing clients are housed or at risk of homelessness but we do see a small percentage of people that are literally homeless. Services are provided throughout Warren and Forest Counties. The Warren and Forest Counties EOC is contracting PATH funds in the amount of $46,421.00

• Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum of Care briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the areas where PATH operates.

Our region is located in the Western PA Continuum of Care (PA-601). The EOC Housing Department staff and Housing Director regularly attend CoC area meetings and actively participate in all CoC training. The Warren-Forest Co. Executive Director is a member of the CoC for our region and is a member of the Regional Homeless Advisory Board (RHAB) and Housing Alliance of PA. The E. O.C. currently operates a permanent supportive housing program and a domestic violence transitional housing program through HUD CoC funding. E. O.C. actively participates in the upcoming coordinated entry process that is due to be implemented in our region by January 2018. The Housing Specialist continues to work with existing housing stock to house consumers and works with other community programs such as the local Housing Authority, and the multitude of services available at Warren-Forest Counties Economic Opportunity Council, local churches, and the Salvation Army to identify resources to prevent homelessness. E.O.C. Housing Specialists chair the Local Housing Options Team that encompasses staff from Mental Health, Drug and Alcohol, Mental Retardation, Housing Authority, Warren-Forest E.O.C., local C.S.P., landlords, Community Resources for Independence ,Warren

County Jail, Area Agency on Aging, Veterans Affairs and local tenants. The L.H.O.T. is continuing to expand their representation of service providers and Mental Health consumers. In addition, the PATH Housing Specialist organizes the "Point in Time Survey" conducted yearly and attends quarterly meetings for the Western Regional Housing Options Coalition. The Warren Forest E.O.C. is a designated Homeless Assistance Program (HAP) coordinating Agency for Warren County.

• Collaboration with Local Community Organizations – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. **Provide specific information about how coordination with other outreach teams will be achieved.**

The E. O. C. Housing Specialist works closely with each PATH eligible client to assist them in accessing needed services within the community. The community organizations that we work closely with are the Forest Warren Human Services, Warren State Hospital, Beacon Light Behavioral Health, Warren County Assistance Office, Forest County Assistance Office, Safe Place, Career Link, Salvation Army, Warren General Hospital, Deerfield Behavioral Health, Veterans Affairs, and Family Services, HANDS, Housing Authority of Warren County, and many other agencies. The Housing Specialist can access rental assistance through Warren-Forest Counties Economic Opportunity Council's Homeless Assistance Program if eligible. Housing Specialist works closely with the agencies listed above to ensure that proper referrals and services are accessible to PATH eligible clients. As Warren-Forest E. O. C. is the only PATH provider in Warren and Forest Counties, no coordination between outreach teams is required. The 2-1-1 system is just starting in the Warren-Forest Area and is another tool in coordinating outreach. Warren Forest EOC, local churches, service providers such as Salvation Army, M. H./D&A caseworkers, and local law enforcement will be incorporated into this system. Word of mouth as well Warren Forest EOC's website provide opportunity for outreach and the local community organizations to contact and send referrals.

• Service Provision – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

- **How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless.**

As a PATH provider we prioritize services by working closely with the various service providers that are available in our community. We connect clients to local case management services provided through Beacon Light Behavioral Health, Forest Warren

Human Services, and Deerfield Behavioral Health as well as housing and mainstream benefit services provided by the E. O. C. Housing Specialist. Referrals for services, applications for employment/benefits, budget counseling/meal planning, and life skills are various topics that are covered through housing service plans. The PATH housing specialist works with each client on an individualized housing plan. Clients are connected to programs and services that will assist them with any mental health and/or substance abuse issues. Clients are also assisted with applications to various housing subsidies, Housing Authority, and private landlords. Clients are also referred to programs offered through E. O. C. such as budget counseling and employment and training.

Street Outreach is provided through the collaboration of the service agencies, county government, and general word of mouth. Warren-Forest E.O.C. is located in a rural community where many individuals move between with family and friends rather than on the street. There are also several campgrounds where homeless individuals can go. Staff works closely with other local agencies to identify and assist those who are homeless.

- **Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services.**

  Warren-Forest Counties E. O. C. provides many programs and services throughout Warren and Forest counties in addition to PATH funds that can be utilized to assist PATH clients. Warren-Forest Counties E. O. C. works in conjunction with the Salvation Army to provide H. A. P. funds for individuals who are moving from transitional housing to permanent supportive housing. Contingency funds are also applied for and utilized to assist with moving clients to permanent housing. Warren Forest E.O.C. Housing program also provides a permanent housing program for individuals with mental illness or co-occurring mental health and substance abuse. Section 8 vouchers and NW9 housing subsidies are also applied for in our goal to achieve stable permanent housing.

- **Gaps that exist in the current service systems.**

  Gaps that are occurring for many consumers are low incomes and lack of ideal employment services (i.e. job coaching services), as well as the inability to

sufficiently cover fair market rents, along with consumers not knowing what resources are available to them, connecting consumers to the correct programs, lack of advocacy for M. H. consumers, and social supports within the counties. Housing for young adults, state hospital discharges, previously incarcerated, dual diagnosed and low income families also seem to be target populations that have difficulty finding and maintaining housing. Another gap is the time management aspect between service providers most likely due to the lack understanding and clarification of HIPPA rules and regulations. Lack of Adult Foster Care system and sufficient family-based transitional housing options are hindrances facing community reintegration efforts. Limited personnel and large caseloads in Mental Health Blended Case Management Services and lack of Supported Living Services inhibit the depth of which these services can be provided.

- **Brief description of the services available to clients who have both a serious mental illness and a substance use disorder.**

  The EOC Housing Specialist works with the dual diagnosis clientele and coordinates with the various staff of these programs available to assure PATH eligible clients receive services while they remain in their home. Consumers, ranging from teenagers to the elderly, with co-occurring disorders are a challenge and frequently use the most costly services. This combination of problems increases the severity of the mental health and substance abuse problems increasing the risk of homelessness. Services include community agencies as follows; Deerfield Behavioral Health, Family Services, Forest Warren Human Services, Beacon Light, Dickinson Center, and Warren General Hospital.

  Physical health care in Forest Warren is provided by primary care physicians at Warren General Hospital, clinics, and doctor's offices.
  Mental Health services are provided by Family Services, Beacon Light Behavioral Health, and Deerfield Behavioral Health. In-patient care is provided by Warren General Hospital, Clarion Psychiatric, Millcreek Community Hospital, Elk County Regional Hospital-Generations Geriatric Unit, Bradford Regional Hospital, St Vincent Health Center, Dubois Regional Medical Center, and UPMC Northwest. Out-patient Services, Individual Therapy, Blended Case Management, Psych Rehab, Certified Peer Specialists and Mobile Medication Management services are provided by Beacon Light Behavioral Health through health choices.
  Forest Warren Human Services provides county oversight

  Family Services of Warren County provides individual counseling, substance abuse services, and a variety of support groups.

  Substance abuse services are provided by Deerfield Behavioral Health and Family Services. Forest Warren Human Services provides the SCA and D&A ICM. Deerfield offers a Certified Peer Specialist.

In-Patient Detox is provided by Deerfield Behavioral Health through Warren General Hospital.

ODP service coordination is provided by the county. Residential services are provided by Lakeshore and Lifestyles.

Sheltered employment is provided by Bollinger Enterprises in Warren, Barber National Institute in Corry PA, and Venango Training Development Center in Seneca, Pa.

Consumers can also utilize Career Link and OVR services for employment opportunities.

- **Describe how the local provider agency, pays for or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data into HMIS.**

  The MH Housing Specialist will attend PA HMIS trainings when they are offered. The Housing Specialist has attended several trainings regarding HMIS, and other evidence based practices, and The Warren-Forest E. O. C. PATH program supports and funds all trainings for the PATH Housing Specialist.

  Warren-Forest E. O. C. has been participating with PA HMIS training since 2010-2011 fiscal years. Ongoing training is web-based through this system and different supplementary webinars are available. All staff attends trainings as frequently as they are offered.

  The Housing Specialist and E. O. C. will continue to participate in the mandated PATH HMIS system.

  The Housing Specialist also attends webinars, and other various trainings, such as those provided by The Housing Alliance of PA on Shared Housing, Medicaid and supportive Housing, Fair Housing, and Youth Homelessness. Staff also attends Mental Health First Aid Training. Any other services or therapy's are referred to specific providers in our local continuum.

- **Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.**

  Warren-Forest E. O. C. is not required to follow 42 CFR Part 2 regulations.

- **Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports(e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)**

  Clients with criminal justice histories may have a hard time in any setting dependent upon the charges that are in each individual's history. Some clients are easier to link to supports that are in place for each aspect mentioned such as job opportunities. Clients are referred to PA CareerLink as well as they are given opportunity to utilize the Employment education and training program provided by Warren-Forest E. O. C. These programs help with resume building, career counseling, employment applications, and work readiness. Reintegration into community comes through referrals and communication with the Warren County Prison, Probation and Parole officers. The PATH Housing Specialist helps provide the structure and routine through establishing house rules and by conducting weekly housing preventative maintenance inspections and monthly cleanliness and environment of care inspections. Communication on community services hours owed and with the PATH Housing Specialist helping to coordinate with other local non-profits such as PAWS Along the River, the local Y.M.C.A. and various local churches allows the clients to complete their hours owed in a timely manner so as to lessen that hindrance. Clients meet with Public Assistance Office Caseworkers as part of PATH intake and access to mainstream benefits and are referred to any provided/needed services through the case management process. Beacon Light provides Mobile Medication services to meet transportation/various medical needs to PATH clients.

• Data – Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For *providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff.*

Warren-Forest Counties E.O.C. has fully utilized PA HMIS for several years. E. O. C. will continue to provide funds for trainings and conferences offered so staff may be trained. All webinar trainings dealing with HMIS are attended as well. New housing staff will attend live, on site trainings, and will attend offered webinars as well. Previously trained staff will function as mentors for new staff as they become familiarized with HMIS. E. O. C. enters data into HMIS for our PATH, ESG Shelter/Rapid Re-housing programs, and Permanent Supportive Housing programs.

• Alignment with PATH Goals- Describe how the services to be provided using PATH funds will target street outreach and case management as priority services

and maximize serving the most vulnerable adults who are literally and chronically homeless.

As a PATH provider we target street outreach and case management as priority services by working closely with the various service providers that are available in our community. Our PATH clients have or are referred to case management services in the community provided through Beacon Light Behavioral Health, Forest Warren Human Services, Deerfield Behavioral Health as well as those provided by the E. O. C. PATH Housing Specialist. Referrals for services, applications for employment/benefits, budget counseling/meal planning, life skills are various topics that are covered through housing service plans. Independent living skills, mental health services, drug & alcohol services, and other needs are sought through local service providers. Clients residing in E.O.C.'s PATH housing are provided quality case management services. The PATH housing specialist works with each client on an individualized housing plan. Clients are connected to programs and services that will assist them with any mental health and/or substance abuse issues. Clients are also assisted with applications to various housing subsidies, Housing Authority, and private landlords. Clients are also screened to determine their need for any of E.O.C.'s other programs such as budget counseling and employment and training, and, when applicable, referrals are made to such programs by the housing specialist. Street Outreach is provided through the collaboration of the service agencies, county government, and general word of mouth.

- **Alignment with State Comprehensive Mental Health Services Plan- Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plan**

Warren-Forest E. O. C. will use PATH funds to increase collaboration between E. O. C. and service providers in Warren and Forest counties in an effort to educate and assist service providers in referring homeless individuals to the PATH program for services. PATH funds will be used to prioritize housing those who are suffering from mental health and/or dual diagnosis to prevent them from becoming chronically homeless. As stated in the Agenda for Ending Homelessness in Pennsylvania (2005), nationally, roughly 80% of the homeless population is situationally or transitionally homeless. E. O. C. PATH funds will be used to provide quality case management services to those who are situationally or transitionally homeless in an effort to obtain permanent housing and prevent chronic homelessness. PATH funds will also be used to provide case management services to those in transitional supportive housing. The housing specialist will work with clients on individualized housing plans. These case management services will be focused on providing clients with proper referrals to supportive services, housing education, assistance with applications, and connection to services in preparation for transitioning to permanent housing (e.g. Utility programs, budget counseling, home ownership education, and prepared renters training).

- **Alignment with State Plan to End Homelessness – Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.**

Warren-Forest E. O. C.'s PATH funds will be utilized to provide effective case management services and transitional housing for those who are homeless or at risk of homelessness. PATH funds will also be used in an effort to improve data collection procedures across two counties as data collection is identified as "one of the challenges to addressing homelessness" (Homelessness in Pennsylvania Task Force Report, 2016). Warren-Forest E. O. C. also serves a large criminal justice population and will use PATH funds to help individuals with criminal records identify barriers and develop solutions with respect to finding quality, affordable permanent housing. These three key areas focus assistance on a certain sample of the homeless population in an effort to prevent them from becoming chronically homeless. Warren-Forest E. O. C. seeks to connect individuals to the necessary supportive services and employment and training programs, as well as working directly with the client to complete applications to various subsidized housing units and housing subsidies.
The Housing Specialist sits on a safety committee at the Warren State Hospital. We will continue to look at all options to integrate disaster preparedness and an emergency response plan and will be working with Forest Warren Human Services and coordinated response information to make county improvements.

• Other Designated Funds- Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

Forest Warren Human Services has Special Grant funding designated specifically for homeless/housing.

Forest Warren Human Services designates Mental Health and County funds for 4 rental properties that provide 15 beds for PATH consumers. The housing is located on the Warren State Hospital grounds and is maintained by Warren Forest E. O. C.

- **Programmatic and Financial Oversight – In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral**

health authorities), describe how these organizations monitor the use of PATH funds.

Forest Warren Human Services provides oversight of EOC through monthly housing meetings to discuss referrals and current individuals living in PATH housing. Quarterly reports are sent to Forest Warren Human Services to monitor the budget spending. EOC as well as Forest Warren Human Services participates in the Local Housing Options Team (LHOT) meetings held bi monthly to discuss housing options for homeless. Invoices are reviewed and approved by Forest Warren Human Services prior to payment.

• SSI/SSDI Outreach, Access, Recovery (SOAR)-Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking(OAT) system. For the grant year 2016-2017, include all of following data:

- The number of staff trained in SOAR
- The number of staff who provided assistance with SSI/SSDI applications using the SOAR model;
- The number of consumers assisted through SOAR
- Application eligibility results (i.e., approval rate on initial application, average time to approve the application)
- The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]

Currently, Warren-Forest E. O. C. is in the process of the web-based SOAR training. 2 staff team members are currently certified and 3 more staff team members will be trained on SOAR. This is due to recent staffing turnover including The PATH Housing Specialist. Currently one consumer SOAR application is in process. Upon completion of the web based training, the PATH housing specialist will arrange with State PATH Contact to conduct the one day in person training.

Blended case managers and the County Assistance office assist clients in applying for social security. The PATH housing specialist works with clients and case managers/CAO to ensure that they have all information necessary for a complete application. Housing specialist also provides referrals for clients to various attorneys that handle appeals.

• Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Warren Forest Counties Economic Opportunity Council provides transitional housing (4 sites where individuals have their own bedroom, with a shared living space, specifically for PATH eligible clients), Faith Inn - 9 unit homeless housing (3 efficiencies /handicapped accessible, 2-2 bedroom, and 4-1 bedroom). PATH eligible clients may apply for this housing. The MH Housing Specialist works closely with all PATH eligible clients to ensure that all E. O. C. transitional housing is a suitable, safe, and affordable while clients are working on goals to obtain permanent housing.

The Warren-Forest Counties Economic Opportunity Council owns several permanent housing properties throughout Warren and Forest Counties. In total, the E. O. C. currently manages 3 apartment units in Tionesta, and 21 throughout the City of Warren. E. O.C. owns Fairweather Lodge properties that are currently managed by Forest Warren Mental Wellness Association. There are a total of 5 units under Fairweather Lodge and 3 more are in process of opening up.

E. O. C. also provides permanent supportive housing in cooperation with HANDS at the Anthems site that includes 8 private apartments (6-1 bedroom & 2-2 bedroom.).

Forest Warren Human Services offers a continuum of housing options ranging from Homeless Housing through our Transitional Housing as well as through the Faith Inn which is funded through the ESG grant, to permanent supported mental health housing. All these housing options are monitored through Warren Forest Economic Opportunity Council (EOC).

- There are currently 15 beds available in four transitional houses through the local EOC. One house has been identified for Transitional Age Youth (TAY)- and for those TAY that qualify are eligible for Independent Living Services through Forest Warren Human Services; the other house has been identified as a Forensic House, for those coming out of incarceration.
- There are eight apartments available for permanent supported housing through the "Housing and Neighborhood Development Services" (HANDS)
- The Housing Authority provides housing for the elderly population, individuals with disabilities and individuals or families with low income.
- 4 Personal Care Boarding Homes are available.
- Faith Inn has 9 unit transitional housing (3 efficiencies/handicapped accessible, 2-2 bedroom and 4-1 bedroom) (EOC)
- 2 efficiency apartments; 1 in Warren County 1 in Forest County
- 5 unit Fair Weather Lodge- supportive housing in Warren county
- 3 Unit Fair Weather Lodge still under construction- supportive housing in Warren County
- 811 project in Forest County- 2 Units, 1 1-bedroom and 1-2 bedroom

- 3-1 bedroom units (EOC)-permanent supportive housing in Warren County
- 4-2 bedroom unit (EOC)-permanent supportive housing in Warren County
- 2-3 bedroom unit (EOC)-permanent supportive housing in Warren County
- 1-1 bedroom unit (EOC)- permanent supportive housing in Forest County
- 1-2 bedroom unit (EOC) – permanent supportive housing in Forest County
- 1-3 bedroom unit (EOC)-permanent supportive housing in Forest County
- 6-1 bedroom units (EOC)-permanent supportive housing in Warren County
- 3 1-bedroom units (EOC) – permanent supportive housing in Warren County
- 1-2 bedroom unit (EOC)-permanent supportive housing in Warren County

• Coordinated Entry- Indicate if/how your organization is engaged with the local coordinated entry processes of your CoC. Please describe the roles of key partners in the CoC

Our region is located in the Western PA Continuum of Care (PA-601) which is currently in the process of launching a coordinated entry system for Western Pennsylvania. At the Western PA CoC meeting/training held on 4/25/2017, a Coordinated Entry update was given and pilot programs are up and running for coordinated entry in in several Western PA counties. An assessment tool and prioritization list are being tested and the system will be introduced to the entire Continuum of Care region.

• Justice Involved- Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

E. O. C. does not have a Crisis Intervention Team.

• Staff Information – Describe the demographics of staff serving the clients; Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients; discuss the extent to which staff are receptive to differences of clients; the extent to which staff receive periodic training in cultural competence and health disparities.

E. O. C. staff serving these populations are 3 females, ages ranging from 32-50 and one male - 37. The Warren Forest Counties E. O. C. delivers services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, traditions, believes, and values. The majority of Warren and Forest Counties primary language is English. For the deaf and hard of hearing population, a certified interpreter is available. The PATH Housing Specialist will receive periodic training in cultural

competency/diversity with one as recently as 05/05/17. Local upcoming trainings as well as previous training classes in cultural competency and counseling of diverse populations provide a knowledge base that assists staff team members continuing to be leaders as agents of change in an ever expanding diverse population of our clientele and community we serve.

Forest Warren Human Services delivers services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, tradition, beliefs, and values. The primary language is English. A certified interpreter is available for the deaf and hard of hearing population.

• Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted, enrolled, and the percentage of adult clients served using PATH funds to be literally homeless.

The demographic composition of Forest and Warren counties is mostly a white population. Ages range from 18-74 with most of those served in the 18-49 year old age range. While geographically large, the population of the two counties for 2016 is approximately 47,346 persons with a declining population as the 2015 estimation was 47,806. Forest County saw a 5.1% drop in population, from (2015) 7,410 to (2016) 7,321 persons. While Warren County saw a 4.3% drop from (2015) 40,396 to (2016) 40,025. Rural communities need to improve access to services, but too often, policies and practices are developed for urban areas and are erroneously assumed to apply to rural areas. Compounding the problems of availability and access is the fact that rural Americans have lower family incomes and are less likely to have private health insurance benefits for mental health care (see US Census data). It is projected for Fiscal Year 2017-2018 that 70+ adult clients will be contacted and 80% of those adults will be enrolled into the PATH program and served by the MH Housing Specialist through Warren-Forest E. O. C. It is projected that the percentage for PATH eligible clients literally homeless will be approximately 5-10%. The number of literally homeless individuals in Warren County remains generally consistent with minor fluctuations each year.

The demographic composition of Forest and Warren counties is mostly a white population. Ages range from 18-74 with most of those served in the 18-49 year old age range. The population of the two counties is less than 50,000.

• Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses and family members will be *meaningfully* involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix 1 "Guidelines for Consumer and Family Participation".

The Warren Forest Counties E. O. C. Board of Directors includes consumers from agency services. Six seats out of eighteen are designated for low income /consumer representation. Agency personnel do not directly plan or evaluate PATH funded services. The agency has employed several PATH clients through E. O. C. and have had PATH clients as volunteers to the agency. Consumers are given opportunity to complete community service hours as volunteers. Family members are kept apprised of the various activities through multidisciplinary team meetings and are given opportunity of inclusion through service providers involved in the treatment planning for those that want to be meaningfully involved. We encourage clients and family members to participate in LHOT.

LHOT has consisted of PATH clients as members. Clients participating in LHOT may participate in all discussion and future housing needs assessments.

Health Disparities Impact Statement-- Please identify efforts to support the Transition Age Youth (TAY) Disparity population by providing the following:

1. **The unduplicated number of TAY individuals who are expected to be served using PATH funds.**

   The Warren-Forest Counties E.O.C. expects to serve approximately 10 to 12 unduplicated transitional age youth in the 2017-2018 year.

2. **The total amount of PATH funds expected to be expended on services for the TAY population**.

   Warren-Forest Counties E.O.C. expects to spend roughly $11,900-$14,280 on services for the TAY population.

3. **The types of services funded by PATH that are available for TAY individuals.**

   TAY individuals will receive similar services to those of the general population. Warren-Forest E. O. C. will provide case management services that will link TAY individuals to community resources, landlords, mental health service providers, and assisting TAY individuals to obtain benefits. Housing services will also be provided which include, but are not limited to, advocated for TAY youth with landlords, assistance with filling out applications for the housing authority, HANDS, Section 8, etc. In addition, the housing specialist will work closely with the Warren County School District's (W. C. S. D.) homeless liaison to ensure that TAY individuals are receiving any and all benefits and services available in order to be able to finish school. The W. C. S. D. homeless liaison will also be able to

assist the Housing Specialist in being able to identify and outreach to TAY individuals.

4. **A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population.**

The TAY population's principle need is to be supported in their efforts to finish schooling. For most, once on their own, they fail to finish high school or obtain a G.E.D. This is pivotal as Warren-Forest E.O.C. will implement a three part approach to assist the TAY population. First, the Housing Specialist will work closely with the client, school, and other agencies to ensure that the individual has the tools necessary to complete their education. The Housing Specialist will also guide them through the maze of available services in order to demonstrate how one navigates the system. Second, E. O. C. provides the TAY population with budget counseling and a prepared renter program. E. O. C. also offers the TAY population an employment and training program that will assist in filling out applications, completing resumes, job interview skills, and maintaining employment. Third, the outcomes will be monitored through case management services and documented in case notes as well as updated in the individuals service plans. EOC utilizes an agency wide ORS system in an effort to measure and track disparities. The ORS system combined with data entry into HMIS provides a measurement and an enhanced ability to track disparities.

- **Limited English Proficiency – Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National origin Discrimination Affecting Limited English Proficient Persons,* available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.**

  Our primary language in the area is English. We are a non-discriminatory agency. Service is not denied on the basis of language. E. O. C. has an agreement with a translation service that can provide translation over the phone 24 hours a day 7 days a week.

• Budget Narrative – Provide a *descriptive* budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example $10,000 federal allocation, $3,333 state match, $1,000 PATH specific base fund match.

Personnel: Warren-Forest Counties Economic Opportunity Council Inc. will use the PATH funds to fund the Supportive Housing Specialist at 100% and the listed positions needed to provide this service.

Fringe Benefits: Warren-Forest Counties Economic Opportunity Council, Inc. offers its staff a full benefit package which includes: Medical, Dental, and Vision insurance and a Tax Shelter Annuity benefit.

Travel: Warren-Forest Counties Economic Opportunity Council, Inc's Housing Specialist will be traveling between the office, consumers' residences, and caseworkers' offices and running a variety of errands. The Housing Specialist will be required to attend training outside the county.

Supplies: In order to maintain Warren-Forest Economic Opportunity Council, Inc.'s Housing Specialist's common overhead costs will be incurred such as telephone, office supplies, postage and insurance.

Total Federal PATH Allocation……..$ 34,816
Total State PATH Allocation……..$ 11,605
Total PATH Allocation……....$ 46,421

Warren County
Warren-Forest Counties Economic Opportunity Council Inc.
PATH Program FY 2017-2018 Budget

Position	Annual Salary*	PATH-funded FTE	PATH-funded Salary	Total
Supportive Housing Specialist	$29,000	0.90	$ 26,100	
Housing Director	$39,562	0.02	$ 1,292	
Subtotal Position				$ 27,392
Fringe Benefits (31%)			$ 8,492	
Subtotal Fringe Benefits				$ 8,492

Travel Local travel 1000 miles @ $.535/mile			$ 535	
Travel to training, workshops and Statewide meetings			$ 30	
Subtotal Travel				$ 565
Supplies Office Supplies			$ 199	
Postage $15.00/month			$ 180	
Subtotal Supplies				$ 379
Training & Technical Assistance			$ 100	
Telephone $65.00/month			$ 780	
Space Costs $75.00/month			$ 900	
Insurance $16.00/month			$ 192	
Subtotal Other				$ 1,972
Indirect Costs – Administrative Costs @ 28.34% of Salaries				$ 7,621
TOTAL				$ 46,421

26. Franklin-Fulton County Mental Health/Intellectual Disabilities/Early Intervention

425 Franklin Farm Lane

Chambersburg, PA 17201

Contact: Jennifer Johnson

Contact Phone #: 7172645387

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-030

State Provider ID: 4230

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 54,558	$ 18,186	$ 72,744	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 54,558	$ 18,186	$ 72,744	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 54,558	$ 18,186	$ 72,744

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 54,558	$ 18,186	$ 72,744	

Source(s) of Match Dollars for State Funds:

Franklin/Fulton will receive $72,744 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 90

Estimated Number of Persons to be Enrolled: 45

Estimated Number of Persons to be Contacted who are Literally Homeless: 54

Number staff trained in SOAR in grant year ending in 2017: 1

Number of PATH-funded consumers assisted through SOAR: 13

Franklin/Fulton County Mental Health/Intellectual Disabilities/Early Intervention

PATH Intended Use Plan

FY 2017--2018

Local Provider Description

Franklin/Fulton Mental Health/Intellectual Disabilities/Early Intervention (MH/ID/EI) is a county agency that operates within the Franklin County Human Services Division of Franklin County government. The provider office address is: Franklin/Fulton MH/ID/EI, 425 Franklin Farm Lane, Chambersburg, PA 17202, in the South Central Region of the State of Pennsylvania. Through a joinder agreement, Franklin/Fulton MH/ID/EI program serves individuals in both Franklin County and Fulton County with a variety of special needs. Currently, the following services are provided by our agency: Outpatient Clinic, Crisis Intervention Services, Respite, Shelter Plus Care, Permanent Supportive Housing, Mental Health Housing, Independent Living Housing, Re-entry Housing, Social Rehabilitation, Drop-In Center, Administrative, Crisis Intervention Team (CIT) training and coordination, Community Law Enforcement Mental Health Co-Responder, Resource Coordination and Intensive Case management, Community Support Program (CSP), Vocational, Transitional and Supported Employment, SSI/SSDI Outreach, Access, and Recovery (SOAR) Program, Franklin County Older Adult Advocacy Team (FCOAAT), Certified Peer Specialist Services, Psychiatric Rehabilitation, Student Assistance Program and Family-Based Mental Health Services.

Franklin/Fulton MH will receive $742,744 in total PATH funds ($18,186 State Match, $54,558 Federal Allocation) to continue the operation of a PATH program that will reach individuals in Franklin and Fulton Counties.

Collaboration with HUD Continuum of Care Program

Many local housing related agencies have been involved in the Regional Homeless Advisory Board in the Central/Harrisburg region in Pennsylvania through the HUD Continuum of Care (CoC) program. Those agencies include: Franklin County Human Services Division, South Central Community Action Program, Center for Community Action, Maranatha Ministries, CandleHeart Ministries, Franklin County Cold Weather Drop In Center, Fulton County Center for Community Action, Supportive Services for Veteran's Families (SSVF), and Waynesboro New Hope Shelter. Several agencies have received funds through the HUD CoC process to increase housing programs and supports in Franklin and Fulton counties. As Franklin/Fulton Mental Health continues to utilize the PATH program and funding, local housing agencies and mental health providers will be involved in the referral process, will help to create new housing opportunities, will serve on the HUD/PATH Advisory Board, and provide/coordinate supportive services.

Franklin/Fulton Counties are a member of the South Central PA CoC RHAB area. The Mental Health Housing Program Specialist II works to establish and/or expand the

number of housing programs and the availability of housing programs for individuals with serious mental illness who are homeless or at imminent risk of homelessness. The Mental Health Housing Program Specialist II attends the local RHAB meetings monthly and the regional CoC meetings semi-annually to network and collaborate with other members of the CoC on these efforts. The Mental Health Program Specialist II serves on the CoC Funding Committee. The Franklin County Grants Manager periodically attends CoC meetings as well and works closely with the Mental Health Housing Program Specialist II to seek appropriate grants related to new housing opportunities. We occasionally provide training and information to our area RHAB on new programs or grant opportunities. We regularly seek partnership with other agencies in meeting the housing and service needs for the homeless population in Franklin and Fulton Counties. This collaboration is expected to be ongoing and will benefit the homeless population of Franklin and Fulton Counties.

This PATH program fits into the HUD Continuum of Care by addressing homelessness through the provision of housing, a basic need of all individuals. Research shows that if a person's basic needs are not being met, it is almost impossible to begin to work on other areas of need. When we help homeless individuals to secure and maintain housing, additional supports will be more effective. Existing housing through this program and within the HUD Continuum of Care is transitional, permanent supportive, and Shelter Plus Care.

The Franklin County Human Services Division including Mental Health and Grants Management, are at the forefront of planning efforts within the county. These agencies serve on numerous boards, taskforces and committees that provide services and supports for the homeless, including the Behavioral Health Advisory Board, the Criminal Justice Advisory Board, the Re-Entry Coalition, the Forensic Initiatives committee, the Re-Entry Case Review Committee, the CCAP Housing Task Force, the DHS Housing Stakeholder Workgroup, the Recovery House Standards Committee, the Olmstead Plan Work Group, the FCOAAT Stakeholder Board, the Fulton County Partnership and Housing committees, the County Block Grant Committee, the HUD/PATH Advisory Board, the Community Support Program, Jail Diversion, and the Housing Task Force/LHOT committee.

Four formal collaborative partnerships between the County and local housing entities exist through the TrueNorth Wellness Services, New Visions, Tharp Community Development, LLC, and Keystone Community Health Services. The details of these collaborations include the following:

TrueNorth Wellness Services provides a campus to accommodate 17 individuals with a diagnosed mental health illness. Support services are provided to the individuals residing there 24 hours a day. Individuals are educated on activities of daily living to work toward independent living. Mental Health contracts with a psychiatric nurse who works with the individuals and also with Case Management services for support and monitoring.

New Visions, through an agreement with Franklin County, provides an eight-bed adult group home with staff available during the day time hours as needed. Independently, New Visions also has 16 individual apartments that receive Case Management support from mental health caseworkers.

Tharp Community Development, LLC has a memorandum of understanding with the county for a housing initiative to rehabilitate substandard downtown multi-family housing units into safe, accessible, affordable housing options for Franklin County. A certain number of units in this initiative (and any subsequent development phases) are dedicated to specialized populations served by Franklin/Fulton MH/ID/EI, Franklin County Human Services, and Tuscarora Managed Care Alliance. This initiative includes an allotment of 811 vouchers for eligible populations. Applications are screened by Franklin/Fulton MH/ID/EI and the developer works within HUD and county guidelines for affordable rent calculations.

Keystone Community Mental Health provides a Specialized Community Residence and it is licensed as a Personal Care Boarding Home. This is group living in the community for eight individuals with special medical needs in addition to Mental Health needs.

The Jail Diversion Program links individuals with a serious mental illness and often co-occurring (substance abuse) disorders who have come in contact with the criminal justice system into community-based treatment, services and/or support systems. Qualified Jail Diversion participants are provided the opportunity to be referred to case management services; such as Intensive Case Management, Resource Coordination, or Administrative Case Management. A Forensic Case Manager refers participants to community providers to address their mental health needs to include psychiatric evaluations, medications, medication management, etc. Participants can also be referred to a Certified Peer Specialist for peer to peer support. Along with mental health services, participants are referred to many different programs for assistance such as housing, medications, birth certificates, etc. Some qualifying participants have received rental assistance or security deposit from the PATH grant. The Salvation Army and other local agencies provide financial assistance to pay the full cost or co-pays of medications. By referring to County programs and providing support, the Jail Diversion Program utilizes the available resources to help individuals live successfully in the community.

Franklin County Housing Re-entry Initiative has been established to assist offenders transitioning from Jail to the community. The Re-entry Initiative team partners with local agencies to assist offenders with obtaining an approved home plan and support offender's community re-entry by building the skills they need. Self-sufficiency is encouraged through education, gaining employment, developing finance skills, and engaging in positive relationships. The goals of the program include reducing recidivism, improving self-sufficiency, enhancing justice reinvestment opportunities, and increasing space available at the Franklin County Jail. The Franklin/Fulton MH/ID/EI Program regularly collaborates with other agencies to coordinate home plans and supportive services for those exiting the Franklin County Jail and is currently participating in the Intensive Re-

Entry Grant Program and on the Re-Entry Case Review Committee to facilitate these efforts.

The Intellectual Disabilities Program, through Franklin/Fulton MH/ID/EI also has an established Independent Living Program in Franklin County. The Independent Living Program was created to better serve individuals with intellectual disabilities who have developed the skills to live independently with minimal support. This program provides supportive permanent housing and supportive services for these individuals to ensure their success with living in the community.

Through the Housing Task Force/LHOT Committee, Franklin/Fulton MH/ID/EI has joined in the creation of a planning committee with numerous agencies and providers, including New Visions, Franklin County Homeless Shelter, New Hope Homeless Shelter, Franklin County Jail, Maranatha Ministries, the Franklin County Housing Authority, Borough of Chambersburg, Franklin County Planning Commission, SCCAP (South Central Community Action Program), Cold Weather Drop In Shelter, Women In Need, Keystone Health System, Individuals, Parents, Faith-Based Groups, Program Planning, Franklin County Adult Services, LINK, PA-211, and the Salvation Army. By working in this collaborative setting, the following priorities have been identified: Create new housing and supports for individuals with mental illness that are facing homelessness or near homelessness, or are returning to the community after incarceration; create more transitional and permanent housing in our area and continue to work with partners to enhance these services; address community housing needs identified during the Homelessness Summit using creative and innovative solutions that utilize the strengths of Franklin and Fulton counties; and improve landlord and human services communication by educating landlords on community human services and benefits of serving those with disabilities. The Housing Task Force/LHOT Committee coordination and oversight is provided by the Franklin County Mental Health Housing Program Specialist II.

Collaboration with Local Community Organizations

Franklin/Fulton Mental Health/Intellectual Disabilities/ Early Intervention Department contracts with Service Access & Management, Inc. (SAM) to provide case management services to qualifying individuals. PATH eligible individuals who are not already open for Mental Health Case Management are referred to SAM for an intake with their agency for case management services if they indicate interest in these services. The purpose of this linkage is to make key support services available to individuals in the PATH program. A case management intake will be encouraged as soon as a person is identified for participation in the program. For interested and eligible individuals, case management will provide regular contact visits with the individual and can be utilized as long as the service is needed. Case management services will assist in navigating medical assistance, Social Security, the health and mental health systems, linking individuals with representative payee services, linking individuals with specialized housing and housing supports, and assisting in the management of day to day activities. The case managers will help individuals to enhance the quality of their lives by effectively and efficiently managing and/or providing needed and accessible human services. For those ineligible

for case management services through Service Access and Management, the Mental Health Housing Program Specialist II and the Mental Health Housing Program Specialist I have the option of working with the local managed care entities, Perform Care and Tuscarora Managed Care Alliance, to seek alternative resources for individuals. The Franklin/Fulton Mental Health program also serves as a resource in these instances. The Mental Health Housing Program Specialist II and/or the Mental Health Housing Program Specialist I will work closely with SAM, Inc. and other entities to ensure that adequate housing assistance and supports are in place for PATH individuals. Reciprocally, these programs also refer eligible individuals to Franklin/Fulton County MH/ID/EI for PATH services on a regular basis. SAM also serves on several outreach boards with the Franklin/Fulton PATH Program staff, in include the HUD/PATH Advisory Board, the LHOT Outreach and Engagement Committee, and the PIT Count Committee.

The following is a summary of available services in the community:

The services of the AHEDD agency will be available to the PATH participants. AHEDD is an agency that offers job coaching and training, secures appropriate attire for job interviews for individuals, resume writing assistance and prepares individuals for job interviews in order to secure employment.

The Keystone Center operates a psychiatric rehabilitation program for adults with mental health illness. The program focuses on individualized goal setting and daily monitoring. Assistance completing a Wellness Recovery Action Plan (WRAP) is available. PATH participants will be referred there as appropriate.

The Mental Health Association is available to the PATH participants. MHA has the ability to provide Certified Peer Specialist services. They also facilitate the Community Support Program meetings on a monthly basis in both Franklin County and Fulton County. A Wellness Conference is held annually for individuals to attend. MHA also offers a Leadership Program to educate individuals on how to participate in community events and to be board members. Additionally, MHA has operates the Individual/Family Satisfaction Team (I/FST) that creates surveys to find out how satisfied people are with the services they receive from providers within our community. MHA staff refer individuals they feel may be eligible for PATH services to Franklin/Fulton MH/ID/EI. MHA staff serve also on the HUD/PATH Advisory Board, the LHOT Outreach and Engagement Committee, and the PIT Count Committee.

The services of the local Career Link office will also be available to participants. Career Link is a source of numerous career-oriented services including job training, occupational rehabilitation, literacy, computer training, and more. This service is available Monday through Friday and can be accessed by individuals during the day and evenings.

Several local behavioral health programs will be available to individuals to use**.** Summit Behavioral Health through Chambersburg Hospital offers psychiatric and behavioral health outpatient programs and numerous counseling support groups on a weekly basis. Keystone Health Center, a Federally Qualified Health Center, also offers psychiatric and

behavioral health outpatient programs and numerous counseling support groups through Keystone Behavioral Health. Pennsylvania Counseling Services is available for psychiatric and behavioral health needs as well as those seeking dual diagnosis services. Momentum Services, Franklin Family Services, Franklin/Fulton Family Behavioral Resources, New Visions, and TrueNorth Wellness Services also provide outpatient behavioral health services in Franklin and/or Fulton County. In addition, there are private practicing therapists that can be accessed in each of the communities.

Women In Need Victim Services offers individual and group counseling in Franklin and Fulton counties to survivors of abuse and assault. Their services are free and confidential to those who qualify. A local domestic violence shelter is available for those who are homeless.

The New Visions Drop In Center in Chambersburg and McConnellsburg offers recreation and group activities for individuals who live with mental illness. The Drop In Center is open six days a week with day with some evening hours in Chambersburg, and two days per week in McConnellsburg. The program provides an environment for social rehabilitation through offering a source of social and recreational support for individuals.

Food pantries, lunchtime meals and clothing banks are provided at numerous churches and organizations throughout the county. They can be accessed by individuals on a monthly basis. Food services include Waynesboro Human Services, Waynesboro Food Pantry, Chambersburg Food Pantry, Falling Springs Presbyterian Church, Fayetteville Food Pantry, First United Methodist Church, Greencastle Food Pantry, Fulton County Food Bank, St. Thomas Food Pantry, The Pantry at Valley Ministries, the Lunch Place, Salvation Army, Five Forks Brethren in Christ, the Chambersburg Hispanic-American Center and Maranatha Ministries Food Bank. Clothing services include St. John's United Church of Christ Clothing Clinic, WIN Victim Services, Christ United Methodist Church Clothing Bank, First United Methodist Church Clothing Room, Five Forks Brethren in Christ Clothing Bank, Goodwill Industries, New Hope United Methodist Church, Salvation Army, The Closet at Valley Ministries, Waynesboro Human Services Clothing and Diaper Bank, and the Fulton County Catholic Mission. Franklin/Fulton MH/ID/EI regularly communicates with these entities regarding referrals for eligible individuals they serve. In addition, Franklin/Fulton MH/ID/EI and Human Services departments have hosted Town Hall and Community Information sessions at some of these facilities in order to provide outreach and information.

Maranatha Ministries, through their financial counseling program, provides financial counseling, representative payee services, and personal finance/budgeting instruction. They also provide transitional housing and rapid rehousing services throughout the county. CandleHeart, an entity of Maranatha Ministries, provides budgeting, parenting, anger management, and life recovery programs. Maranatha's Cold Weather Shelter and CandleHeart program refer individuals to the PATH program for assistance and call the PATH program when they locate an individual living on the streets who is in need of emergency or safety supplies. The PATH program refers individuals to both ministries for assistance they may be eligible for. Maranatha's Food Bank regularly provides

emergency food allotments to the Franklin/Fulton MH/ID/EI PATH and HUD program participants.

Family Care Services provides representative payee services for individuals with mental illness. They refer eligible individuals to the PATH program for assistance. PATH staff refer individuals in need of rep payee service to Family Care if this is indicated in their needs assessment.

Females in the PATH program who need assistance with independent living skills will be referred to the House of Grace. The House of Grace is open Monday through Friday and provides the following services to help women succeed in life: cooking, cleaning, budgeting, canning, social skills development, sewing, computer skills, and a "Dress for Success Program" to assist in personal appearance for interviews.

Emergency shelter housing is provided by three programs: The Franklin County Shelter for the Homeless in Chambersburg through South Central Community Action Program (SCCAP), New Hope Shelter in Waynesboro, and the Cold Weather Drop-In Shelter operated by Maranatha Ministries in Chambersburg. The Fulton County Catholic Mission also assists those needing emergency shelter by providing short-term vouchers for a local motel. Women In Need Victim Services also provides emergency shelter to battered women and their children. Together, these organizations provide emergency housing to more than 90 homeless people a night at any given time in the county. The Mental Health Housing Program Specialist II and/or Mental Health Housing Program Specialist I will outreach to these and other local agencies to advocate for housing for individuals, and grow housing resources/supports for individuals. PATH staff regularly communicate and collaborate with these programs to meet the needs of individuals experiencing homelessness that they serve. Staff from the emergency shelters serve on the HUD/PATH Advisory Board, the LHOT, and the PIT Count Committee.

The County of Franklin offers the following programs that can assist individuals in gaining independence in Franklin County:

The Franklin County Area Agency on Aging (AAA) provides a wide array of support services, Senior Centers, and functions as a resource for residents who are age 60 or older to help seniors maintain their homes and quality of life. In addition to the AAA, Franklin County LINK program offers resources for the aging and disabled population though educating and providing resources to aging and disability services providers.

Referrals to similar Fulton County services will be made as needed. The County, through the Mental Health office, has established Letters of Agreement with many of the service providers listed above for individual services.

Service Provision:

PATH Program Services and Goals

Street outreach and case management are priority services. PATH funds will be used to pay the salary and benefits of the PATH Coordinator (the Mental Health Housing Program Specialist II) and supporting staff (the Mental Health Housing Program Specialist I) to compensate for the time spent doing administrative duties, case management, and community outreach. Community and street outreach will include coordinating and participating in the annual Point-In-Time Count, contacting individuals who are attending free meals at the Salvation Army and other local agencies and churches, going to housing agencies, homeless shelters, job fairs, and other community events, as well as street outreach. SAM Inc. has increasingly familiarized itself with PATH Outreach services and supports and regularly refers an increasing number of homeless and near homeless individuals for services and supports. PATH funds will be used to support street outreach by providing expense reimbursement for travel to and from these agencies and events. Outreach will include providing individuals with contact information, program information, necessary survival supplies, apartment start up supplies, and community information on where their basic needs can be met. Intakes into the PATH program can also be done on-the-spot or an appointment for an intake can be made at that time.

PATH funds are used to fund mileage, lodging and meals for PATH staff to attend trainings and conferences. PA HMIS trainings and HMIS TA Conferences are attended whenever possible to ensure staff are up to date on the latest information and evidence-based practices. PATH staff also participate in HMIS and homelessness webinars to increase their knowledge and skills.

Emergency items, emergency food, and safety items are provided to individuals who demonstrate a need. Franklin/Fulton MH/ID/EI collaborates with SAM, the Catholic Mission in Fulton County, and Maranatha Ministries to distribute emergency and safety items to those with the need for them. The Franklin/Fulton MH/ID/EI has a Housing Expansion fund that is used to supplement the outreach and case management needs for PATH applicants. In addition, Franklin/Fulton County MH/ID/EI pays for services through the Mental Health Association, Service Access and Management, and local mental/behavioral health providers that can be utilized by PATH participants if they have no other payer. The Franklin County Veterans Administration is located in the Franklin/Fulton County MH/ID/EI building suites allowing for ease in referring veterans for additional services.

Through regular contacts with the mental health case management department at SAM and through the PATH Coordinator and support staff, individuals who are enrolled are assisted in achieving their goals until the individual is discharged from the program. Referrals to needed services (housing, mental health, behavioral health, medical, veteran's benefits, county assistance, food, clothing, furniture, utility assistance, transportation, social security, education, employment, etc.) are assessed and provided on an ongoing basis. In addition, each PATH participant is provided with a copy of the county "Where to Turn" resource guide. A three month follow up is done with each

assisted applicant to ensure their needs continue to be met. Follow-up through satisfaction surveys will be provided by the Mental Health Housing Program Specialist II and/or Housing Program Specialist I.

Gaps

The number of individuals needing services continues to grow each year. With the growth in the number of individuals, the following gaps have been identified in the services we provide:

- Lack of new dollars entering the system to assist individuals
- Lack of residential forensic services available for the seriously mentally ill offender. Those without approved home plans continue to populate the Franklin County Jail. Assistance with finding those offenders home plans to transition them from the jail in to the community is needed
- Lack of landlords willing to work with programs to assist with housing for individuals with mental health or co-occurring disorders, criminal records, suffering from homelessness, having poor credit, having poor employment history, or who are low income
- Lack of enough residential services available for the transitioning youth (ages 18-26) population from Juvenile Probation and from Children and Youth Services
- Lack of multi-lingual staff to communicate with the increasing number of minority and non-English speaking individuals
- Lack of safe, affordable, and adequate housing and housing supports in the two-county area
- Lack of human service and disability knowledge among local landlords
- Lack of landlord knowledge of Housing First principles

Specifically, in regards to the mental health population served, the lack of safe and affordable housing units has been identified as a top priority in housing needs for the county. In addition, residential services available for individuals with mental health illness who are ex-offenders has been identified as a significant programming gap. The Housing Task Force and LHOT teams, along with the Franklin County Re-Entry Coalition, are working to address the housing needs of individuals in the mental health service system, those with co-occurring disorders, and those re-entering the community after incarceration who have one or more disabilities, or who are suffering from homelessness. The Mental Health Housing Program Specialist II is working with the Grants Manager in identifying grant opportunities for the creation of more safe, affordable, and supportive housing for individuals with disabilities in both Franklin and Fulton counties, as well as for supplemental funding to support existing programs that regularly run out of funds before the end of the program year.

The Franklin/Fulton PATH program helps to decrease this "gap" by assisting individuals to gain access to affordable housing in both counties, and to provide continued assistance and supports to establish and maintain housing. PATH funds will be used to support PATH funded staff (Mental Health Housing Program Specialist II and Mental Health Housing Program Specialist I), supplies/materials necessary for job performance, and housing support services for individuals. Additional monies pay for community outreach

and training events for homeless or at-risk individuals, outreach materials, safety and emergency supplies, emergency food, apartment start-up kits for those exiting homelessness, and training/travel for the MH Housing Program Specialist II and/or Housing Program Specialist I. The Mental Health Program Housing Specialist II and/or Housing Program Specialist I will be located in the Franklin/Fulton County Mental Health Department, and will closely collaborate with the Franklin County Jail's Director of Specialty Services as well as with other providers in the community.

Services available to those with SMI and substance use disorder

The PATH funded staff, in coordination with mental health staff, will use the following services available for individuals who have serious mental illness and a substance abuse disorder:

- Planning of Housing. Working with local agencies outside the mental health area to establish housing for individuals and to enter into letters of agreement with housing entities to provide housing to the PATH population.
- Improving the Coordination of Housing. Working with local agencies to better coordinate housing for individuals. The MH Housing Program Specialist II will work with agencies to improve supports and resources available to individuals and to provide links to county mental health services and homeless assistance services. The Mental Health Housing Program Specialist II serves as the county Local Lead for many housing initiatives, which facilitates coordination efforts.
- Security Deposits and one-time back rent payments to landlords to prevent eviction. Case management services will assist individuals with monetary assistance in the form of security deposits for those experiencing homelessness and one-time rental payments equal to one month's back rent for those facing eviction and homelessness to assist them with maintaining their housing, as needed.
- Providing assistance to eligible homeless individuals to obtain income support services, including housing assistance, food stamps, and supplemental social security income benefits. Case management will assist individuals with co-occurring disorders to ensure they receive necessary services, and will also be responsible for connecting the individual with Drug and Alcohol services. Integration of these agencies has been identified as a priority, as well.
- Reading material and information will be made available at local homeless shelters and at the PATH office on current drug trends, treatment facilities, and Al-Non, NA and AA meetings

The PATH funded staff, in collaboration with Mental Health staff, will also work with behavioral health and substance abuse service providers to make sure that PATH program participants have access to needed treatment services. Co-occurring programs that exist within the County include Pennsylvania Counseling Services, Roxbury Outpatient, Pyramid, C&S Reed, True North, and Laurel Life. Roxbury Treatment Center also provides 28 day rehabilitation and has an inpatient MH unit on the same property.

Trainings

The Franklin/Fulton Mental Health Department provides opportunities to participate in training. "Sharing Resources Network" (SRN) is distributed by the Franklin County Mental Health department. The SRN provides a comprehensive list of training opportunities weekly, via email, to agencies, programs and individuals. Some of the trainings are free while others do have fees. Human Service Training Days provides for training opportunities on an assortment of topics on a yearly basis. The Mental Health Housing Program Specialist II and/or Housing Program Specialist I regularly attend the RHC Housing Summit conference as well as other housing summits during the year. As other mental health and housing training opportunities arise, PATH-funded staff are encouraged to attend. The PATH budget allows for travel to the trainings in addition to the costs of the trainings and conferences.

Activities have been implemented to facilitate migration of PATH data into HMIS, according to the schedule established by the State PATH Coordinator. The Mental Health Housing Program Specialist II and Mental Health Housing Program Specialist I will attend online and in-person HMIS trainings as offered by DCED on using the PA-HMIS system. It is to our advantage that the Mental Health Housing Program is mandated to enter data in to PA-HMIS for other programs such as Supported Housing Programs and Shelter Plus Care. Therefore, familiarity with PA-HMIS does already exist.

Enrollment/Intake forms have been revised to include the information that is necessary for the data entry in PA-HMIS. The intake packets contain the specific information needed to enter in to PA-HMIS. PA-HMIS data is used regularly to guide programmatic decisions.

The Mental Health Housing Program Specialist II has a membership with the PA Housing Alliance, which enables free attendance at a variety of online and in-person trainings throughout the year that relate to housing and homeless prevention topics. Landlord/tenant training topics are also frequently explored through Alliance trainings.

Military Families

The PATH program works in partnership with the local chapter of The Department of Veterans Affairs and this region's Supportive Services for Veteran's Families program. Any referrals submitted to PATH by the Veterans coordinators will be prioritized and referred appropriately to needed mental health services such as counseling for PTSD, anxiety disorders, and major depression. The Director of Veterans Affairs for Franklin County is located in the same suite as PATH, participates in the PIT Count, and serves on the HUD/PATH Advisory Board. Regular discussions are held regarding homeless veterans with mental health diagnosis who may need homeless assistance, including PATH services. The Franklin/Fulton MH/ID/EI program sponsored a SOAR training for Franklin County and the Franklin County Department of Veterans Affairs staff all took advantage of this opportunity to better assist the individuals they serve.

The Franklin County Housing Task Force collaborated with the local VFW for the annual mandatory Point In Time Count and plans to continue to do so. This networking opportunity was encouraged by the Director of Veterans Affairs for Franklin County.

The Mental Health Housing Program Specialist II is currently working with the Franklin County Department of Veterans Affairs, South Central PA CoC, and Franklin County Housing Authority to obtain VASH-vouchers to assist the veterans in the Franklin/Fulton county area. These vouchers would add additional housing supports for our veterans, including not only individuals, but also their families.

Recovery Support

Individuals enrolled in PATH are referred to services that promote recovery in the community such as Community Support Programs which includes the Leadership Program, Certified Peer Specialist Program, Social Rehabilitation programs, and Psychiatric Rehabilitation programs. Enrolled individuals are also encouraged to seek officer positions in the programs as well as attend other meetings that are open to the community.

Individuals open in PATH are often able to access services through other funding streams because of the Mental Health Housing Program Specialists' roles in Franklin/Fulton MH/ID/EI. Franklin/Fulton PATH funds currently provide a main support for housing with rental assistance and security deposit. Following a Housing First model, the program recognizes that individuals need to satisfy shelter, food, and other basic necessities before the recovery process can continue successfully. A majority of the individuals enrolled in PATH receive targeted case management services and are linked to services and resources in the community.

Individuals are encouraged to build natural supports in the community. Engagement in the faith-based communities within the county is encouraged to build natural supports. Building those relationships in the community through volunteer efforts, attending faith-based services, and community meals are suggested to individuals to build peer relationships that can be ongoing.

Through the PREP Train-the-Trainer program, the Mental Health Housing Program Specialist has been able to support individuals' in their recovery process by providing prepared renter education. In addition, Franklin/Fulton MH/ID/EI has promoted trainings to outside agencies and providers in the PREP training in order to increase trainings to renters in the community in order to promote stable housing while also preventing evictions. An additional 37 PREP trainers were trained in the spring of 2017. Some individuals in the counties are also supported by providing permanent housing through our additional housing programs.

During community outreach activities pamphlets from the Fulton/Franklin County Drug and Alcohol programs are made available. Additionally, there is information on local

AA and NA meetings. At a previous outreach event, a Drug and Alcohol Intake worker was available for on-the-spot intakes.

An addition to the current PATH intake packet is currently being considered. We believe that PATH individuals need to be informed about WRAP (Wellness Recovery Action Plan). During the intake process an individual can be informed of what a WRAP is and if a WRAP would be beneficial in their recovery process. If so, the Mental Health Housing Program Specialists will make the necessary referrals to assist the individual in the WRAP process.

42 CFR Part 2 Regulations

While not directly falling under 42 CFR Part 2 regulations, Franklin/Fulton MH/ID/EI strictly follows confidentiality policies for protecting participant information as required by Federal HIPAA laws. No protected information is shared with any entity without the express written release of information of the individual. Specific agency procedures are as follows:

-Upon hire, all staff will receive HIPAA training from Franklin County's Privacy Officer. In addition, all employees and volunteers will sign a Confidentiality Statement through the Human Resources office.
-All staff will have access to, and must abide by, Franklin County's HIPAA policies and all HIPAA laws.
-Annually, MH/ID/EI staff will review HIPAA policies and procedures.

Data

Franklin/Fulton Mental Health housing for McKinney-Vento programs are currently entered into the PA-HMIS system. Franklin/Fulton PATH program has been able to enter PATH individuals' data into the HMIS system for several years. The intake form for PATH was revised to ensure it was capturing the information that needs to be entered in to the PA-HMIS system. The program goal is to have each individuals' information entered in to HMIS immediately following the enrollment of the individual. Updating information on the individuals in PA-HMIS is completed promptly upon obtaining the new information.

Data obtained from PA-HMIS has been able to provide improvements on how the PATH coordinator focuses outreach events. Since PA-HMIS provides data on the demographics of individuals in Franklin and Fulton County who are experiencing homelessness, the PATH Coordinator can better plan for specific areas of need, such as Veteran's benefits, HIV/AIDS, Drug & Alcohol, etc. As HMIS continues to be used for PATH, more data will be available on the populations and demographics of those experiencing homelessness. Planning efforts will continue to be more collaborative with those providers who are focused on the specific needs that are identified in the PA-HMIS system.

The Mental Health Housing Program Specialists do have the ability to participate in the on-line manager and case manager PA-HMIS trainings, as they are offered. In addition to travel, supplies and operating costs in the budget allow for the Housing Program Specialist II and/or Housing Program Specialist I to continuously attended PA-HMIS trainings if/when necessary, both on-line and at conferences. Ensuring that multiple staff within the agency are trained to enter data into PA-HMIS will better support PATH data being entered in to PA-HMIS.

Alignment With PATH Goals

The main goal of the Franklin/Fulton County program is to provide assistance to individuals with a serious mental illness or co-occurring disorder who are experiencing or at risk for homelessness with obtaining or maintaining stable housing. The program recognizes the importance of the Housing First Model in addressing local disparities with this population. In addition to housing rental assistance to achieve this goal, individuals receiving assistance are connected with resources that they may need for mental health, physical health, case management, peer support, employment or income, education, and other supportive services that will assist them with achieving permanent housing independence.

Services to be provided using PATH funds include street outreach to connect with vulnerable populations. The Housing Program Specialist II and the Housing Program Specialist I engage the community during these street outreach events, providing information and emergency supplies. Street outreach is a priority service in Franklin and Fulton Counties.

Street outreach is conducted during the Point In Time Count in both the winter and summer. Planning for those outreach events is started well in advance to the actual count date. Initially, the PIT count is discussed by the PIT Coordinator (Mental Health Housing Program Specialist II) at the Housing Task Force/LHOT Meeting. There are then two subcommittee planning meetings held by the Housing Program Specialist II. The PIT count process is discussed, including the purpose of the count, the importance of the count, and safety guidelines. Groups of volunteers are established and coverage areas are designated. The coordinator also mails out letters to all county law enforcement agencies and the school homeless liaisons explaining the PIT count and that volunteers will be in the communities for the count. The county Information and Referral (PA-211) employee also makes flyers that are distributed by hand to individuals by local agencies to advertise that volunteers will be in the community and at the local Salvation Army.

Outreach events are held in the community during the year as well. PATH collaborates with the Franklin County LINK program to hold these events. Previous events include “Help for the Hungry and Homeless” and “Help for Heat and Housing”. These events are advertised to target the literally homeless community. Events are held in recognition of National Hunger and Homeless Awareness Week in November. At outreach events, human service agencies are present in one location to assist those experiencing homelessness as a “one stop shop”. For example, individuals can have a volunteer assist

in completing applications for services such as transportation, case management services, medical assistance, PATH, etc. Additionally, individuals are provided with a community resource guide, are fed a hot meal, and are given needed safety and emergency supplies.

Street Outreach will be conducted on a regular basis between Point In Time counts and structured outreach events. This outreach will be completed by partnerships with housing agencies, human service providers, formerly homeless volunteers, and PATH staff. Former homeless volunteers participate in outreach activities and street outreach. The formerly homeless volunteers are able to provide insight and suggestions on approaching and serving the homeless population.

Case management begins during initial contacts with literally homeless individuals during street outreach. Case management remains involved with the individual, ensuring assessment of needs is completed and referrals are made to appropriate support services. After assistance is provided, case management remains involved for up to three months, at which time a three month follow up assessment is done to ensure maximum independence is achieved. If further referrals or resources are needed, these are provided as needed.

Alignment with State Mental Health Services Plan and Plan to End Homelessness

The Franklin/Fulton County PATH program targets outreach and case management to the priority populations and goals identified by the state plan to end homelessness. The program gives special priority to those identified as literally and chronically homeless, transitioning age youth, veterans, formerly incarcerated, and all applicants must have a serious mental illness or co-occurring disorder. The Franklin/Fulton County PATH program seeks to provide emergency supplies, immediate referrals and connections with needed services (food banks, employment, CAO, D&A services, MH services, and case management). In addition, housing assistance funding is used to help those that are literally homeless with funding for the security deposit in order to obtain housing and those that are at imminent risk of homelessness with a one month rental payment to maintain their housing. Outreach efforts are coordinated with places that have contact with these populations, to include: shelters, schools, veterans organizations, housing authorities, local law enforcement, community agencies, and mental health service providers. The main goals are to stabilize housing and assist the individual with accessing needed services in order to help them to stay stable, consistent with state goals. When available, funding is combined with other resources to maximize services provided to each individual. These other resources can include HUD housing programs, block grant funding, and county housing funding.

As a county government entity, Franklin/Fulton MH/ID/EI staff are part of the county Continuity of Operations Plan. Under this plan, if a disaster or other emergency occurs, staff are required to continue to find ways to serve constituents in need of services the agency provides. This includes procedures for addressing immediate needs, as well as needs during the community recovery phase for up to 30 days. Direct mental health support is offered to the community, as well as triaging other needs and handing out

emergency supplies. Locating shelter for those that are homeless and connections with social support services are included in emergency response efforts. Several county employees hold certifications in Psychological First Aid (emergency response to psychological aspects of disasters/emergencies), Mental Health First Aid (responding to mental health emergencies), Youth Mental Health First Aid, and Crisis Intervention. The county regularly holds drills to practice for emergency preparedness and response.

Other Designated Funds

As noted previously, the Franklin/Fulton County PATH Program coordinates with other county funding to maximize services to individuals eligible for PATH assistance. When possible, individuals are diverted into a permanent housing program or situation, some of which are managed by Franklin County MH/ID/EI. The Franklin County MH/ID/EI program has established a Housing Expansion Program that allows for flexible funding for a variety of needs these individuals may have, including rental assistance if there are openings in the program. For the 2016-2017 funding year the Franklin/Fulton County PATH program ran out of housing assistance funding. County allocated funds from the state block grant were utilized to extend the program's ability to continue offering this assistance to individuals eligible for PATH assistance.

SOAR

In the past years Franklin/Fulton MH/ID/EI has undergone various internal changes, including case management services now being provided through a contract agreement with Service Access and Management, Inc. (SAM). Previously, because of various staff changes, Franklin/Fulton had been unable to train any PATH staff in SOAR, therefore the number of PATH funded consumers assisted through SOAR had been zero.

Franklin/Fulton MH/ID/EI and PATH programs recently sponsored an SSI/SSDI Outreach, Access, Recovery initiative. The Mental Health Housing Program Specialist II coordinated an effort to provide funding incentives from the Franklin County MH/ID/EI department to area agencies working with individuals facing homelessness to be trained in and to utilize the SOAR process. It was initially proposed to train up to 8 case workers from a variety of these agencies, however, interest was so great that 18 case workers were trained.

Area agencies that now have one or more SOAR trained case workers through this initiative include: Franklin/Fulton PATH program, Franklin County Veterans Administration, South Central Community Action Program, Franklin County Shelter, Maranatha Ministries Shelter/Food Bank, CandleHeart Life Recovery Program, Service Access and Management, Supportive Services for Veterans Families, and Franklin County Adult Probation (Jail In-Reach). The face-to-face training was completed the beginning of March 2016 and to date, no applications have been fully completed. However, as of April 25th, 2016 there are 13 applications actively being worked on across these participating agencies. It is anticipated that up to 15 individuals may be assisted by the end of the PATH 2015-2016 FY. Franklin County MH/ID/EI is provided a funding

incentive for each completed application to help offset the time and financial burden that completing each application creates. The Mental Health Housing Program Specialist II is working on locating funding to sustain the incentive program.

Access to Housing

The Franklin and Fulton areas need additional housing resources to serve a growing homeless and mentally ill population. There are eight CRR beds available, 16 apartments through the supported living program, and eight beds at the Specialized Community Residence (SCR) available to the Mental Health population in Franklin County. The Franklin County Housing Authority continues to have a waiting list for individuals seeking housing. The Franklin County Shelter for the Homeless, Maranatha Cold Weather Shelter, and the New Hope Shelter provided housing to over 350 unduplicated men, women and children throughout the past year. The shelters estimated that nearly 1/2 of the homeless population they served were diagnosed with mental illnesses.

The shelters find housing resources and support for the homeless, often working hand in hand with the Mental Health Housing Program Specialists, Mental Health case managers, the Homeless Assistance Program, outside agencies, and the Housing Authority to place individuals on wait lists for housing.

The Franklin County Jail has connected with the New Hope Shelter, New Hope Ranch, Maranatha Cold Weather Shelter, Noah's House, and CandleHeart Program to provide a home plan for individuals who are in jail and cannot be released due to the lack of a home plan. A recent re-entry grant was received that will allow for master lease and transitional housing options for up to ten women re-entering the community. There are currently re-entry initiatives to expand the amount of re-entry housing for various populations in Franklin County.

The Mental Health Program Housing Specialist II does regular outreach to housing agencies to develop housing resources and supports for individuals, to include: the Housing Authority, New Visions Housing Program, Homeless Shelters, Women In Need Battered Women's Shelter, HOMES programs, landlords/apartment agencies, Housing Choices Vouchers, CandleHeart Life Recovery Program, and Maranatha Transitional Housing programs. In addition, the Mental Health Housing Program Specialist II serves as the County Housing Local Lead Agent and the Local Lead for the 811 Program, as well as the coordinator for the Housing Task Force/LHOT Committee, the LHOT Planning and Outreach Committees, the HUD/PATH Advisory Board, and the 811 Steering Committee. This allows for maximal networking and outreach opportunities with area housing and homeless prevention providers.

The Housing Task Force/LHOT Committee is working on a Housing Needs Assessment for Franklin/Fulton Counties. So far it has identified many Housing Resources that exist in the two county areas. The Identified Housing Resource List Continuum includes:

Emergency Shelter:

New Hope Shelter
New Hope Ranch
New Hope Cold Weather Shelter
Franklin County Shelter for the Homeless
Women In Need, Victim's Services Shelter
Maranatha Ministries Cold Weather Drop-In Shelter
Fulton County Catholic Mission

Transitional Housing:
Maranatha Ministries
CandleHeart Life Recovery Program
New Hope Ranch
Franklin County Housing Re-entry Initiative
Second Chance Ministries Forensic Transitional Housing

Permanent Housing:
Franklin County Housing Authority
New Visions
Barclay Village
Franklin/Fulton County Mental Health Housing HUD Programs
Franklin/Fulton County Mental Health Housing Shelter Plus Care Program
Franklin County Mental Health Housing Expansion Program
Franklin County Intellectual Disabilities Independent Living Program
Tharp Community Development, LLC

Housing Support Services:
Franklin/Fulton County Homeless Assistance Program
Waynesboro Human Services
Various Area Churches (seasonally)
Tharp Community Development, LLC
Salvation Army
Maranatha Ministries
PATH
811 Housing Voucher Program

While individuals overwhelmingly desire to live independently, the County lacks the adequate resources to be able to help them succeed in doing so. Franklin/Fulton County Mental Health uses the above-mentioned programs to their fullest housing capacity, and there are waiting lists for all the housing entities. This demonstrates the need for the PATH program to continue to provide outreach to housing entities in the area on behalf of the mental health individual who is experiencing homelessness or is at imminent risk of homelessness, to enable the individual to transition from homelessness and/or maintain housing.

Coordinated Entry

The Program Specialist II and Program Specialist I serve on the committee through the Pennsylvania HUD CoC to create a coordinated entry system for our state. The Program Specialist II collaborates regularly with members of the CoC on coordinated entry initiatives. The Franklin/Fulton Mental Health Housing Programs will participate in the Pennsylvania Coordinated Entry System once this system is operational. The coordinated entry system will be governed and monitored by the CoC.

Justice Involved

The PATH program supports individuals who have been involved in the forensic system and have experienced mental health and substance abuse issues and are moving toward recovery. Individuals have demonstrated this by successfully completing the Jail Diversion Program, the Day Reporting Center (DRC) where all services are inclusive in the program, and have successfully completed their probationary terms. The Mental Health Housing Program Specialists are team members on the Jail Diversion treatment team and Case Review Committee and therefore work closely with the Director of the DRC as well as the Director of Specialty Services at the Franklin County Jail. The Mental Health Housing Program Specialist II is a member of the Franklin County Re-Entry Coalition and regularly participates on committees to develop programs and services for the co-occurring population. It is estimated that 20-25 percent of PATH applicants have current or past criminal justice system involvement.

Staff Information

Staff members who serve the individuals in the PATH program come from a wide variety of backgrounds. The Mental Health Housing Program Specialist II was hired in 2015 and has an employment background of working with individuals with mental illness and co-occurring disorders as a Licensed Behavioral Specialist, Mobile Therapist, Outpatient Provider, Evaluator, and Program Supervisor. The Mental Health Housing Program Specialist II also teaches Psychology at a local college and has an employment background in educating/training staff and consumers in a variety of mental health and co-occurring disorder areas. The Mental Health Housing Program Specialist I was hired in 2014 and has extensive experience working with individuals with mental health diagnoses.

The PATH program will engage individuals and family members as volunteers in the PATH program in the planning, implementation and evaluation of PATH funded services. Many staff and individuals are familiar with both Franklin and Fulton Counties. This establishes a connection with the programming and individuals.

The Franklin County Human Services Division ensures departments in human services are in compliance with federal and state regulations related to Affirmative Action (AA) and Equal Employment and Educational Opportunity (EEO), including the Americans with Disabilities Act (ADA) and County policies and procedures related to hiring,

promotions, sexual harassment, and discrimination. New hire training includes non-discrimination and cultural sensitivity components. In addition, the County hires for its positions throughout human services from the State Civil Service Commission. Staff must meet eligibility requirements per civil service guidelines. The County regularly conducts protected class, harassment, and discrimination investigations and formulates these findings into written reports.

The mission statement for MH/ID/EI states "Franklin/Fulton Mental Health/Intellectual Disability/Early Intervention partners with the community to develop and arrange for the availability of quality services and supports for individuals and families". The County Human Services Division, including Mental Health, has a long history of positive involvement with both the homeless and the SMI population. Many services and programs have been established over the last 25 years throughout the Human Services Division to be able to successfully serve these populations, and through the PATH program this success will continue. Human Services and the County provide cultural competence and diversity training programs for county staff on a yearly basis that helps to foster diversity by:

- Providing training (Human Services Training Days) and educational programs through the HCQU on social equity issues for county employees
- Providing materials and translation services for a multi-linguistic population
- Advising departments on equitable employment practices and searches; and
- Being proactive in assisting departments to increase and retain a diverse administration and staff

The County has a responsibility for documenting physical and other disabilities of individuals and employees and providing general oversight and coordination of services and accommodations appropriate to the specific disability and consistent with the laws and accepted standards of practice of the Commonwealth. The County also has a responsibility to ensure that materials and evaluation of programs are culturally appropriate to the populations served in County Human Service programs. In addition, through groups listed below, the County gets regular feedback and suggestions for programs and services:

- Behavioral Health Advisory Board
- Housing Task Force/LHOT
- Community Support Program
- Franklin County Re-Entry Coalition
- Individual/Family Satisfaction Team

The PATH program will get regular feedback and suggestions from the Housing Task Force/LHOT committee and the HUD/PATH Advisory Board while implementing and evaluating the program.

The Franklin County Human Services Division, which includes MH/ID/EI, is committed to ensuring equal opportunity and access to supportive services, housing, education, and

employment opportunities for all persons involved in the PATH program regardless of race, color, sex, national origin, age, religion, veteran's status or disability. The staff members that provide services in the PATH program follow the County Human Services Ethics Code which includes sensitivity to various populations.

The Mental Health Housing Program Specialist position, Human Services, and case managers will be sensitive to the needs of any age, gender class, disability, racial or ethnic group that may exist among the PATH population. Staff will advocate for adequate housing on behalf of any special population identified through the implementation of this program. PATH brochures are available in English and Spanish for outreach and informational purposes.

Client Information

- Franklin and Fulton County residents.
- Individuals with serious mental illness or dual diagnosis (SMI and Substance Abuse).
- In and out of county homeless shelters/streets, community programs serving the homeless, or revolving in and out of jail, or transitioning from youth services.
- Individuals needing support with everyday life skills, such as cooking, medication management, cleaning, etc.
- Do not have adequate income supports to afford them reasonable housing
- Do not have federal assistance, and/or Medicaid or health insurance that covers mental health services
- Have a limited or fixed income and are often receiving Social Security benefits or benefits from the Department of Public Welfare.

The projected number of adult clients to be contacted using PATH funds is expected to be 80-100 individuals throughout 2017-2018. This will be accomplished through community outreach in Franklin and Fulton Counties. Outreach will be conducted during street outreach, at local job fairs, community events, homeless shelters, the Salvation Army, free community meals, Community Support Program meetings, during the Point-In-Time Count, and other locations where a homeless population may exist.

The projected number of adult clients to be enrolled and assisted using PATH funds during the 2016-2017 year is 40-50 through the continuation of housing resources and supports. The age of individuals to be served are any adults, men and/or women, 18 years of age and older, including adults with children. The PATH program specifically will target increasing housing opportunities, resources, and supports for individuals with mental illnesses who are homeless and/or at imminent risk homelessness. The individuals on the mental health housing wait list who are literally homeless, those who are in shelters, those waiting to come out of prison, or those at imminent risk of homelessness, are the population we hope to be able to benefit through the operation of the PATH program.

The PATH program will target increasing housing opportunities, resources, and supports for individuals with mental illnesses who are homeless and/or at imminent risk of homelessness. It is best to serve a small number of clients that can be served well, and can receive adequate housing services (security deposits, rental assistance, etc.) within the 20% budget guideline for Housing Services directed by OMHSAS-PATH. The program estimates between 40-50 individuals will be served throughout the12th grant year.

Based on historical statistics, it is projected that 60% of individuals served with PATH funds will be literally homeless and 40% will be at imminent risk of homelessness.

Consumer Involvement

- Individuals and family members are offered opportunities to serve on boards and steering committees (PATH/HUD Advisory Board, MH/ID Advisory Board, Community Support Program, Franklin County Block Grant Planning Committee)
- MH/ID office supports the right of an individual with disabilities to be able to work and succeed in employment
- The PATH program involves individuals and family members in the implementation and evaluation of PATH funded services, as well as in the PIT Count
- Case managers involve individuals and family members in recruiting possible/preferred housing locations and resources, and examine barriers that exist in securing housing
- Mental Health Housing Program Specialists seek feedback during encounters with individuals receiving PATH/HUD services to determine if any additional supports are needed
- Mental Health Housing Program Specialists will work with outside agencies and housing entities to support the creation of additional volunteer opportunities for individuals served in the PATH/HUD programs

Health Disparities Impact Statement

Franklin/Fulton MH/ID currently collects basic demographic information as part of the PATH intake process. This information is tracked via PA-HMIS and internal mechanisms to provide a broad overview of PATH participants' demographics.

Based on historical data, it is expected that Transition Age Youth (TAY) will comprise at least 25% of participants served using PATH funds. Given projections for number of people served in the 2016-2017 grant year, the actual number of TAY served using PATH funds is expected to be approximately 8-10 individuals. The total amount of PATH funds expected to be expended on services for the TAY population is estimated at $3,700.00. This figure includes rental assistance, outreach, informational materials, and safety and emergency supplies to be dispersed, as needed.

PATH funds will be utilized for the following services which are available for TAY individuals: rental assistance and security deposit payment; street outreach throughout the year and during PIT counts; purchase and/or development of educational materials (i.e. brochures); purchase and disbursement of safety and emergency supplies.

An increased focus on outreach to TAY individuals as well as improvement of information sharing with relevant organizations/agencies will be utilized during the 2016-2017 grant year. PATH staff intends to continue collaboration efforts with Juvenile and Adult Probation, Children and Youth Services, and local high schools by providing detailed information regarding the PATH program and any other services that may be helpful to TAY individuals experiencing homelessness/at imminent risk of homelessness. Outreach will also include posting information pertaining to services, community events, assistance, etc. for people experiencing homelessness in areas that are identified to be frequented by young adults.

In general, PATH funds will be utilized to measure, track and respond to disparity-vulnerable populations. PATH funds will allow for PATH staff to coordinate outreach activities, including occasional meals for people experiencing homelessness while they receive information and access to relevant services.

Limited English Proficiency

PATH funds will allow for provision of materials in both English and Spanish. Through a contract with Bopic, a Spanish interpreter is available, if needed. The PATH staff continue to expand services to and collect data on individuals who are served through PATH funding and identified as disparity-vulnerable subpopulation.

Budget Narrative

Personnel:

Funding of $14,548.44 is being requested to provide for the full-time salary, 22.30% time, of a MH Housing Program Specialist II and funding of $12,985.63 to provide for the full-time salary, 22.30% time, of a MH Housing Program Specialist I. These positions will be located in the Franklin/Fulton County Mental Health Department, whose work concentration is to increase and create housing resources in the county for homeless or at imminent risk of homelessness persons with serious mental illness. Total request for salaries is $27,534.07.

Fringe Benefits:

Funding of $8,921.29 is being requested to provide for the full-time fringe benefits of a MH Housing Program Specialist II and Housing Program Specialist I. Fringe benefits include the following costs: FICA at $1,971.99, health insurance at $3,680.20, retirement at $2,987.17, life insurance at $25.33, worker's compensation at $151.41 and state unemployment at $105.46. Total request for fringe benefits is $8,921.29.

Travel:

Funding is requested to pay for meal and travel costs for the MH Housing Program Specialist II and Housing Program Specialist I. Costs include monies for the MH Housing Program Specialist II and Housing Program Specialist I to be able to attend specific trainings on housing/homeless issues and mental health issues that are within the Mid-Atlantic region (sponsored by HUD, PHA, NAMI, etc.) to have the latest information that will assist in PATH program success. Costs associated with the trainings include per diem meals at $75.00, lodging at $400.00, gas & maintenance of county vehicles at $25.00 and estimated registration fees of $300.00. Other costs associated with the PATH program include the MH Housing Program Specialist II and Housing Program Specialist I local travel to housing entities, shelters, Housing Task Force meetings, evaluation meetings and regional housing/homeless meetings at $1,100.00. Total travel request: $1,900.00.

Supplies:

Funding is requested for supplies necessary to ensure efficient operation of the PATH program and to supply individuals experiencing homelessness with greater access to needed emergency, safety, new apartment set-up, hygiene, and habilitation resources. The following supplies enable the MH Housing Program Specialists to efficiently and successfully implement the PATH program: general office supplies—paper, pens, stapler, etc. at $250.00 and safety/emergency/apartment set-up/hygiene/habilitation supplies at $11,479.88 for a total of $11,729.88 for Supplies.

Other:

Other costs include the delivery of case management and support services for consumers in the PATH program; security deposits and one-time rental assistance payments for 40-50 individuals experiencing homelessness or at imminent risk at approximately $500 each, not to exceed $14,549.00. Internet/computer service for a year and the purchase of 2-laptops for staff (Purchases are done every four years for computer equipment replacement) at $5,100.00, postage costs at $100.00; administrative costs are computed at 4% of the total budget and include amounts for rent and utilities, with any excess expense amounts to be covered by in-kind funds. Administrative costs included here of 4%, $2,909.76, include the costs of space and utilities to house the PATH staff at $10.39 a square foot in Occupancy (254 sq. ft, with additional amounts for these administrative costs included as an in-kind expense.) Total request for other expenses: $22,658.76.

In-Kind:

In -kind services provided toward the project include the following items as outlined below at a value of $14,456.42:

MH Dept. Supv. of MH Housing Program Specialist II @ 3.8%	$4,359.99
MH Dept. Admin. Assistant II Time @ 0.96%	$418.75
MH Dept. Admin. Assistant I Time @ 1.25%	$483.23
MH Dept. Fiscal Officer Time @ 3.08%	$1,987.59
County Match (on State allocation)	$545.58

Administrative Expenses	$1,744.87
Additional Funding for Rental Assistance to Applicants	$5,000

In addition, although Franklin/Fulton MH is continuing a PATH program to specifically expand existing housing and increase new housing programs for homeless/near homeless mentally ill individuals, currently Franklin/Fulton MH housing components provide over $1,677,230.00 in current supportive housing program costs and expenses for mental health individuals, of which, if openings existed, could possibly benefit PATH program eligible individuals in the future. Supportive housing costs and expenses through Franklin/Fulton MH and HUD:

TrueNorth Wellness Services
$743,528.00
New Visions
$293,262.00
Keystone Service Systems
$378,653.00
HUD Grants Yearly
$261,787.00

Franklin/Fulton Counties
PATH Program
FY 2017-2018 Budget

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
Position				
Program Specialist I	$ 51,468.99	25.23%	$12,985.63	$12,985.63
Program Specialist II	65,239.63	22.30%	14,548.44	14,548.44
sub-total	116,708.62		27,534.07	27,534.07
Fringe Benefits				
FICA Tax	4,169.39		1,971.99	1,971.99
Health Ins	7,781.08		3,680.20	3,680.20
State Unemployment	222.97		105.46	105.46
Worker's Comp	640.69		151.14	151.14
Retirement	12,661.72		2,987.17	2,987.17
Life Insurance	107.37		25.33	25.33
sub-total	25,583.22		8,921.29	8,921.29
Travel				
Local Travel for Outreach	800.00		800.00	800.00
Travel to training and	300.00		300.00	300.00

workshops				
Staff Training/Registrations	300.00		300.00	300.00
Lodging for Trainings	400.00		400.00	400.00
Meals	75.00		75.00	75.00
Gas/Maint - Cty Vehicles	25.00		25.00	25.00
sub-total	1,900.00		1,900.00	1,900.00
Equipment				
Supplies				
Office Supplies	250.00		250.00	250.00
Safety and Emergency Supplies	11,479.88		11,479.88	11,479.88
sub-total	11,729.88		11,729.88	11,729.88
Other				
Rental Assist/Security Deposits	14,549.00		14,549.00	14,549.00
Postage	100.00		100.00	100.00
Internet/Computer	5,100.00		5,100.00	5,100.00
Administrative Costs	5,000.00		2,909.76	2,909.76
sub-total	24,749.00		22,658.76	22,658.76
				72,744.00

27. Greene County Department of Human Services

19 South Washington Street

Waynesburg, PA 15307

Contact: Zabryna Karnes

Contact Phone #: 724-852-5276

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-069

State Provider ID: 4269

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 31,802	$ 10,601	$ 42,403	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 31,802	$ 10,601	$ 42,403	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 31,802	$ 10,601	$ 42,403	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 31,802	$ 10,601	$ 42,403	

Source(s) of Match Dollars for State Funds:

Greene County will receive at total of $42,403 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 55

Estimated Number of Persons to be Enrolled: 30

Estimated Number of Persons to be Contacted who are Literally Homeless: 19

Number staff trained in SOAR in grant year ending in 2017: 9

Number of PATH-funded consumers assisted through SOAR: 7

Greene County Human Services

2017-2018 PATH IUP

Local Provider Description –
Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

PA-069 Greene County – Greene County Human Services, 19 South Washington Street, 3rd Floor, Waynesburg PA 15370. The Greene County Department of Human Services is the provider organization requesting $42,403 ($10,601 State PATH and $31,802 Federal PATH) to implement the PATH Intended Use Plan for Greene County. Greene County Human Services will be also allocating $13,941 from the DHS Block Grant for a total of $56,344.00 for the intended use of PATH. (all highlighted will change once Marcy will get back to me

The Greene County Human Services Department provides administrative over sight for the County Mental Health, Intellectual and Developmentally Disabled, Drug and Alcohol, Children and Youth, County Shared-Ride Transportation, Housing Initiatives and other special Human Services projects. Greene County Human Services Department serves the residents of Greene County.

The mission of the Greene County Department of Human Services is to establish relationships with individuals, families, providers and other interested parties, so that the human services needs in Greene County are met in the most effective and cost-efficient manner possible. The Department will accomplish this mission by effectively managing the county's resources and maintaining a service delivery system to improve the quality of peoples' lives.

The structure and function of the Greene County Department of Human Services exists to provide a variety of services meant to assist people in developing and maintaining a healthy lifestyle. The Department identifies the needs in Greene County and actively pursues public and private resources to meet them. The Department also improves coordination between and among a variety of services and programs.

Collaboration with HUD Continuum of Care (CoC) Program –
Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the areas where PATH operates.

Greene County Human Services Department is one of two Greene County voting participants on the Southwest RHAB (Southwestern Regional Housing Advisory Board), the other is held by Connect Inc. our subcontracted agency for HUD awarded programs. As a voting member of the Southwestern Regional Housing Advisory Board, we are also a voting member of the Western Region COC which is the regional HUD Continuum of Care Program. Greene County Human Services Department actively participates in all monthly meetings and

serves on subcommittees for the SWRHAB and bi annual meetings of the Western Region COC meeting Greene County Human Services works with other community programs such as the local Housing Authority, Catholic Charities, the Carmichaels Ministerium, United Way, Greene County ESG Program, the two local Oxford Houses; one for women and one for men, Voting member on the steering committee of the Greene County VOAD (Volunteer Organization Active in Disaster) team, Tri- County Patriots for Independent Living (TRIPIL), and the Salvation Army to identify resources to prevent homelessness. Greene County Human Services co-chairs the Local Greene County Housing Options Partnership (GCHOP/LHOT)/ Local Housing Options Team (LHOT) which brings together stakeholders from Mental Health, Drug and Alcohol, Intellectual Development Disabilities, Housing Authority, local CSP, Area Agency on Aging, Veterans Affairs, Greene Arc, Inc. and local individuals who have an interest in housing in the county. Greene County Human Services Administrator is a liaison to the Redevelopment Authority of Greene County.

The Greene County's PATH Housing Outreach Specialist participates in the Local Greene County Housing Options Partnership GCHOP/LHOT, Block Grant Advisory Committee, Food Partnership Advisory Committee, the Permanent Supportive Housing Advisory Board, Communities that Care, the Red Cross Emergency Food and Shelter Program Advisory Committee, and the Co-Occurring Disorder Council.

Greene County Human Services has been named the Coordinated Entry access point for Greene County. Trainings and HMIS assignments have already been completed. Staff have been completing the assessments since January 2017 to make sure all of the kinks are worked out, but we will officially be administering the Coordinated Entry Assessments as of July 1, 2017.

The PATH Housing Outreach Specialist is already known in the community as the current centralized intake person for the county to complete a housing assessment on all those who are homeless or in imminent risk of being homeless, it will be a smooth transition. The PATH Outreach Housing Outreach Specialist will be responsible to enter the Coordinated Assessments into HMIS, and to maintain the list, ensuring it is current and accurate at all times.

Collaboration with Local Community Organizations –
Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
Greene County Human Services partners with many local organizations providing key services to PATH eligible clients. Many of these services include Primary Health Care, Mental Health Services (In-patient, Out Patient, and Community Based), Case Management, Substance Abuse Treatment and Case Management, Employment and Housing organizations.

Physical health care in Greene County is provided by primary care physicians at Washington Health Systems of Greene County, clinics, and doctor's offices. Cornerstone Care, Blacksville Clinic and Carmichaels Clinic, a federally qualified health center, provides a majority of health care and dental services to our individuals.

Mental Health outpatient services are provided by Greene County Human Services Mental Health Program, Centerville Clinics MH, Inc., SPHS, The Stern Center, Washington Health System of Greene Hospital, Intermediate Unit One and Cornerstone Care. The local hospital, Washington Health Systems of Greene, has a Behavioral Health Unit and outpatient program. Greene ARC provides the following mental health services; psych rehab, social rehabilitation, peer support and oversight of the Open Arms Drop In Center. Value Behavioral Health Care, the Medicaid managed care organization, is a large payor of services for our individuals with behavioral issues.

The Greene County Human Services Housing Program administers the Housing Assistance Program (HAP), Children and Youth Special Grants for Housing and the MH Housing Contingency Program. The Greene County Housing Program also administers the ESG Program that targets families with children, case management, veterans, the forensic population, and single youth age individuals age 21-25, which includes some PATH eligible clients. Greene County Human Services through Connect Inc. provides the Permanent Supportive Housing Program, Transitional Housing, and Rapid Re-Housing for Greene County residents.

Greene County Human Services Drug and Alcohol Programs provide prevention, case management, intensive case management, level of care assessment, and resource and referral services. Clients are referred to SPHS C.A.R.E. for Drug and Alcohol outpatient services and various de-tox/ rehabilitation centers for inpatient services.

G-PATH (Greene County's Project to Assist in the Transition from Homelessness) eligible clients can utilize the local OVR program, Southwest Training program, Washington and Greene Job Training, and PA Careerlink and also have the opportunity to work with a trained Certified Peer Specialist that is able to assist with employment issues.

Greene County Human Services implements the County's ESG, and DHS HAP programs that provides funding to assist with rental and utility emergencies. The County also works with the Greene County Housing Authority and our SSVF Programs for those who meet eligibility. The County meets with local landlords on a regular basis to keep the lines of communication open and to encourage them to provide rental units to our low income individuals. HUD Permanent Supported Housing, Shelter Plus Care, and Transitional Housing also assist G-PATH eligible clients if they meet the eligibility guideline criteria. The Drug and Alcohol recovery community opened two Oxford Houses (3/4 House, one for men and one for women) and Greene County Housing Program assists prospective residents who meet eligibility.

GCHS Housing Program has been a lead in pulling together a collaborative effort to create a warming center in Greene County. Through working with the Greene County United Way, Waynesburg University, Salvation Army, local churches, the local hospital, the Greene County Commissioners and other community volunteers we are able to provide a cold weather warming center that is called; Warm **Night, 25 Degrees and Below.** The program has a house that sits at the Greene County Fairgrounds, which is in the center of the county. This location is available when the temperature were 25 degrees and below according to www.accuweather.com for Waynesburg PA. Our local Mental Health Hotline was the mechanism for clients to register. If persons or families registered before 4 PM we were open from 7 pm till 7 am. We provide a warm place to sleep and referee information. So if need be we can help their situation long term.

Service Provision –
Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

- **How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless literally and chronically homeless**.

Greene County Human Services Department has implemented a single point of contact to provide coordinated and comprehensive services that is offered to PATH consumers as well as other homeless individuals. A PATH

Housing Outreach Specialist, employed by Greene County Human Services, provides outreach activities to homeless persons who are presented in various ways to the Greene County Human Services Department. The PATH Housing Outreach Specialist is a part of the team that provides a single point of assessment for the County when it comes to individuals with housing needs especially those with behavioral health issues. Every client with a housing need completes a centralized assessment. We are using the Coordinated Entry, Centralized Intake Assessment from the Western COC. We are also entering each assessment into the HMIS data system. The client is then referred to a program within the continuum of care that best fits their needs and that they are eligible for. Through this process clients "have one stop" to find the appropriate services that they are eligible for and will not have to do extra unwarranted leg work during their time of crisis. This enables service providers to have clients coming to them that are eligible for their programs, which saves a great deal of staff time since the initial screening and some of the intake paperwork, such as ID's income and verifications are already taken care of.

The participants in G-PATH will be homeless as defined under HUD definition. The PATH Housing Outreach Specialist is trained especially in working with the homeless as well as community housing resources. (The participants in G-PATH will be homeless as defined under HUD definition.) This centralized assessment model allows better collaboration across the housing system. This creates a better working relationship between not only other services providers but with landlords and the Ministerium. Regular meetings occur with the Salvation Army to make sure that services being rendered are not duplicated. Greene County Human Service Housing Program (GCHSHP) facilitates a quarterly landlord meeting to address the landlord's concerns and to assure better coordination and assistance for their tenants. GCHSHP also works closely with the local Red Cross to meet the needs of those who may have found themselves homeless due to a disaster. The PATH implementation is an objective of our DHS Block Grant, under a transformation priority of "Supportive Housing". This further enhances housing collaboration throughout all Greene County Human Services.

The PATH Housing Outreach Specialist is also trained as a Certified Peer Specialist (CPS). The PATH Housing Outreach Specialist also participates on the Permanent Supportive Housing Advisory Board, Co-Occurring Disorder Council, Consumer Support Program, GCHOP/LHOT meetings. The Greene County Housing and Family Resources Director meets for supervision with the PATH Housing Outreach Specialist weekly to staff client situations and to ensure that community program services are used effectively and efficiently.

Greene County PATH Housing Outreach Specialist maintains a mechanism for tracking the number of referrals received for PATH services as well as the agencies or programs that make the referrals. This data is documented on a monthly and year-to-date basis and regularly reported to Greene County Human Services Department for collation and summary of the program. This data is being entered in HMIS.

The Greene County PATH Housing Outreach Specialist is available on an immediate basis during work hours to conduct outreach services to the homeless. The PATH Housing Outreach Specialist is educated on all community resources and be responsible to understand the eligibility of those resources. The Greene County PATH Housing Outreach Specialist can assist the homeless person or family with finding the resources to insure that the referral is a success. Referrals to the PATH Outreach Specialist come from various sources especially agencies, churches, law enforcement, schools, public officials, and walk in's.

- **Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services**

The Greene County PATH funds will be utilized for street outreach to maximize this service. Case management will not come from these dollars. Case management is offered through human services from an array of other funding sources. The Human Services Block Grant will provide General Case Management to those who may need a case manager for a short time because of the issue they may be having or will be able to link them up

with a more permanent caseworker depending on the need and human services area that will best serve them. The Greene County Human Services Housing Program administers the Housing Assistance Program (HAP), Children and Youth Special Grants for Housing, SOAR services, Drug and Alcohol Intense Case Management and the MH Housing Contingency Program through Block Grant dollars. The Greene County Housing Program also administers the PHARE Veterans Program that targets families with children, case management, veterans, the forensic population, and single youth age individuals age 21-25, which includes some PATH eligible clients. Greene County Human Services through Connect Inc. provides the Permanent Supportive Housing Program, Transitional Housing for Greene County residents. Also through PCCD dollars a Master Leasing program is available with case management to those with a criminal background, this is offered through the Drug and Alcohol Program under Greene County Human Services. Also SSVF programs that cover our area are utilized when working with a Veteran. All of these services mentioned come from other funding areas and all help to support the PATH population.

- **Gaps that exist in the current service systems**

Currently Greene County has no shelters in the County. Greene County Housing Program works with Greene County Transportation to provide transportation to out of county shelters. The main family shelter that we have used for many years, is now closing in Washington County. So at this time there are no Family Shelters near us. We have a Women's Shelter in Washington County, but if a mother has a male child over the age of 8 then he can not stay with her, the child would need to go to the over men in the Men's Shelter.

GCHSHP face a challenge when it comes to transportation. Many individuals who are homeless are reluctant to cross county lines and do not have transportation to an out of county shelter, this is also an excuse for some of our homeless individuals not to follow through with serves. Greene County Human Services Housing Program also administers the HAP program, which enables us to utilize that fund for Emergency Shelter in Hotels/ Motels, but we are challenged with this the availability of this resource due to the Marcellus Shall industry have these rooms occupied on a daily basis.

One way the we address the obstacle of no in-county shelters is by being a key part of a group of people, both from local services agency and community volunteers, who have come together to open a warming shelter. GCHS has been working with the Greene County United Way, Waynesburg University, Salvation Army, local churches, the local hospital, the Greene County Commissioners and other community volunteers to continue efforts for the second year of providing a cold weather warming center that is called; **Warm Night, 25 Degrees and Below.** FY 15-16 was our first year of offering this services. In 2016-2017 we expanded this program from 20 degrees to 25 degrees, from the months of January and February in 2016 to December, January, February and March this program year. This program is staffed with 31 volunteers trained by GCHS Housing Program. Residents who needed this service were invited to one location this year, The Greene County Commissioners allowed the program to utilize a house that is located at the Greene County Fairgrounds. This is another improvement from last program year, last program year we had four locations, every two weeks' volunteers moved all the supplies from one location to the next, this took a toll on the volunteers. This past year, being in one location was one of the reasons that we expanded the length of the program. A consistent "home" for our project has help with storage, transportation of supplies and possible hours of operation. This location was available when the temperature was 25 degrees and below according to www.accuweather.com for Waynesburg PA. Our local Mental Health Hotline is the mechanism for clients to register. If persons or families registered before 4 PM we were open. During the four months of this program we were open 7 nights and served a total of 6 individuals. All individuals who utilized the program ended up accepting longer term housing help from Greene County Human Services. This house at the Greene County fairgrounds will remained set up in case of an emergency throughout the year, a small core of volunteers did agree to be called in necessary throughout the year, if an emergency did arise. This program was identified to be needed because there was no program or place in our county for people to go who did not have adequate shelter from the cold.

We are continually working on our relationship with the Greene County Housing Authority (GCHA). PATH clients who are residents of the GCHA sometimes struggle as good renters due to the nature of their behavioral health issues. Most recently the GCHA has started to look at us as a case management resource for their tenants. Referrals are occurring more often which in turn means fewer evictions. We will continue to foster this growing relationship, as we work closer together in the future. The Greene County Housing Authority has partnered with our housing program for a Master Leasing Program that is funded through PCCD which helps those with forensic backgrounds receive housing and wrap around services that help them maintain housed.

Another challenge the Greene County Housing Program has is with reluctant unmotivated clients. Many of these individuals and families are CYS referred. We find that these clients rapidly "burn bridges" with our resources and as a result sometimes become chronically homeless. The Greene County PATH Housing Outreach Specialist spends a lot of time working with these clients, but many of these clients do not follow through and keep resurfacing.

- **Brief description of the current services available to clients who have both a serious mental illness and a substance use disorder**
  -

Individuals with co-occurring mental illness and substance abuse disorders are served through Greene County's Co-Occurring program. Beginning in August 2000, Greene County developed a Co- Occurring Council to ensure the wellbeing of individuals with co-occurring disorders who reside in Greene County. It provides an interactive working forum to collectively foster and support collaborative systems of care. It brings together a group of representative agencies servicing dually diagnosed individuals for the purpose of removing the barriers to service and supporting those individuals in addressing the complex needs they face, proposing innovative solutions that bring effective resolution to system problems or inefficiencies; and promoting education and training of individuals, groups, and agencies regarding the complexity of issues in the dual diagnosis of mental illness and substance abuse. The Greene County Co-Occurring Disorder Council consists of the following partners:

- SPHS C.A.R.E Center Drug and Alcohol Program
- SPHS Sexual Assault Counseling and Advocacy Program
- Centerville Clinics Mental Health, Inc.
- Community Action Southwest
- Greene County Children and Youth Services
- Greene County Drug and Alcohol Program
- Greene County Probation Services
- Greene County Human Services Mental Health Program
- Greene County Human Services Housing Coordination Program
- Office of Vocational Rehabilitation
- Value Behavioral Health
- SPHS Connect, Inc.
- Greene County Human Services Forensic Re-Entry Program

A representative from each of these agencies attends the bi-monthly co-occurring council meetings and offers support and services. The Council also makes recommendations for referrals to the G-PATH program. The PATH Housing Outreach Specialist has the opportunity to refer persons who they feel are appropriate for an assessment for co-occurring service. The PATH program participants can then receive this structured level of support which includes an opportunity for input from a variety of providers and other entities.

- **How the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data in HMIS**

Greene County Human Services supports and funds evidence based programs throughout the categoricals provided by Greene County Human Services. During fiscal year 2014-2016, Greene County Human Services Department provide training to GPATH staff as well as providers of homeless services in: Motivational Interviewing, DCORT 101, CORE Training, PREP refresher training, Understanding and Engaging Homeless Individuals, Drug and Alcohol Rules of Confidentiality, Veterans Assistance Challenge Forum, Confidentiality and Boundaries in Recovery Oriented Service, Recognizing and Reporting Child Abuse and Mandated and Permissive Reporting in Pennsylvania, Point In Time Training, HIPAA and HMIS: Protecting and Securely Sharing Client Information training, HMIS training, and Community That Cares 101. DCED HMIS webinar trainings are at no cost, which has allowed Greene County Human Services to participate in the trainings and report all requested information into HMIS data system. There is a line item in the budget for trainings in the event that additional training that incurs expenses is necessary.

Within FY 2016-2017 our G-PATH program staff have attended PATH Webinars Introducing the New PATH, Trainings on Benefit Programs and Other Resources for the Homeless, Benefit Programs and Other Resources for the Homeless: Employment Resources, PA HMIS: 2016 Update trainings, PAYS Training, PA PDX Technical Assistance Training, Equal Access and Gender Identity Rules Training, PATH HMIS Learning Community, PATH Data Flow Training, PATH Contact HMIS Policy Development, PA HMIS Training Coordinated Entry Training, Western COC, Housing First Training, Addressing Circumstance of the Past training, DASH Training, Obsessive Compulsive Disorder Training. Youth Mental Health First Aid, Housing First, Warming Center Volunteer Training, Mental Health First Aide for Adults and Crisis are some of the trainings that staff have attend to best help those who need our services.

All HMIS Data entry training has been provided by the COC or SW RHAB. It has either been offered in Person or by webinar.

- **Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.**

Greene County Human Services (GCHS) follows the 42 CFR Part 2 Regulations. GCHS also includes under its umbrella of programs the Drug and Alcohol Program. This Drug and Alcohol Program coordinates trainings including a confidentially training specific to the 42 CFR 2 Part regulation and all staff of the G-PATH program have been trained. Also upon hiring each employee under the Human Services umbrella, regardless of program signs a Greene County Human Services Program Employee Statement of Confidentiality. Another more general confidentiality agreement is also signed with the County's Human Resource Department. Regular training is mandatory and followed.

- **Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)**

- **Data –**
  Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For *providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff*.

Greene County Human Services Department currently has all appropriate staff trained and using the newly updated HMIS system and will continue to attend on-going trainings such as the PA HMIS System Update classes that are offered. We will be able to train new staff with the help of the PA HMIS Data Entry Reference Guide and from the past webinars that are archived on the www.newpa.com/pahmis website. All Greene County Housing Program staff will continue to utilize HMIS on an ongoing base.

Alignment with PATH goals –
Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

- The goal of the Housing Outreach Specialist is to help reduce the homeless population in our Community by conducting mobile outreach and providing assessment, crisis intervention, and resource referral to homeless individuals and families in need. These services are provided under the Greene County OMHSAS PATH Grant.

The goals of the G-PATH program align with the objectives of the funding source. G-PATH's goal is to reduce or eliminates homelessness for individuals with serious mental illness or co-occurring serious mental illness and substance abuse disorders or those who are imminently at risk of being homeless. The G-PATH program uses the continuum of housing and human service related resources to help those that are found through constant street outreach. Greene County Human Services will link those who are most vulnerable to the appropriate services, whether it is Case Management, Health Insurance, or housing options through the continuum. The PATH Outreach Specialist will be utilizing the Coordinated Entry Assessment and entering the assessments into HMIS, where all Chronically Homeless individuals will be place on a waiting list based on need, so that services from the 20 county region can possibly help them with the Housing First type of care, once there is an opening.

Alignment with State Comprehensive Mental Health Services Plan –
Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

- The Housing Outreach Specialist upon complement of assessment will refer individuals to local service providers such as Peer Specialist, Recovery Specialist, Blended Case Managers, Drug and Alcohol Intensive Case Managers, or even a General Case Manager if needed.

The G-PATH program meets with the Mental Health Director on a regular basis. The Housing Outreach Coordinator works with the Mental Health staff, is a part of any necessary Multi-Disciplinary Team Meetings, works with the local BHU and is a part of our Local Housing Team meetings to ensure that we are available for referrals, since those involved would work with those with Serious Mental Illness and or a Co-occurring Disorders. The PATH Housing Outreach Specialist also helps work the local Produce to the People Food Distributions, visit local soup kitchens at various churches, and works with various other human Services agency in efforts to link this vulnerable population to other supportive services. The PATH Housing Outreach Specialist will arrange an appointment for individuals that may not have insurance to one of three programs to insure that they can receive the physical and mental health care that they need. SOAR services are also available through the GCHS system. With these collective efforts through outreach and referral the G-PATH program tries to help homeless individuals with serious mental illness secure safe and stable housing, improve their health and live life to the fullest.
For those individuals that maybe chronically homeless, we are joining efforts through our COC to utilize the coordinated assessment tool and system when it is available and help place those who agree to be helped, even out of county into Permanent Supportive Housing and or a shelter.

The G-PATH Program staff is on both the Disaster Crisis Outreach and Referral Team (DCORT)and the Volunteer Organization Active in Disaster (VOAD) team. We are housed within the same department and stay in constant communication with the Mental Health Disaster Coordinator which is also out Mental Health Director and DCORT contact. We are current on trainings and we are on the Emergency Planning Team to assist those individuals that have been impacted by crisis or disaster by providing emotional and therapeutic activities to ease stress, foster a compassionate presence and to aid in community resilience.

Alignment with State Plan to End Homelessness –
Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

- Greene County Human Services Housing Outreach Worker works diligently with local landlords to build a strong relationship in the efforts to find affordable housing options for individuals that are served through programming such as Permeant Supportive Housing, Rapid Rehousing and HAP.

Joint efforts of state, local and federal authorities and the community at large:

Greene County is following the State's Guiding Principles and General Approaches to end homelessness. We are a part of the COC through both the Western RHAB and the SWRHAB, We are Chair of our local GHCOP/LHOT teams and regularly attend trainings offered by HUD to stay current.
We are the local contact for the County of Greene for the Coordinated Entry Process, all Coordinate Entry Assessments will follow the COC plan and be entered into HMIS.
An approach that is holistic and client centered:
We are client centered, we meet clients where they are comfortable and we listen to the needs that they feel need addressed.

Addressing all of the many facets of homelessness including different demographics, causes, geographic, forms and levels and a clear focus on homeless prevention;

We have a full Continuum of housing options in Greene County to services those with housing needs from Homeless Prevention, HAP dollars helping with eviction, to case management helping landlords and tenets to mediate differences, to helping those who are Chronically Homelessness.

The aggressive expansion of affordable housing opportunities;
Greene County Human Services works with local landlords to increase the safe and affordable rental stock in Greene County. With this program we work with landlords through PHFA dollars to bring rental units up to code once the unit is up to code the landlord agrees to work with us offering the units to our clients for up to three years at fair market rent.

Embracing the philosophy of Housing First;
All housing staff have been recently trained in Housing First and utilizes the principles in our practice.

The use of best practices in data gathering and strategic planning;
All staff have been trained and are using HMIS to collect data.

Other Designated Funds –
Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

There are Block Grant Dollars that are specifically ear marked for serving people who experience homelessness and have a serious mental illness, through the Mental Health Contingency Program and is operated by the Housing Program, these dollars can be used for Emergency Shelter, first month's rent or back rent for evictions. These dollars are available to PATH eligible clients.

Programmatic and Financial Oversight –
In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

The Greene County Housing Program will utilize HMIS as a way to collect and review data. GCHSHP do comply to all reviews that are scheduled by the Bureau of Policy, Planning, & Program Development. The PATH Housing Outreach Specialist does have supervision weekly to review all housing intakes and referrals. Also the GCHP utilizes the GCHOP/LHOT monthly meeting as mechanism to report out to the community at large. GCHS does comply with all state and federal audit and reporting requirements.

SSI/SSDI Outreach, Access, Recovery (SOAR) –
Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. For the grant year 2016-2017, include all of the following data:

- **The number of staff trained in SOAR**
- **The number of staff who provided assistance with SI/SSDI applications using the SOAR model;**
- **The number of consumers assisted through SOAR**

- **Application eligibility results (i.e., approval rate on initial application, average time to approve the application)**
- **The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.**

Greene County Human Services has a lead SOAR certified person on staff; Referrals are currently being made to this person from the PATH staff and outside agencies. In 2013-2014 (March 4-5, 2013) Greene County Human Services had 9 individuals trained in SOAR. In February 2014 a new lead person trained via web based and has become certified, this role is shared with other roles that he has. Referrals are being seen from the local hospital and other agencies to the lead person. In FY 2016-17 the SOAR Outreach certified person started 7 applications, out of those 7 application 3 has been approved, and 4 are not able to be contacted. The SOAR certified person also completed 30 general case Social Security cases, of those that had housing issues but according to Social Security and HUD do not fit the homeless definition, but out of those that he helped with general case management, 18 received their Social Security Benefits. The SOAR Application are still lengthy and do take a lot of man hours, each on differs depending on the client. This is because the homeless population are so transient after the initial assessment, but on average at least 35 hours is spent on each application.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

1. The Housing Authority of the County of Greene provides housing for the elderly population and individuals or families with low income. They also currently manage 28 section 8 vouchers throughout the County. Greene County Human Services Department has partnered with the Housing Authority for a Master Leashing Program that is targeted to serve individuals with a forensic back ground.

2. Greene County's Housing Coordination services include establishing relationships through a landlord outreach initiative. This initiative has been successful in assisting the County's housing programs in offering individuals housing choice options and helping residents maintain in their current housing once case management is utilized. Also through these relationships the GCHSHP has offered through PHARE dollars a grant program called Rental Rehabilitation. If a local landlord that has worked with us in the past has a unit that needs to be brought up to code, then there is a grant that can help with the costs to make it meet HUD regulations. The match is 50/50 with the limit of the grant being $7,500. Once the unit is brought to code the landlord agrees to rent to a person in a Housing Program at fair market rent for three years.

3. Greene County Human Services offers, through Connect, Inc., Permanent Supportive Housing, Master Leasing, Shelter Plus Care and Supportive Services programs for individuals who are transitioning from homelessness.

4. Greene County Human Services Department administers two ESG programs which address the needs of families with children, veterans, the forensic population, and single youth age individuals age 21-25.

5. The County also utilizes personal care homes if that level of service is indicated.

6. Greene County Human Services, through Connect Inc., has a six unit transitional house available. Support services through Connect, Inc., PA Careerlink for employment and Greene County Human Services case management are available to those tenants to assist them in finding permanent housing

7. Throughout the months of December 2016 through March of 2017, a ollaborative program called Warm Nights 25 Degrees and Below, help with giving individuals a safe warm night sleep. These services helped anyone who registered through our MH CRISIS Hotline. It offered a warm safe place from 7 PM to 7 AM and also connected those who registered with services through G-PATH.

Coordinated Entry – Indicate if your organization is part of a coordinated entry program. If so, explain the coordinated entry process and through whom it is governed/monitored.

Greene County Human Services (GCHS) Housing Program is the Coordinated Entry site for Greene County starting in July of 2017. This provides a single point of contact and assessment process that has been created by and has become standardized with in the Western CoC, which we are a voting member of. The Coordinated Entry process provides an assessment of coordinated and comprehensive services for those with a housing need. Clients in need of housing complete a centralized assessment. This assessment is provided by the PATH Housing Outreach Specialist. From this assessment, the client is then referred to a program in our continuum of housing programs that best fits their needs and that they are eligible for and are placed in the HMIS data system which can open up housing opportunities within a 20 county region. Through this process clients are offered a "one door" approach to be assessed for services and will not have to do extra unwarranted leg work during their time of crisis. This enables our service providers to have clients coming to them that are eligible for their programs, which saves a great deal of staff time since the initial screening and some of the intake paperwork, such as ID's income and verifications are taken care of. Clients seeking assistance through CYS Contingency Funds, Mental Health Contingency Funds, PATH, ESG, HAP and all other programs in the housing continuum utilize this process.

Justice Involved – Please describe your agency's efforts to minimize the challenges and foster support for PATH clients with a criminal history. Examples include jail diversion and other local, regional and state programs, policies and laws in your area. Indicate the percentage of your PATH clients with a criminal history.

The Housing Outreach Specialist will refer eligible participants to the Forensic Reentry Specialist who is housed in the Drug and Alcohol Program under Greene County Human Services. This person helps to coordinate treatment services for individuals involved with the justice system with drug or alcohol issues and/or mental/behavioral issues, develop Reentry plans, make referrals to treatment, monitor individuals progress in treatment and treatment reports to the court for monthly Reentry Court, assess individuals who are ordered by the court for D&A and make recommendations. This is also the same person who helps to coordinate an Integrated Reporting Center/IRC; This program serves individuals from both county and state parole who are in need of services upon release or as a sanction for individuals in jeopardy of violation because of their D&A or MH, until they can gain access to services. Approximately twenty percent of the PATH caseload has a criminal background.

Staff Information –

Describe the demographics of staff serving the clients
Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients
Discuss the extent to which staff are receptive to differences of clients
Identify the extent to which staff receive periodic training in cultural competence and health disparities

(http://www.ThinkCulturalHealth.hhs.gov).

The PATH staff serving the targeted population consists of the Greene County Housing PATH Outreach Specialist. The Greene County PATH Housing Outreach Specialist is from Greene County, and she has previously been involved herself in the County's housing programs and systems. She is experiencing her own mental health recovery and has been certified by the state to be a Certified Peer Specialist. She has also been trained to administer SOAR applications.

The Outreach Specialist was homeless (couch surfing) when she came to work for Greene County Human Services Department. She became involved in activities needed to be accomplished to be considered for our Permanent Supportive Housing Program. She completed 40 hours of peer certification and is current with all updates and additional trainings offered. She is currently using skills learned in peer certification, including WRAP, to provide outreach to the homeless. She is a single mother of two children.

Greene County Human Services Department has provided many trainings to stakeholders working with homeless including: SOAR training, Peer Employment Community Training, Drug Trends, Cultural Competence Capacity Building training, Homelessness Among Veterans Webinars, Community Builders (a ten week class that educates participants on the community, boards, and leadership) Finding Evidence Based Practices to Promote Public Health, Crisis Intervention Training, two HMIS trainings and PREP Training. The HMIS trainings the Homeless Outreach Specialist attended were entitled "Caseworker and Intake Procedure Training" Part I and II. The HMIS training that was received will help our Homeless Outreach Specialist with the basics needed information for when HMIS is a requirement of PATH. It has also helped with structuring the initial assessment. These trainings were attended in FY 2012- 2013. In this past FY (2013-2014) she has attended: Motivational Interviewing, Psychological First Aid, PREP, IDD Cross Training, Substance Abuse STI's and Teen Pregnancy- Increasing Risk of HIV, and CTC 101.

During fiscal year 2014-2015, Greene County Human Services Department provided training to GPATH staff as well as providers of homeless services in: DCORT 101, PREP refresher, Understanding and Engaging Homeless Individuals, Drug and Alcohol rules of Confidentiality, Confidentiality and Boundaries in Recovery Oriented Service, Recognizing and Reporting Child Abuse and Mandated and Permissive Reporting in Pennsylvania, Point In Time Training, HIPAA and HMIS: Protecting and Securely Sharing Client Information training, HMIS training, and Community That Cares 101. DCED HMIS webinar trainings are at no cost, which has allowed Greene County Human Services to participate in the trainings and report all requested information into HMIS data system.

Within the current FY 2015-2016 our G-PATH program staff attended Youth Mental Health First Aid, Housing Options for Individuals with ID, Housing First, Warming Center Volunteer Training, Community Planning Part 1 and 2, PATH HMIS TA, Mental Health First Aide for Adults and Crisis Response DCORT Training.

Within FY 2016-2017 our G-PATH program staff have attended PATH Webinars Introducing the New PATH, Trainings on Benefit Programs and Other Resources for the Homeless, Benefit Programs and Other Resources for the Homeless: Employment Resources, PA HMIS: 2016 Update trainings, PAYS Training, PA PDX Technical Assistance Training, Equal Access and Gender Identity Rules Training, PATH HMIS Learning Community, PATH Data Flow Training, PATH Contact HMIS Policy Development, PA HMIS Training Coordinated Entry Training, Western COC, Housing First Training, Addressing Circumstance of the Past training, DASH Training, Obsessive Compulsive Disorder Training. Youth Mental Health First Aid, Housing First, Warming Center Volunteer Training, Mental Health First Aide for Adults and Crisis.

Greene County Human Services Department Housing Program co-chairs the GCHOP/LHOT meeting that currently has about 45 people/stakeholders on the mailing list, with a regular attendance of approximately 25. GPATH activities are an agenda item for every meeting. We utilize GCHOP which includes consumers to advise and ensure that our PATH information is dissemination and outreach materials are true to our philosophy on addressing areas of cultural competence. At the monthly GCHOP/LHOT meetings there is an educational, housing related, presentation. A report from GCHOP/LHOT is also given at every monthly Consumer Support Program (CSP) meeting with discussion and feedback being shared from consumers on housing issues.

The Greene County Human Services Department understands the cultural aspects of the community that will contribute to the program's success and this is evidenced by the background of the staff hired for outreach, the trainings that are planned and most of all, the utilization of feedback from consumers of service in planning. Greene County's SOC is required to develop a cultural competency plan and the PATH Housing Outreach Specialist participated in this process.

Currently, a multi-linguist population has not shown a need in our services. We have a plan that when this need arises, to utilize the services of the local university.

As a part of the Department of Human Services Block Grant, a work group for LGBTQI issues has been in operation. The initiative has offered and the PATH Outreach Specialist has attended specific trainings for professionals and support to individuals in the LGBTQI population. We will continue to attend training and be a part of this discussion. PATH staff are hosting the June 2017 meeting from GHCHOP/LHOT that has a presenter on Human Trafficking, with recent findings, the LGBTQI populations are found to be a large part of the victims of Human Trafficking.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients served using PATH funds to be literally homeless.

The majority of PATH eligible clients fall into the 18-34 and 50-64 years age groups. They are Greene County residents, primarily Caucasian, speak English and meet the definition of homeless.

- **Projected number of adults clients to be contacted using PATH funds**

The projected number of adult clients to be contacted using PATH funds will be 55.

- **Projected number of adult clients to be enrolled using PATH funds**

Approximately 30 adult clients will be enrolled (as in seen for outreach services) using PATH funds.

Percentage of adult clients served with PATH funds projected to be "literally" homeless (i.e., living outdoors or in an emergency shelter rather than at imminent risk of homelessness)

Approximately 35% of the adult clients served with PATH funds are projected to be "literally" homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See **Appendix I** "Guidelines for Consumer and Family Participation".

The PATH Housing Outreach Specialist is a part of this population. She and other consumers are on the Block Grant Advisory Committee, Permanent Support Housing Advisory Committee and the Food Security Partnership Advisory Committee. PATH individuals/ consumers are invited to participate at the GCHOP/LHOT meetings where they are asked for feedback on various PATH activities and processes. PATH eligible individuals play an active part in the Consumer Support Program monthly meetings and subcommittee meetings. The Greene County Mental Health Program utilizes consumer input in developing and implementing mental health services and the DPW Block Grant plan. PATH eligible individuals are invited and participate in housing needs surveys and subcommittees that address their specific needs and interests.

Our PATH Housing Outreach Specialist is a part of the consumer population. She and other consumers are on the Block Grant Advisory Committee, Permanent Support Housing Advisory Committee and the Food Services Partnership Advisory Committee. PATH individuals/ consumers are invited to participate at the GCHOP/LHOT meetings where they are asked for feedback on various PATH activities and processes. PATH eligible individuals play an active part in the Consumer Support Program monthly meetings and subcommittee meetings. The Greene County Mental Health Program utilizes consumer input in developing and implementing mental health services and the DHS Block Grant plan. PATH eligible individuals are invited and participate in housing needs surveys and subcommittees that address their specific needs and interests.

Budget Narrative – Provide a descriptive budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example: $10,000 federal allocation, $3,333 state match, $1000 PATH specific base fund match. See **Appendix C** for a sample detailed budget.

Greene County Human Services employs a full time Housing Outreach Specialist.

As with any full time employment, Greene County Human Services offers health insurance, life insurance, retirement, workers compensation, etc. to the Housing Outreach Specialist.

Greene County Human Services will provide travel reimbursement to the Housing Outreach Specialist through mileage reimbursement if she needs to utilize her own vehicle. It is the expectation. When available, that the Housing Outreach Specialist will utilize the County's Mental Health vehicle Greene County has no in-county shelter so travel to Washington or Fayette County is necessary to assess individuals in a shelter.

Supply costs are for general supplies needed to do business…phone, postage, copies, etc.

Greene County Human Services will allocate $13,941.00 from the Human Services Block Grant/County Match to ensure that the PATH program can operate to its fullest.

Our state Allocation will be $10,601.00 and our Federal Allocation utilized will be $31,802.00.

Greene County				
Greene County Human Services & Greene Arc, Inc.				
PATH Program				
FY 2016-2017 Budget				
	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**Total**
Position				
Case Manager-Outreach	**$26,821.00**	**$20,184.77**	**$6,636.23**	**$26,821.00**
Peer Support Supervisor	**$6,822.00**	**$ 5,134.06**	**$1,687.94**	**$6,822.00**
sub-total	**$ 33,643.00**	**$25,318.83**	**$8,324.17**	**$33,643.00**
Fringe Benefits				
Case Manager-Outreach	**$21,580.00**	**$16,240.54**	**$5,339.46**	**$21,580.00**
Peer Support Supervisor	**$546.00**	**$410.91**	**$135.09**	**$546.00**
sub-total	**$ 22,126.00**	**$ 16,651.44**	**$ 5,474.56**	**$ 22,126.00**
Travel				
Local Travel for Outreach	**$ 150.00**	**$ 112.89**	**$ 37.11**	**$ 150.00**
Travel to training & workshops	**$ 150.00**	**$ 112.89**	**$ 37.11**	**$ 150.00**
sub-total	**$ 300.00**	**$ 225.77**	**$ 74.23**	**$ 300.00**
Supplies/Equipment				
Office supplies	**$ 150.00**	**$ 112.89**	**$ 37.11**	**$ 150.00**
Consumer-related items				**$ -**
Cell Phone				**$ -**
sub-total	**$ 150.00**	**$ 112.89**	**$ 37.11**	**$ 150.00**
Other				
Staff Training	**$ 125.00**	**$ 94.07**	**$ 30.93**	**$ 125.00**
One-Time rental assistance				**$ -**
Security deposits				**$ -**
Client Transportation				**$ -**
sub-total	**$ 125.00**	**$ 94.07**	**$ 30.93**	**$ 125.00**
Total PATH Budget	**$ 56,344.00**	**$ 42,403.00**	**$ 13,941.00**	**$ 56,344.00**
Path Allocation	**$ 42,403.00**	**$ 31,802.00**	**Federal**	
	$ (13,941.00)	**$ 10,601.00**	**State**	
			additional State	**75.26%**

28. Huntingdon/Mifflin/Juniata County - Service Access and Management, Inc.

100 East Market Street

Lewistown, PA 17044

Contact: Kate Xanthopoulos

Contact Phone #: 7172420351

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-076

State Provider ID: PA-076

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 31,859	$ 10,620	$ 42,479	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 31,859	$ 10,620	$ 42,479	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 31,859	$ 10,620	$ 42,479	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 31,859	$ 10,620	$ 42,479	

Source(s) of Match Dollars for State Funds:

Huntingdon/Mifflin/Juniata will receive a total of $42,479 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 28

Estimated Number of Persons to be Enrolled: 6

Estimated Number of Persons to be Contacted who are Literally Homeless: 4

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Juniata Valley Behavioral and Developmental Services
Counties of Huntingdon, Mifflin and Juniata

Service Access and Management Inc.
PATH INTENDED USE PLAN
FY 2017-2018

Local Provider Description
Service Access and Management Inc., HMJ Base Service Unit
100 East Market Street
Lewistown, PA 17044

Service Access and Management Inc. (SAM Inc.) Base Service Unit is a locally based non-profit organization that provides emergency delegate services, case management services, housing specialist services and intake/assessment services in Huntingdon, Mifflin and Juniata Counties for individuals who are in need of access to local mental health services. Service Access and Management Inc. is currently providing specialized housing case management services to individuals residing in 14 Master Leasing apartment units within Huntingdon and Mifflin Counties as well as providing administrative oversight and transitional housing support to 10 individuals residing in our 2 local Community Residential Rehabilitation (CRR) homes. The Service Access and Management Inc. Base Service Unit Housing Specialist is the designated PATH Coordinator and assumes all responsibilities for coordination of PATH services in the Tri-County Area. SAM Inc. also coordinates the use of PATH resources for rental assistance, security deposits, first month's rent, and payment for PATH participants who receive drug and alcohol services.

Juniata Valley Behavioral Health and Developmental Services (JVBDS) is the fiduciary for the PATH program in Huntingdon, Mifflin and Juniata Counties. SAM Inc. works with JVBDS to create the PATH budget for the fiscal year. Fiscal year 2017-2018 includes a change in the structure of payment for PATH services specific to the drug and alcohol services available to participants. Clear Concepts Counseling will no longer be contracted directly with JVBDS to perform assessments and counseling to eligible PATH participants. These services will be directly billed to and paid by SAM Inc. There are two primary reasons for this change. Clear Concepts Counseling has significantly underspent its PATH allocations each fiscal year since the implementation of PATH in our counties requiring contract amendments late in the fiscal year to ensure the funds are utilized efficiently. Also, this allows for PATH participants who reside in western Mifflin County and Huntingdon County access to a closer provider, Mainstream Counseling. SAM Inc. will develop and have in place agreements with both providers that specify PATH eligible services and the rates at which they will be invoiced.

Service Access and Management Inc. Base Service Unit Housing Specialist has demonstrated success in the management of the HMJ Master Leasing Program and has extensive knowledge of local community resources and housing options available within

the three county area. PATH funding provides resources for Service Access and Management Inc. to maintain a dedicated case manager charged with these service linkages, assisting persons with a transition to permanent housing and follow-up with the individual for a period of time to ensure success. Because of the increase in the homeless individuals involved in the criminal justice system this has created a huge impact on our services. Service Access and Management Inc. Base Service Unit will be allocated $42,479 to provide PATH coordination services and funding to support PATH participants in obtaining and maintaining permanent housing within our 3 county service area. This allocation is broken down into $31,859 in federal funds with a state match of $10,620.

Service Access and Management Inc. will work closely with the Shelter Services Inc. and Huntingdon County Community Action Center to promote and expand the current PATH program. Many of the individuals identified as eligible for the PATH program will also be eligible for the existing Master Leasing Program that is currently coordinated jointly by the BSU and Advocacy Alliance. The Master Leasing Program currently has 8 units to serve individuals who may otherwise not be eligible for subsidized housing options and 6 units to serve forensic population through a separate grant.

Collaboration with HUD Continuum of Care Program

The Tri-County currently has no providers participating in the HUD Continuum of Care program. There is no official participation or HUD funding provided locally for such projects, it is widely believed by stakeholders that such services are being provided by other means. The goal of all stakeholders that serve PATH eligible individuals is for rapid re-housing following a period of homelessness with the appropriate supports in place. Through the PATH program there is a continuum of care or as we call it intensive case management where an individual is followed while living at the shelter and there is continuation through their transition into public housing, Section 8, Master Leasing, or private rental. We consider this to be an extra layer of support while the individual is also being seen by other agency representatives.

Collaboration with Local Community Organizations

Service Access and Management Inc. Base Service Unit is an active participant on the Human Services Council in each of our three counties, Criminal Justice Advisory Boards in each of our three counties and holds Letters of Agreement with 44 Tri County Human Service providers and is an active member of Mifflin County Communities That Care.

The Base Service Unit Housing Specialist is a member of the local Housing Coalition in Mifflin County and the Community Action Center workgroup in Huntingdon County. The BSU is also a stakeholder in the Local Lead Agency (LLA) referral process that provide access to any potential HUD Section 811 programs that may be developed. The BSU will work with Mifflin/Juniata Human Services Department (LLA) for Mifflin and Juniata Counties and with the Center for Community Action (LLA) in Huntingdon County.

We provide outreach through presentations of housing related services and resources to local provider agencies and work to establish collaborative relationships with local landlords.

The Tri-County is home to a number of organizations that provide a wide range of services to PATH eligible clients. The Mifflin/Juniata United Way provides self-sufficiency case management and can be accessed for issues such as budgeting and income maintenance. There are also three Blended Case Management (BCM) providers in the Tri-County that can serve the target population by assisting with linkages to primary health care, mental health services, substance abuse services, and housing and employment services. BCM is a flexible program in which the individual can receive very intensive or less intensive contact with case management depending on need. JVBDS has contractual relationships with each of these providers and meets quarterly with the BCM supervisors to discuss coordination issues, crisis response and other program issues.

The Service Access and Management PATH Housing Coordinator will coordinate outreach with all Blended Case Management providers, Supported Living Program staff, certified peer specialist providers, mobile crisis staff and Drug and Alcohol Case Management staff through invitations to meetings and the provision of mobile services to individuals served in the PATH Program.

PATH eligible clients will also have access to a wide range of mental health services that can be accessed as needed, all of which have contractual relationships with the County Mental Health Program:

- **Universal Community Behavioral Health (UCBH):** Psychotherapy, Psychiatric Services, Blended Case Management, and telephone and mobile crisis.
- **Community Services Group (CSG):** Site-based and mobile Psychiatric Rehabilitation, Certified Peer Specialist Services, Supported Living Program, Wellness Center, Nurse Navigator and Clubhouse.
- **Keystone Human Services:** Community Residential Rehabilitation, Mobile Psychiatric Rehabilitation and Certified Peer Specialist Services.
- **Sunshine Connection (Mifflin County), Juniata Friendship Club (Juniata County) and Huntingdon County Drop-In Center (Huntingdon County):** Social rehabilitation drop-In centers available to individuals in all three counties.
- **Advocacy Alliance:** Consumer/Family Satisfaction Team can provide employment opportunities for PATH eligible individuals.
- **Service Access and Management:** Base Service Unit, Administrative Case Management, Blended Case Management, and Certified Peer Specialist (forensic-focused).
- **Northwestern Human Services Juniata River Center:** Blended Case Management.

- **Keystone Human Services, CSG and Advocacy Alliance/Peer Star:** Certified Peer Specialist.
- **Primary Health Network:** Federally Qualified Health Care Center.
- **Clear Concepts Counseling:** Substance Abuse assessment and outpatient services in Mifflin and Juniata Counties.
- **Mainstream Counseling:** Substance Abuse assessment and outpatient services in Huntingdon County.

Service Provision

- **Describe any gaps that exist in the current service systems.**

PATH funds will be used to fill a gap that exists annually in Drug and Alcohol services for the target population. Individuals residing in the Shelter currently have access to Clear Concepts Counseling or Mainstream Counseling for assessment and counseling, but the funding is normally depleted each fiscal year by mid-April. PATH funds will be used, for PATH eligible clients, to ensure there is no loss of access to those services after Single County Authority (SCA) funding is depleted.

Transportation for individuals is limited to Mifflin Juniata CARS for medical assistance funded service appointments and Persons with Disability transportation also through Mifflin Juniata CARS. Both services are limited to daytime hours and with no affordable transportation for hours outside of the Monday through Friday 8:00 AM -5:00 PM. PATH Funding could be utilized for individuals needing to access transportation outside of what the current system provides for employment, evening support groups including AA, NA, Intensive Outpatient Program through Clear Concepts etc. PATH funding will be used to supplement the gaps in transportation services that may have presented a barrier to individuals seeking treatment or pursing employment.

The PATH Coordinator will work with all PATH enrolled individuals to complete benefits applications for all public benefits through the local county assistance office, Social Security Disability Income or SSI, Veterans Administration benefits. The PATH Coordinator will assist with linkage to various human service agencies including Veterans Multi Service Center Inc, local food banks, Salvation Army and PA Career Link.

As described on page 5 the PATH Coordinator will be trained in Critical Time Intervention (CTI) The provider agency Service Access and Management Inc has an online training library available for staff through Network of Care e-learning system. The PATH coordinator will also attend annual trainings provided through DREXEL and the Aging and Behavioral Health Coalition which are offered and funded by OMHSAS.

Service Access and Management Inc. is not a provider of Drug and Alcohol Services. SAM Inc. does comply with all laws and regulations related to HIPPA. SAM Inc has specific policies surrounding Confidentiality of Individual records and Release of any information for individuals served. The agency does have a method for an individual to revoke their consent for the release of information for any entity at any point in time. SAM Inc. utilizes an encrypted secure email system and all mobile devices are password secured. The agency is able to provide a copy of all policies surrounding confidentiality of records if it is requested.

- **Provide a brief description of the services available to clients who have both a serious mental illness and a substance use disorder.**

  From the inception of the PATH in HMJ and throughout the planning, the PATH program has been focused on an integrated program for individuals with serious mental illness and substance use disorders (SMI/SA). A high percentage of individuals who meet the eligibility requirements for the program will have a dual-diagnosis of SMI/SA and meeting their needs will require well-coordinated and integrated services. The PATH case manager will work closely with Clear Concepts Counseling and Mainstream Counseling to access the appropriate services for each individual and will monitor participation and progress through team meetings and individual meetings with each client.

  In addition to the integration of PATH case management and substance use disorder services, PATH eligible clients will have access to all of the services that are provided by the aforementioned community providers. Although not specifically designed as dual-diagnosis services, the mental health supports available in the Tri-County will be an integral part of supporting individuals as they transition from homelessness to permanent housing.

- **42 CFR Part 2 Regulations:** Service Access and Management, Inc. are not required to follow these regulations.

- **Linkages for Clients with Criminal Justice Histories**

  SAM Inc. employs a full-time Forensic Coordinator administrative case management position that works closely with the Housing Coordinator to meet the needs of individuals involved in the criminal justice system. The Forensic Coordinator is responsible for authorizing psychiatric services within the county jails of Mifflin and Huntingdon and also making referrals to appropriate programs and agencies following release. PATH receives referrals for those individuals with mental health, housing needs, and/or drug and alcohol services. Because both positions reside in the same Base Service Unit, coordination between the two is seamless.

Data

Service Access and Management Inc. enters all PATH data into the PA HMIS system which is administered by DCED. SAM Inc. began data entry into the PA HMIS system in July 2016 when they took over coordination of the program.

Alignment with PATH Goals

The Tri-County PATH program will require enrollment and participation with the PATH case manager. The PATH case manager will be responsible for oversight of all cases that require the use of PATH funding for services being rendered.

Street outreach in a primarily rural area looks somewhat different than it does in a large urban location. As is evidenced in the point-in-time homeless count, the Tri-County Area sees very little "street" homelessness. There are known locations where some people have been known to live outdoors during periods of homelessness and these areas will be a target of outreach by the PATH case manager.

Mifflin/Juniata Human Services Office does a Point in Time Survey twice yearly by going out to different areas and looking for homeless individuals. Because of our rural area and the presence of our shelter there have only been two individuals found and they refused services and shelter.

The Tri-County PATH case management component will utilize the Critical Time Intervention (CTI) Model which is a time-limited case management model that is empirically supported to prevent homelessness in persons with mental illness following an institutional stay, including stay in an emergency shelter.

Alignment with State Mental Health Services Plan and State Plan to End Homelessness:

Service Access and Management Inc. has developed a detailed agency Emergency Response Plan and Utilizes a local Crisis Response Team to complete emergency disaster drills.

Mifflin County Office of Public Safety, local Red Cross and local Salvation Army are all local emergency service agencies that would be utilized in the event of a local emergency or natural disaster. Each PATH individual will have a crisis plan developed by the PATH Housing Specialist in their Individual Service Plan. All individuals opened with Service Access and Management Inc. for PATH services receive a handout at intake that provides all local emergency numbers.

The Huntingdon, Mifflin and Juniata County area is focused on three areas for improvement, outreach and access to services. Individuals with mental health and/or substance abuse disorders may also have involvement with the criminal justice system while the entire area struggles with the challenges of serving the homeless population in rural areas.

- **Former Inmates:** SAM, Inc. currently accesses both county jails located in the Tri-County area. Forensic Administrative Case Management provides coordination for psychiatric services while an individual is incarcerated as well as release planning that includes housing and supportive services. For individuals housed in the Mifflin County Correctional Facility, there may be access to forensic master leasing, psychiatric and therapy services prior to and after release through a grant funded by PCCD.

- **Individuals with MH/SA:** JVBDS through its contract with SAM, Inc. focusses on individuals with mental illness who are involved in the criminal justice system. Often, there is a prevalence of a co-occurring disorder such as substance abuse. For these individuals, PATH services can include access to certified drug and alcohol counseling services in addition to mental health supports. Release planning can also include referrals to programs such as master leasing, supported living, case management, psychiatric rehabilitation, drop-in centers, clubhouse (vocationally based psychiatric rehabilitation), certified peer specialist, and outpatient psychiatric services.

- **Rural Homelessness:** The Tri-County Area experiences a different kind of homelessness than urban areas where 'street homelessness' is often very visible. While not unheard of, it is unusual to see a prevalence of individuals residing on the street or under bridges. Aside from individuals who use Shelter Services as a resource, most individuals experiencing homelessness in rural areas reside with extended family or friends in a 'couch surfing' scenario. HMJ will use case management systems and incorporate drop-in centers into outreach efforts to identify these individuals and attempt to engage them in services.

Other Designated Funds

Currently, there are no other designated funds from the Mental Health Block Grant, Substance Abuse Block Grant or base funds specifically dedicated to the PATH target population.

SSI/SSDI Outreach, Access, Recovery (SOAR)

Local human service providers from multiple agencies were trained in SAMHSA's SSI/SSDI Outreach Access and Recovery (SOAR) initiative. Case management units, drug and alcohol providers and homeless assistance providers were trained on April 8th and 9th, 2013. For several reasons, SOAR has not gained traction in the Tri-County Area. Staff turnover and lack of coordination from local CAOs has not been conducive to

maintaining a consistent and effective program. It should also be noted that many individuals were already in the appeals process for obtaining benefits. Initiating a SOAR application would re-start their application process and many were not willing to do that. HMJ may re-visit SOAR in the future, but at this time it is not an active process.

Housing

In 2009, a Master Leasing Program was implemented to provide housing to individuals with serious mental illness and other co-occurring issues that would preclude them from accessing other subsidized housing options. The target population for master leasing is individuals who have past and present credit issues, criminal histories, poor rental histories, and substance abuse issues. Advocacy Alliance and the BSU develop each master leasing unit on an as-needed basis through well-established relationships with local property owners. The units are inspected prior to development to ensure cleanliness, safety and affordability. Advocacy Alliance then signs a lease with the property owner giving the mental health system the ability to house an individual who might not otherwise pass the scrutiny of a private rental background check. In return, the property owner is guaranteed rent whether the unit is occupied or not. Service Access and Management Inc Base Service Unit also guarantees the landlord that their property will be kept in good condition and that any damages cause by the client will be satisfactorily fixed. In addition, participants in Master Leasing are required to participate in team meetings and services recommended by the planning team of which they are a part. This model has insured the highest rate of success because participants are receiving assistance with problems that have previously contributed to their chronic homelessness. The Master Leasing Program will be the main strategy used to house PATH eligible clients as it builds skills, confidence and stability in an individual thereby giving them the best opportunity to remain in permanent housing.

Other housing options are available and can be accessed according to need and eligibility. Keystone Human Services provides Community Residential Rehabilitation Services (CRRS) in the Tri-County area. It is a 24/7 staffed group home model that provides support and skill building for individuals with SMI who are not yet ready to live independently. Placements into CRRS are temporary and transitional until stability is attained. The ultimate goal is for the individual to obtain and maintain safe, permanent and affordable housing.

Coordinated Entry

There is currently no formal Coordinated Entry program operating in Huntingdon, Mifflin and Juniata Counties.

Justice Involved

Service Access and Management Inc. is currently providing specialized forensic case management services for local and state correctional facilities for the Tri County Area. The Service Access and Management Inc. Base Service Unit Housing Specialist has

worked in coordination with the Mifflin County Human Services Department to develop 6 Forensic Master Leasing Units which have been at capacity serving individual in community reentry from institutional criminal justice settings. Individuals with criminal justice involvement have also been served in regular Master Leasing units and the Base Service Unit works in close coordination with probation departments and parole departments to monitor and support these individuals in maintaining community tenure.

Mifflin County has conducted two Crisis Intervention Team trainings that have trained approximately 20 local police officers. The first was held January 26-30, 2015 and the second was held May 16-20, 2016. Additional CIT trainings will be held as funding permits.

Staff Information

The Service Access and Management Inc. Base Service Unit Housing Specialist/PATH Coordinator is based out of the Mifflin County office location and travels to Huntingdon and Juniata county office locations on a minimum weekly basis or more if needed. The staff is experienced in working with a variety of populations and has specific course credits from Elizabethtown College in serving culturally diverse populations.

The PATH Coordinator has experience with providing blended case management service services for 1 year and experience in intake and service planning.

Service Access and Management provides annual Cultural Competence training for all staff (to be held May, 2017) and staff completed Transgender Best Practices training on June 30, 2016.

Client Information

As reported in 2015 census data, the average population in the Tri-County Area identifies as approximately 95% Caucasian. The two largest minority populations identify as African America approximately 3% and Hispanic at approximately 2%. It is anticipated that the demographics of PATH eligible clients will be commensurate with these percentages.

The Tri-County Area also has an estimated 14% of the population living below the federally defined poverty level and the average monthly cost of a rental unit is $588.00.

The Service Access and Management Housing Coordinator will be on site at the Mifflin County Shelter Services Inc. on a weekly basis at minimum to enroll any PATH eligible individuals and gather data regarding the number of homeless individuals being served through our local homeless Shelter. The Housing Coordinator will also provide monthly outreach to the 3 local Blended Case Management provider agencies to identify any PATH eligible individuals who may not be involved with the local homeless shelter.

Based on the local homeless shelter being at full capacity during much of fiscal year 2016/2017 it would be expected that the anticipated number of individuals who will be enrolled in PATH during FY 2017/2018 could increase by as much as 80%. The percentage of clients to be served who are literally homeless is estimated to be 60%.

There are currently 12 individuals enrolled in the HMJ PATH Program. The projected number of individuals to be enrolled in PATH during 2017/2018 is 22.

Consumer Involvement

The Tri-County PATH Program will promote consumer, family and any consumer identified informal supports in all aspects of service planning.

The consumer, family and any identified informal supports will be included in team meetings and appointments as desired.

All services will be delivered in a consumer directed, holistic manner that promotes individual recovery.

Individuals will be encouraged to develop Wellness Recovery Action Plans (WRAP) and Advanced Directives that promote personal choices and preferences related to services and treatment.

Service Access and Management Inc. will develop a PATH program survey to be completed with all participants on an annual basis or upon exiting the program. The survey results will be shared with the Juniata Valley Behavioral and Developmental Services.

Health Disparities Impact Statement

The transition aged youth population has not been a focus of the Huntingdon, Mifflin, Juniata PATH program to date. While all adult providers serve individuals who are 18 years and older, there is no specific programming aimed at a transition aged population. Over the next fiscal year, data collection will take place within the context of the PATH program identifying participants who are 18-26 years of age and what specific needs they present. This age range of individuals can have a variety of backgrounds including residential treatment facility, involvement with Children/Family Services and even forensic involvement. In many cases, this population is in need of skill development to achieve success in independent living situations. PATH will develop a system that identifies individuals in the program who are of target age and in need of independent living skills. If data supports the development of special programming to meet the needs of transition aged youth, the PATH program will accommodate that need with programming that enhances activities of daily living as well as vocational rehabilitation and training. During the 2016-2017 fiscal year, there were two individuals served who were within the target age range. Both have since been closed from the program. An

additional four individuals in the age range were contacted during outreach, but were not enrolled in the program.

Limited English Proficiency

Service Access and Management, Inc. uses the services of Interpretalk which is a phone-based interpreter service that can be used for any language. In addition, all promotional materials and documents used for the program are available in Spanish.

• **Budget Narrative** – Please see below.

Service Access and Management, Inc.
Huntingdon/Mifflin/Juniata
PATH Program
FY 2017-2018 Budget

PERSONNEL Position	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
PATH Coordinator/Housing Specialist	$30,328	.50	$15,164	$15,164
sub-total			$15,164	$15,164
FRINGE BENEFITS Position				
PATH Coordinator/Housing Specialist				$6,894
sub-total				$6,894
TRAVEL				
Local Travel for Outreach				$750
Travel to training and workshops				$750
sub-total				$1,500
SUPPLIES/EQUIPMENT				
Cell Phone		.50		$289
sub-total				$289
Other				
Admin/Check Processing				$2,910
One-time rental assistance				$5,000
Security deposits				$5,000
Client transportation				$250
POS: Drug and Alcohol Assessment/Treatment				$2,000
CTI Training				$3,472
sub-total				$18,632
Total PATH Budget				**$42,479**

SERVICE ACCESS AND MANAGEMENT, INC.
PATH 2017 – 2018 Budget Narrative

Funding Breakdown
Service Access and Management, Inc. will be allocated $42,479 in total PATH funds. $31,859 of these funds will be federal while $10,620 will be state match. There are no other funding streams attributed to the PATH program.

Personnel:
PATH Case Manager:
- Meet as needed (minimum bi-weekly) with individual participants in program to develop and monitor goals
- Link to needed services and monitor participation and progress; collect data
- Assist participants in finding appropriate affordable housing
- Attend housing meetings and appeals with participants
- Help participants who are transitioning with basic purchases to establish residency
- Assist with other activities including job search, job application assistance, CAO/HA application assistance, hygiene lessons, and budgeting
- Maintain tracking records for evaluation of program

Fringe Benefits (%):
Fringe benefits including dental/vision insurance, worker's compensation, life insurance and FICA taxes total $6,894.

Travel:
The PATH Case Manager will be responsible for assisting participants with activities vital to their housing transition which may include travel to different locations. Travel will be directly related to the goals of the individual and their housing transition. Examples may include trips to the grocery store, Social Security Office, Career Link, or County Assistance Office (CAO). When possible and appropriate, case management will assist people in accessing community transportation resources such as MATP for medically necessary appointments. The Case Manager will also attend meetings at provider agencies and trainings as necessary.

Supplies:
- **Equipment:** Cellular phone service and mobile data services.

- **Supplies:** The majority of supplies necessary for the function of the PATH Case Manager will be provided in-kind by Service Access and Management, Inc.

Other:
- **Security Deposit Assistance:** When necessary, these funds will be used to pay for a security deposit related to a participant's initial transition from homelessness.
  Rental Assistance: When necessary, these funds will be used to subsidize a rental unit when an individual is in danger of losing housing.

Purchase of Service Agreements

Service Access and Management will have purchase of service agreements with two local drug and alcohol providers, Clear Concepts Counseling and Mainstream Counseling Services. When a need is indicated during PATH intake and the participant is agreeable, a referral will be made based on consumer choice where assessment and treatment can be accessed when there is a lack of insurance coverage.

Critical Time Intervention

The PATH coordinator, supervisor and other housing support individuals will receive CTI training during the 2017-2018 fiscal year.

29. Lancaster County

150 Queen Street

Lancaster, PA 17603

Contact: John Stygler

Contact Phone #: 7172998027

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID:

State Provider ID:

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 91,098	$ 30,366	$ 121,464	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 91,098	$ 30,366	$ 121,464	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 91,098	$ 30,366	$ 121,464	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 91,098	$ 30,366	$ 121,464	

Source(s) of Match Dollars for State Funds:

Lancaster County will receive a total of $121,464 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

Estimated Number of Persons to be Contacted who are Literally Homeless: 0

Number staff trained in SOAR in grant year ending in 2017: 5

Number of PATH-funded consumers assisted through SOAR: 10

PATH Intended Use Plan FY 2017-18
Lancaster County

Lancaster County PATH Programs Overview

Local Provider Description – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

The PATH Program is coordinated through the Lancaster County Behavioral Health and Developmental Services (LCBHDS) which is the local governmental agency that administers and oversees public mental health services. This year, LCBHDS will eliminate ourselves as a PATH provider and will allocate all the PATH funds to two subcontracted housing/mental health provider agencies.

A. Tabor Community Services – is a local non-profit agency that provides supportive housing, transitional and permanent housing, credit counseling and homeless services to residents of Lancaster County. Tabor receives $77,760 for their PATH services. The allocation is as following: $55,277 in PATH Federal funds, $18,426 in State PATH funds and $4,057 in other funding to provide the PATH Critical Time Intervention service (PATH CTI).

   Tabor Community Services
   308 E King St
   PO Box 1676
   Lancaster, PA 17608
   717-397-5182

   PDX Name – PA-051 Lancaster: Tabor Community Services

B. Community Services Group – is a statewide provider of mental health, intellectual disabilities and children's behavioral health services. Community Services Group receives $47,761 per year. The allocation is as following: $35,821 in PATH Federal funds and $11,940 in state PATH funds for the PATH Homeless Outreach Case Management (PATH HOCM) services.

   Community Services Group
   320 Highland Drive
   Po Box 597
   Mountville, PA 17554
   717-299-4636

PATH Intended Use Plan FY 2017-18
Lancaster County

PDX Name – PA-065 Lancaster: Community Services Group

Enclosed is a separate intended use plan for each provider as well as a comprehensive budget. Total PATH allocation for Lancaster County for FFY 2016-17 is $121,464 of which $91,098 are federal PATH funds.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the areas where PATH operates.

Lancaster County and City are within the HUD CoC PA-510. LCBHDS, Tabor and Community Services are a part of the Lancaster County Coalition to End Homelessness (LCCEH) (HUD Continuum of Care lead agency). Each agency participates in one or more of the subcommittees identified in the Heading Home plan. LCBHDS's Executive Director, Deputy Director of Administration and Tabor's President are members of the Leadership Council for LCCEH. Community Services Group's President is a board member of LCCEH's board of directors.

Each agency utilizes Coordinated Entry and Assessment. Tabor is the Coordinated Entry organization for the CoC PA 510 and is accessed through the United Ways 211 system. Both PATH providers and LCBHDS regularly refer people experiencing homelessness to coordinated entry and assessment.

Tabor Community Services	Member of the Coalition to End Homeless. Provides housing supports, housing outreach services, subsidized housing, and budgeting services. Provider of coordinated entry and assessment services of the homeless system.
Community Services Group	Member of Homeless Provider Network and Homeless Support Network. Provides a large array of mental health services to include Intensive Case Management, Psychiatric, social and vocational rehabilitation, clubhouse, partial hospitalization, residential, supportive housing, outpatient services

LCCEH separated from LCBHDS and has become part of Lancaster General Hospital (LGH) under a contract with the County of Lancaster to provider oversight of the county's homeless system. Lancaster County contracts with Lancaster General Hospital for $789,000 to provide this oversight in FY

2016/17. LCBHDS will continue to meet on a quarterly basis with LCCEH, working on specific needs of the people experiencing homelessness in Lancaster County. All three agencies utilize the 211 system to access the homeless services funded through CoC, ESG and CDBG funds through a coordinated entry and assessment system funded by HSBG and CoC funds.

There are separate IUPs included on each provider regarding their responsibilities.

Collaboration with Local Community Organizations – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

Partnerships include:

1. Lancaster County Coalition to End Homelessness (Lancaster General Hospital) – Coordination of the homeless system
2. Community Services Group mental health treatment, rehabilitation and case management including PATH Case Manger dedicated to serving the people experiencing homelessness
3. Tabor Community Services – Supportive housing, budget and credit counseling
4. Recovery Insights – Peer support services
5. Mid Penn Legal Services – Legal services to obtain entitlement and benefit income
6. Office of Vocational Services – vocational services and funding
7. Keystone Service Systems – mental health rehabilitation and long term housing support
8. The Lodge Life Services– homeless outreach, HUD permanent housing, long term housing support, representative payee
9. Water Street Rescue Mission – homeless shelter, drug and alcohol services, medical and dental services, furniture, clothing and food banks
10. Salvation Army - Furniture and clothing bank
11. Goodwill – vocational services, furniture and clothing
12. Behavioral Healthcare Corp – mental health treatment and social rehabilitation services
13. Southeast Clinic – medical services
14. Ephrata Area Rehabilitation – vocational
15. Lancaster County Housing Authority – housing subsidy
16. Lancaster City Housing Authority – housing subsidy
17. Arch Street Center – mental health drop-in center
18. ICAN of Lancaster – mental health drop-in center
19. Council of Churches – food bank, emergency winter shelter

20. Philhaven Hospital – mental health treatment services, mental health diversion program
21. Lebanon Veterans Administration – Federal veteran services
22. Lancaster County Veteran Affairs Office – Local government veteran assistance office
23. Various Landlords in the community
24. Community Basics – housing development
25. Housing Development Corp – housing development
26. Lancaster County Drug and Alcohol Commission – drug and alcohol services
27. Compass Mark – drug and alcohol services
28. Various housing development companies
29. Lancaster County Probation and Parole
30. Lancaster County Prison – local jail
31. Re-Entry Management of Lancaster – criminal justice reentry program
32. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
33. Ingermen Housing Development – low income housing development

LCBHDS organizes several stakeholder meetings and other opportunities for networking with other outreach teams and community and natural resources. LCBHDS's Housing Specialist maintains an email listserv that allows communication across the entire mental health system, including all PATH providers, of different governmental and community resources to those who are being served. The PATH HOC meet with the local homeless emergency shelter provider every week to discuss current cases and how they can work together. Lancaster County named Lancaster Housing opportunity Partnership (LHOP) the Local Lead Agency for housing under Department of Human Services housing initiatives to coordinate affordable housing for those with disabilities.

Service Provision – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

A. PATH Critical Time Intervention Program (PATH CTI)

Critical Time Intervention (provided by Tabor Community Services) is on SAMHSA's National Registry of Evidence-based Programs and Practices as an effective model to work with people who are either homeless or institutionalized and are experiencing a serious mental illness. PATH CTI is a time limited supportive housing program for people who are experiencing or at risk for becoming homeless. The PATH CTI worker will be responsible for supportive housing, housing search, linking to non-mental health community and natural supports

and teaching the person and their service/treatment team skills to work effectively together.

The services include: housing support to include housing search, community service and resource linkage.

B. Community Services Group Homeless Outreach Case Manager (PATH HOCM)

The PATH HOCM will outreach to people experiencing homelessness that may have a serious mental illness to access the mental health system. If the people meet the criteria of PATH, the PATH HOCM will enroll them in the program. This access includes supporting the person in obtaining mental health case management, applying for benefits including income, medical and other social service benefits, link the person to employment resources and to build relationship with people to increase their participation in social services that could benefit them.

The service include: Outreach Case Management

There are separate IUPs included on each provider regarding their responsibilities.

a. How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless.

Lancaster County's PATH programs serve to fill two gaps in services to people who are homeless and those who are at risk. The first is to provide outreach through the PATH HOCM that will assist people in obtaining mental health and other social service supports for people who are literally homeless. Lancaster County has not historically and does not current have a significant number of chronically homeless adults (6, 2016 PIT Count; 7, 2015 PIT Count).

The CTI program was designed as a homeless prevention program so people with mental illness do not end up in the homeless system or in unsafe living situations. While this program will continue to support this group, Lancaster County has shifted part of this resource to serve the transitional age group who are literally homeless or significantly at risk of homelessness. This group might be accessing LCBHDS's HUD programs that would subsidized the person's housing and utilities until they obtain an income and other benefits that would allow them to become self-sufficient.

PATH Intended Use Plan FY 2017-18
Lancaster County

b. Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services.

LCBHDS, in coordination with the County of Lancaster has leveraged a great deal of funds to support PATH participants, which each contracted agency has access to. These funds include HSBG funds that funds the all of mental health services that are not treatment service. These services include: additional supportive housing services, drop-in centers, mental health and/or drug and alcohol treatment services, mental health and/or substance abuse case management, psychiatric rehabilitation services, supportive employment and other mental health and substance abuse recovery oriented services. In addition, PATH participants have access to funds for first month's rent, security deposits, bridge subsidies and Master Leasing funded through HealthChoices housing reinvestment plan. LCBHDS has three HUD grants that provide full subsidies to people who are HUD defined homeless and have no income. Several transitional age people have been served by Tabor's CTI program and have participated in LCBHDS's HUD programs. PATH HOCM supports people to access not only mental health services but other community and public resources and/or services. All three agencies leverage funds and services from several non-profit and faith based organizations which include, food banks, clothing banks, rental assistance, furniture banks, medical services and dental services.

c. Gaps that exist in the current service systems.

A gap in services to those experiencing homelessness in Lancaster County is meeting the exact criteria of HUD's definition of homelessness. People who are homeless are not thinking about meeting a criterion; they are trying to survive by whatever means they have. This can include doing things that would make them ineligible for HUD funded services like doubling up with family or friends temporally, renting a motel or hotel room until their financial means are expended, moving into transitional housing that does not meet HUD definition of Transitional Housing or renting a room that far exceeds their ability to pay which results in them becoming homeless for a portion of each month due to using all their financial means. The PATH CTI can support people who fall into one of these gaps to support them in attaining permanent safe and affordable housing. An additional gap people open with LCBHDS have are services to support people who are in time limited residential programs and state institutions find safe and affordable housing. Housing search and developing relationships with landlords is a specialized set of skills. We have found that a good housing agency can work with landlords on behalf of the person in services to negotiate rent or utility reductions, special accommodations and other amenities that are a necessity to the success of many of the people who receive these mental health services. The housing agency can be the place the landlord can access when there are issues with the tenant versus the landlord starting the eviction process immediately.

Another gap identified in LCBHDS is that people experiencing homelessness lack street outreach that would engage them in moving toward recovery. People who are homeless are not thinking about treatment of their mental illness, they are trying to survive by whatever means they have. This can include behaviors that would increase the negative symptoms of mental illness which could include self medication with drugs and/or alcohol, developing poor relationships, remaining on the fringe of society where services are not available and committing minor crimes.

The last gap recently identified by Lancaster County are those who are homeless or at risk of homelessness that are transitional age, Lancaster identifies this group as 18-24. In the first year of focusing on this group has in theory significant results. In 2016, this age group represented 6.5% (2015 PIT 10%) of those who were in emergency shelter and 5.4% (2015 PIT 6.4%) were in a homeless transitional housing program were 18-24. This group represent 8.7% (2014 PIT 6.2%) of the total HUD defined homeless population in Lancaster County. This also represents a 33.3% decrease of those 18-24 who are experiencing homelessness from the 2015 PIT count to the 2016 PIT count. The total decrease of those people experiencing homelessness in Lancaster County and City CoC was 5.8%. With LCBHDS's targeting of this population, we believe these specialized services and supports is having an impact on the transitional age homeless population decrease over the last three years. LCBHDS has worked with the transitional age populations with mental illness through specialized programs to include targeted case management, residential rehabilitation and support groups. PATH CTI will continue to focus half the caseload on those in the transitional age group who are literally homeless or at significant risk of homelessness.

d. Brief description of the current services available to clients who have both a serious mental illness and a substance use disorder

People in the PATH CTI program and those who are opened with LCBHDS mental health services through the PATH HOCM will have access to the mental health services contracted with LCBHDS which includes supported housing, vocational rehabilitation, treatment services, social rehabilitation, Drop-in Centers and advocacy and self-help programs. In addition, the mental health case managers have experience in linking people who have substance abuse disorders to those services that are available to them. With the initiation of the HSBG program, Lancaster County now has some flexibility in moving funds to services that are needed by the residents of the county. Medicaid expansion has supported more people getting into drug and alcohol services. Lancaster has also seen a significant increase in PATH participants eligible for Medicaid through the Medicaid expansion initiated last fiscal year. Getting more people with disabilities enrolled in Medicaid has allowed a decrease need for HSBG funds for treatment services and those funds can be shifted to mental health and substance abuse services and other resources to support the person's recovery.

e. How the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data in HMIS.

The CTI or Critical Time Intervention program is a SAMHSA evidence-based practice to support people who are experiencing homelessness and have a mental illness. The program uses the CTI manual as a guide for the service delivery and LCBHDS is in the process of investigating some resources to support the CTI program to improve. Both Tabor and Community Services Group's PATH funded employees have attend the SOAR training conducting by Mid Penn Legal Services. LCBHDS utilizes a Housing First model for housing services and/or resources. Housing First does not put treatment or service requirements on a person who is in need of permanent housing to obtain those housing services and/or resources. LCBDHS does require a person to open with one of Lancaster's level of mental health case management to access LCBDHS funded services and/or resources. While the people working with the PATH HOCM might not be open with LCBHDS, this program would access homeless system and community resource in assisting the person with obtaining housing.

Each agency has a staff development budget to send PATH funded employees to trainings that are pertinent to their work. Trainings that have been utilized in the past include motivational interviewing, homelessness, housing first, mental health disorders, local services and clinical approaches. Lancaster sends representative from both providers and LCBHDS to the annual Pennsylvania PATH Conference.

LCBHDS Housing Specialist coordinates HMIS for PATH purposes and has program director rights to the new system to provide training of PATH provider staff in the use of HMIS. Lancaster migrated to a new HMIS system, July 1, 2015, Case Worthy. This new system is still being worked through for the PATH data points. All PATH funded positions have computer tablets and field access to the internet and databases to better serve individuals and input data in real time. LCBHDS is working with LCCEH (HMIS Lead Agency) in developing policies and procedures to include recommending an online training manual for Case Worthy.

f. Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

Both agencies are not drug and alcohol service providers and are not required to follow the 42 CFR Part 2 regulations.

g. Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH

clients with a criminal history (e.g. jail diversion, active involvement in reentry)

LCBHDS is very active with the criminal justice system. Lancaster County's criminal justice related services/resources for those with mental illness and/or drug and alcohol addictions include: Mental Health Forensic Case Manager, Mental Health Crisis Intervention Police Liaison, Mental Health Court, Drug Court, Veteran Court, Crisis Intervention Training to the local and state police agencies, Re-entry Management Program, Special Offenders Probation Parole Services, provide mental health groups and treatment in the local jail, Day Reporting Center at Career Link, Master Leasing Program for those discharged from local jail, Transition to Community (a RTFA serving people coming from local jail or prison who need mental health treatment), MISA Group which includes coordination between LCBHDS, Drug and Alcohol Programs, Lancaster County Prison, District Attorney, Probation Parole and the County Commissioners and serving on state committees that target prison reform and diversion for those with mental illness. These services, supports and planning activities are in coordination with local social service agencies, local jail, District Attorney's Office, Probation and Parole and elected officials.

LCBHDS is now targeting PATH CTI to work with some of the people referred through the MISA group. These people are currently incarcerated with high barriers to being released from jail to include no housing, significant behaviors and/or symptoms of mental illness and/or consistent drug and/or alcohol use, few or no positive natural supports, consistent negative interaction with law enforcement and other issues that cause them to be incarcerated repeatedly or for long periods of time. PATH CTI will work to find immediate permanent housing for them while they are still incarcerated, utilizing resources and funds by LCBHDS. Once released, the PATH CTI worker will engage with them frequently along with their other supports to increase their success in the community. The ultimate goal is for the person to reduce or eliminate negative interactions with law enforcement which results in incarceration.

LCBHDS is working with Lancaster Housing Opportunity Partnership to educate landlords, property manager and housing development companies about the realities of those with criminal histories who have a serious mental illness. This education will hopefully allow landlords to give people with criminal convictions an opportunity to rent from them.

1. **Data – Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff.**

LCBHDS is integrally involved with HMIS having both PATH and HUD grants. The County of Lancaster is providing funding to the Lead Agency through HSBG funding and will continue in a lead role with the LCCEH.

Michael Foley from LCCEH is the HMIS Lead and responsible for the HMIS system. Lancaster migrated to a new HMIS system, July 1, 2015 that will better accommodate the new PATH data points. All PATH staff have been trained in using HMIS being utilized by Lancaster County. LCBHDS is recommending that there will be on-going training for current staff, training new staff and providers as they enter the system. LCBHDS will work with the HMIS Lead Agency to encourage them to develop policies and procedures for training the staff and to include developing a training manual and online training. Each contract with the PATH providers requires the entry of data in HMIS as part of the service provision. LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. As of July 1, 2016, Lancaster PATH providers were fully utilizing HMIS for the PATH programs as developed by the software vendor.

Alignment with PATH goals – Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Lancaster County has identified gaps in the service system to the most vulnerable adults who are literally homeless and meeting chronic at times. The PATH HOCM is meeting with people on the streets, at free meals, at MH drop-in centers and other locations that have literally homeless adults. The program is designed to develop relationships with those people who are literally homeless with a serious mental illness and/or substance abuse disorder. As relationships are developed, the PATH HOCM attempts to get the person to engage in treatment and social services.

Tabor's PATH CTI program prioritizes people who are literally homeless with a target of half the caseload working with adults 18-24 who are literally homeless or at significant risk of homelessness. We have also started targeting people who are currently incarcerated who do not have permeant housing upon release from local jail. This group can historically be released to temporary housing, including homelessness which increases their risk of recidivism and/or reincarceration.

Alignment with State Comprehensive Mental Health Services Plan – Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS)identified in their PATH state plan in targeting adults who are in the category of transitional age, aged 18-30, and literally homeless as a priority group. Lancaster has dedicated several resource specific to PATH funding and specific to all adults in this category. Tabor's PATH CTI program has at least half their caseload dedicated to working with this priority group. In addition, several resources have been dedicated to assist those transitional age adults in

obtain housing, utilizing the housing first model, while setting expectations on them in working toward become self-sustaining through attaining income, both competitive work and/or benefits/entitlements and learning how to be a good tenant, neighbor and member of their community. LCBHDS has also dedicated first month's rent, security deposits and bridge subsidies to this group who are literally homeless and have an income to sustain their own housing.

In addition to the state PATH goals, LCBHDS has also included both PATH programs as part of their Olmsted Plan submitted. These programs provide critical supports to reduce the need for those with mental illness for long term institutionalization, including state mental health hospitals, long term homeless shelters and transition housing and other setting that are not integrating them into our community. Lancaster submit both programs in the Human Services Block Grant plan submitted to the state every year outlining the service and programs planned for the next fiscal year including some outcomes. This is how the state provides updates on their initiatives and whether the counties are following their direction.

Alignment with State Plan to End Homelessness – Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

PATH HOCM is integral in meeting the state's plan to end homelessness, through the outreach to those who are literally homeless. The Case Manger is meeting people on the street, at the free meals, mental health drop-in centers and at the emergency shelters, to encourage people with mental illness and/or substance abuse disorders in engaging with social services to obtain housing, treatment service, community services and resources and taking personal responsibility to improve their situation. The PATH HOCM has been very involved in linking people up to mental health and/or substance abuse services by attending intakes with the person, attaining and providing clinical documentation for those intakes and supporting the person through the process. Being open with LCBHDS does increase available resource and/or services a person may have access to. LCBHDS has been dedicating a vast amount of resources to those literally homeless for many years in order to reduce the burden on the homeless system and to properly serve people with mental illness. Lancaster's PATH programs have been recognized through newspaper articles, by the state offices and local officials as successful models in reducing homelessness for those with mental illness.

Lancaster County has not historically and does not current have a significant number of chronically homeless adults (6, 2016 PIT Count; 7, 2015 PIT Count). This is because of the array of services, both public and private that are provided to those in need. While affordable housing is an issue in Lancaster, people seem to find places to live, whether with family, friends, natural and

community supports or faith based options. LCBHDS has 47 HUD PSHP units that are dedicated to those people with serious mental illness and no income who are HUD defined homeless. Managing these resources for the most vulnerable population that has no natural resources and no income or ability to attain an income in a short period of time has been successful in reducing the number of people in long term homelessness or with multiple episodes.

Each agency is required to have an emergency/disaster preparedness plan for those who they serve. As part of their plan, the agencies test and modify these plans as needed in order to be ready for a local or national emergency. Lancaster has a local Emergency Management agency that is responsible for directing the local community in what actions to take during an emergency/disaster. This system is tested regularly to assure the community is ready for an emergency/disaster. The supportive housing programs teach each person how to they would be alerted through this system and informed about their options during an emergency/disaster.

Other Designated Funds – Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

LCBHDS receives through the State of Pennsylvania both CMHBG and SSBG funds. LCBHDS also has three HUD funded PSHP that serves 47 people in fully subsidized one bedroom units for a total of $462,708 with $115,677 local matching funds and/or in-kind provided through HSBG. While none of these funds are dedicated to PATH services specifically, these funds have direct impact on those people who are receiving PATH funded services. LCBHDS utilizes CMHBG funds for supportive housing and peer support for those who are not eligible for Medicaid or are uninsured. LCBHDS utilizes SSBG funds for supportive employment. LCBHDS allocates an additional $4,057 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded services $125,521. The state allocation of PATH funds is $30,366 and PATH federal allocation is $91,098.

Programmatic and Financial Oversight –In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

The state of Pennsylvania provide both PATH federal and state PATH match funds to Lancaster County through the Human Services Block Grant. These funds are categorized as PATH and are only used for the providers and programs submitted through the PATH intended use plan. LCBHDS contracts with the providers through either a fee for service or program funding for the PATH

services. As part of the contacting process, LCBDHS requires an annual budget submitted by the provider, a service description, quality assurance plan, outcome based goals and other supportive documentation. The contract specifies that PATH funds can only be used for approved expenses as required by the PATH regulations. The provider is responsible to provide LCBDHS with a 6 month, 9 month and annual profit/loss statement. A copy of the provider's annual single audit is obtained by LCBHDS. Included in the contract is LCBHDS's right to audit the provider as needed. LCBHDS provides the state with how the funds were expensed through the annual Human Services Block Grant report, which shows which categorical the funds were expensed.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. For the grant year 2016-2017, include all of the following data:

- **The number of staff trained in SOAR**
- **The number of staff who provided assistance with SI/SSDI applications using the SOAR model;**
- **The number of consumers assisted through SOAR**
- **Application eligibility results (i.e., approval rate on initial application, average time to approve the application)**
- **The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]**

As March 31, 2017, three of the three direct service staff funded by PATH have been SOAR training as provided by Mid Penn Legal Services, Valerie Case. There has been no turnover of the direct service professionals in the last year. There were 16 consumers supported by PATH Outreach Case Management and 1 consumers through PATH CTI program with a SOAR application in 2015-16. In addition, several LCBHDS and CSG Mental Health Case Managers are SOAR trained and are supporting people who are homeless in obtaining income benefits through this process. Lancaster at this time is not collect data on SOAR and there are no staff solely dedicated to SOAR. Lancaster has integrated SOAR into the mental health system through Case Management and outreach.

PATH Intended Use Plan FY 2017-18
Lancaster County

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

LCBHDS has significantly expanded their resources and partnerships with supportive housing providers, both housing authorities and housing development companies. These include Tabor Community Services, Community Basics, Lancaster County and City Housing Authorities, Ingerman and The Lodge Life Services. LCBHDS's HUD Permanent Supportive Housing Program which brings the number of available units to 47 for those single unaccompanied adults experiencing homelessness. LCBHDS is continuing looking at other funding opportunities in housing including partnering with a housing development corporation to set aside and a long term project-based subsidy of 6 units for people with mental illnesses. LCBHDS and Tabor have developed many more partnerships with local landlords and property management companies and have become agencies that the landlords are willing to partner with.

LCBHDS oversees the contract with Lancaster Housing Opportunity Partnership for their oversight as the Local Lead Agency. The Local Lead Agency is responsible for the oversight of the LIHTC properties set asides for those with a disability and for the management of Pennsylvania Housing and Finance Administration's 811 grant for subsidized housing for those with a disability. As part of this partnership, LCBHDS's Housing Specialist has developed literature on educating landlords about working with people who have mental illnesses and those who have experienced mental illness to include how to access community and crisis services when a tenant is experiencing symptoms that effect their other tenant's safety and rights and potential damage to their property. LCBHDS presents on how the community can support people with mental illness in being successful in their own permanent housing at the annual Disabilities in Housing conference. PATH funded positions has been meeting with potential landlords and having discussions about what mental illness is and how to decrease the stigma around mental illness and homelessness. This work has significantly expanded opportunities to people and landlords have been willing to take more risks with some of the individuals who do not have satisfactory rental histories, credit histories and criminal backgrounds.

Coordinated Entry – Indicate if/how your organization is engaged with the local coordinated-entry processes of your CoC. Please also describe the roles of key partners in the CoC.

Both providers participate in the coordinated entry program developed for the homeless system. The process includes calling the United Way 211 system to request support if a person is experiencing homelessness. If the person is assessed on the phone as meeting HUD defined homelessness, they are then referred to Tabor's Coordinated Housing Assessment Referral Team (CHART), for an intake worker to provide an intake and determine what homeless services a person might be eligible for. LCCEH oversees the contract with Tabor for CHART and is

responsible for monitoring and governing under a contract with the County of Lancaster.

PATH CTI is not directly receiving referrals from CHART because of the requirement of being open with LCBHDS. PATH HOCM utilize the system when homeless services and/or resources are needed for people they support who are not open with LCBHDS. When needed, PATH HOCM will refer people to CHART to access the Rapid Rehousing services and other homeless services and/resources that can support people in attaining permeant housing when they might not qualify or voluntarily engage in public mental health services. LCBHDS has invested in a vast array of resources for housing and/or resources for people open with LCBHDS. LCBHDS has relied less on the homeless system to serve the people open with the agency, this reduces the burden on the homeless system. Lancaster 2016 PIT count reflects this investment, in that only 16.3% of those counted reported a mental illness, while Pennsylvania is at 25.2% and the United States is at 19.6%. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's mental health case manager or LCBHDS's Housing Specialist.

Justice Involved – Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

LCBHDS, Tabor and CSG all work with a significant number of people who are currently in the criminal justice system or have convictions that could present barriers to obtaining housing. LCBHDS's Housing Specialist provides a full housing assessment of a person referred to Tabor's PATH CTI and other housing services and/or resources that include a full criminal background check. This assists the person's team to work through potential barriers to housing. Pennsylvania has a Unified Justice Portal, in which any person has access, including landlords and property managers. Being upfront of criminal history has been very important in developing relationships with the landlords and property managers. The other issue with criminal background is that with Low Income Tax Credit Properties, the housing development companies and property managers have set very strict criteria on criminal history. Understanding what a person's barriers to those units and how to appeal the rejection of the person's application is very important.

All three agencies work closely with the local courts, prison and probation/parole services to improve a person's chance of being successful in reentry back into their community. Lancaster has a great number of jail diversion and justice related programs for those with mental illness and/or substance abuse disorders. These programs include Mental Health Court, Drug Court, Special Offenders Probation and Parole Services for those with mental health and/or intellectual disabilities, Mental Health Forensic Case Management, and Mental Health Hospital/Forensic Intake Worker. In addition, LCBDHS has developed tools that help the justice system in determining the best course of action for

someone who is being released from jail that has no permanent housing to return too.

LCBHDS estimates that nearly 80% of the people working with the PATH programs have some sort of criminal history. It is estimated that 25% have felonies. The group that Lancaster has found to have the greatest barrier to finding permanent housing are people with convictions that would place them on the Sexual Offender's list, arson, manufacture/sales/distribution of controlled substances and multiple conviction of domestic violence.

The County of Lancaster through Probation/Parole Services provide Crisis Intervention Training to both local and state law enforcement and the local prison guards. While not every officer or even police jurisdiction has participated in CIT, there have been well over 200 officers trained in the last 6 years the CIT program has been established. It is hard to estimate the number of law enforcement officers who have been trained since there are so many jurisdictions of local, state and federal officers who are responsible to Lancaster County.

Staff Information –

- **Describe the demographics of staff serving the clients**
- **Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients**
- **Discuss the extent to which staff are receptive to differences of clients**
- **Identify the extent to which staff receive periodic training in cultural competence and health disparities**

Tabor PATH CTI has one FTE supportive housing case manager who leads the CTI process and the team leader who supervises the case manager. Community Services Group PATH HOCM has 0.8 FTE Case Manager that will provide the outreach case management and a Supervisor who also works in the field a couple hours per week. Of the four employees being funded with PATH funds, the demographics include four females, all four are Caucasian with the ethnicity of four non-Hispanic. One person is Spanish/English bilingual. There are several opportunities to PATH staff to receive training on cultural competency through internal trainings and conferences they attend. The direct service employees, provider supervisors and LCBHDS's Housing Specialist will attend the annual Pennsylvania PATH Conference.

Lancaster County offers cultural competency training a minimum of annual to their internal employees. In addition to the annual training, our office encourages both internal staff and providers to attend the various cultural competency trainings and workshops offer by advocacy groups, providers, and County and State agencies. We disseminate training opportunities to the providers of the PATH grant through a local list serve email distribution by our office.

PATH Intended Use Plan FY 2017-18
Lancaster County

Client Information –

- **Describe the demographics of the client population**
- **Project the number of adult clients to be contacted**
- **Identify expected number of adult clients to be enrolled**
- **Give estimated percentage of adult clients served using PATH funds to be literally homeless**

Both programs will target people who are experiencing homelessness or are at risk of becoming homeless. For the PATH CTI service, the demographics will include any person residing in Lancaster County who is 18 years and over and of any race, gender, ethnicity, religious belief and meets the OMHSAS Serious Mental Illness criteria, which is defined as a person who has a diagnosis of psychotic NOS disorder, schizophrenia, major depression, mood disorder and/or borderline personality disorder and has a secondary history that impedes their ability to function in the community successfully. In addition, the person must agree to be open in LCBHDS's services for PATH CTI services. LCBHDS is dedicating half the PATH CTI case manager's caseload to those 18-24 years old. The PATH HOCM will target anyone over the age of 18 who is homeless and is in need of mental health supports.

The number of contacted clients for PATH CTI will be 35 and the projected number of enrolled clients that will receive PATH CTI services for FY 2017-2018 is 30. Estimated percent of the clients to be literally homeless is 60%.

The projected number of contacted clients that will receive PATH HOCM services for FY 2017-2018 is 220 people. The PATH HOCM will enroll an estimated 140 clients. Estimated percent of the clients to be literally homeless is 100%.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be *meaningfully* involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix I "Guidelines for Consumer and Family Participation".

Lancaster County is committed to involving people in recovery in the planning, implementation and evaluation of any of the programs they provide or contract for. This is evidenced by the number of people with mental illness and family members who serve on the active advisory boards and committees. These include the Community Support Program, LCBHDS Advisory Board, NAMI Family Meeting and the Stakeholder's Planning Meetings. Family members are active members of all the groups/boards mentioned previously. The Housing Specialist attends the NAMI meeting four to five time a year to discuss housing initiatives with the family members, including all the PATH programs. Any of the PATH participants would be encouraged to participate in any of these advisory boards or committees. LCBHDS's Housing Specialist attends all the

stakeholder meetings in order to discuss Lancaster's PATH programs and to receive stakeholder feedback on changes or current status Lancaster encourages Peer Support programs to recruit Certified Peer Support Specialist(s) that have experienced homelessness in their life.

Health Disparities Impact Statement – Please identify efforts to support the Transition Age Youth (TAY) disparity population by providing the following:

- **The unduplicated number of TAY individuals who are expected to be served using PATH funds**
- **The total amount of PATH funds expected to be expended on services for the TAY population**
- **The types of services funded by PATH that are available for TAY individuals**
- **A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population**

Both programs will serve TAY. PATH CTI will have at least 50% of their caseload dedicated to the TAY population. Tabor expects to serve 15 people in this subpopulation. Additionally, PATH HMHOC will serve approximately another 30 people within this subpopulation based on the percentage who are homeless within this age range. We project that the total amount expended on this subpopulation will be approximately $38,880 for Tabor's PATH CTI and $7,164 for CSG's PATH HOCM. These services will include outreach and supportive housing services but will be able to access any of the additional services and/or resource offered by LCBHDS if opened with the office. We will work with LCBHDS's and CSG's Transitional Age Case Mangers in linking these young adults to PATH services and other mental health and/or drug and alcohol services. If the young adult is identified as homeless and with mental illness and/or drug and alcohol issues, CSG's PATH HOCM will attempt to engage with them and linking them to community and public services. These contacts will be tracked in HMIS through entry exit and service provision entries.

PATH Intended Use Plan FY 2017-18
Lancaster County

Limited English Proficiency – Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.

LCBHDS requires all contracted providers to provide services to limited English proficiency people. Each providers either accesses an interpretation service or employs bi-lingual staff to assure every person in services can be communicated with, including those who are deaf and hard of hearing. LCBHDS also contracts with interpretation service for every language, including sign.

PATH Intended Use Plan FY 2017-18
Lancaster County

Budget Narrative – Provide a *descriptive* budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example: $10,000 federal allocation, $3,333 state match, $1000 PATH specific base fund match.

Personnel:
Cost associated with a portion of the salaries for the Critical Time Intervention Worker and Outreach Case Managers who will provide the direct service provision. Cost associated with a portion of the Team Leader who provide direct supervision to the CTI Worker. This line item includes the following breakdown: $54,528 in Federal PATH, $18,176 in State PATH and $2,023 in other funding for a total of $74,727.

Fringe Benefits:
Cost associated with a portion of fringe benefits that include employer shared taxes, physical health, dental and optical insurance, employer shared retirement plans, worker compensation insurance and unemployment insurance for each of the above funded position. This is based on the same allocation methodology used to calculate the portion of the PATH grant that fund the salaries of each position. This line item includes the following breakdown: $12,567 in Federal PATH, $4,189 in State PATH and $560 in other funding for a total of $17,315.

Travel:
Provide mileage reimbursement to employees for utilizing their own vehicles to provide services to participants in the PATH funded program within the community or at their home in Lancaster County. This line item includes the following breakdown: $4,201 in Federal PATH, $1,400 in State PATH and $55 in other funding for a total of $5,656.

Equipment:
Cost of replacement and/or maintenance of existing equipment in supporting PATH funded positions and services. This line item includes the following breakdown: $560 in Federal PATH, $187 in State PATH and $0 in other funding for a total of $746.

Supplies:
Costs associated with office supplies needed to do day to day business of the PATH program. This line item includes the following breakdown: $914 in Federal PATH, $305 in State PATH and $0 in other funding for a total of $1,218.

Other:
Staff training with provide for cost associated with training and education to increase the competencies of the staff to provide services to the participants of the

PATH funded program. Building and equipment maintenance is for contract for equipment upkeep like copiers and scanners and for office building upkeep. Purchased services would be the professional services the organization need to maintain their computer technology associated with direct service provision, audits required by contract and regulations and other outsourced services to support the program under the agency. Protective Payee Services is a service offered to the participants of the PATH funded program to support them in managing their income to assure timely payment of rent, bills and other cost associated with maintaining a home. Communication cost would include telephone, cell telephone and internet access associated with direct service provision. Utilities are costs that include electric, gas, oil, trash removal, water and sewer associated to the office space used by the direct service staff. Office rent is the rent allocated to the program for space utilized by the direct service staff. Insurances would include professional liability, umbrella, property insurance and other liability insurance. Administrative costs would be allocated indirect costs associate with implementing the PATH funded program. These include salaries and benefits of the indirect or support staff and rent, utilities, communication, purchased services, supplies and equipment allocated in administrative support of the PATH funded program. This line item includes the following breakdown: $18,330 in Federal PATH, $6,110 in State PATH and $1,419 in other funding for a total of $25,859.

In – Kind Supports:

The participants will have access to mental health services provided through county funding to include treatment, psychiatric rehabilitation, vocational, social rehabilitation, case management, housing supports and advocacy/self-help services.

PATH Intended Use Plan FY 2017-18
Lancaster County

Lancaster County
PATH Program
FY 2016-17 Total Budget

*Please add additional rows as necessary

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
CTI Worker	$35,460	1 FTE	$35,460	$35,460
Team Leader	$51,790	0.09 FTE	$4,661	$4,661
Outreach Case Manager	$29,790	.8 FTE	$29,790	$29,790
Outreach CM Supervisor	$48,000	0.1 FTE	$4,816	$4,816
sub-total	**$165,040**	**1.99 FTE**	**$74,727**	**$74,727**
Fringe Benefits				
CTI Worker				$10,589
Team Leader				$1,431
Outreach Case Manager				$3,743
Outreach CM Supervisor				$1,554
sub-total				**$17,317**
Travel				
Local Travel for Outreach				$5,656
sub-total				**$5,656**
Equipment				
Replacement and/or maintenance of existing equipment				$746
sub-total				**$746**
Supplies				
Office Supplies				$1,218
sub-total				**$1,218**
Other				
Staff training				$700
Building and Equipment Maintenance				$900
Purchased Services				$3,474

PATH Intended Use Plan FY 2017-18
Lancaster County

Protective Payee Services				$1,800
Communication				$2,400
Utilities				$600
Admin Costs				$14,719
Office Rent				$616
Insurance				$650
sub-total				**$25,859**
Total PATH Budget			**$125,523**	

30. Lancaster County - Community Services Group

790 New Holland Ave

Lancaster, PA 17602

Contact: Kristin Labeziusk

Contact Phone #: 7172935104

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID: PA-065

State Provider ID: 4265

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Community Services Group will receive a total of $47,761 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 35

Estimated Number of Persons to be Enrolled: 30

Estimated Number of Persons to be Contacted who are Literally Homeless: 21

Number staff trained in SOAR in grant year ending in 2017: 2

Number of PATH-funded consumers assisted through SOAR: 5

PATH Intended Use Plan FY 2017-18
Lancaster County

Community Services Group
PATH Homeless Outreach Case Management
PATH Intended Use Plan FY 2016-17
Lancaster County

Local Provider Description – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

Community Services Group is a statewide provider of mental health, intellectual disabilities and children's behavioral health services. Community Services Group would receive $47,761. The allocation is as following: $35,821 in PATH Federal funds and $11,940 in state PATH funds for the PATH Homeless Outreach Case Management (PATH HOCM) services of PATH funds to deliver the PATH Homeless Outreach Case Management (PATH HOCM) services.

Community Services Group
320 Highland Drive
Po Box 597
Mountville, PA 17554
717-299-4636

PDX Name – PA-051 Lancaster: Tabor Community Services

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the areas where PATH operates.

Community Services Group is a member of the Lancaster County Coalition to End Homelessness (LCCEH) (CoC HUD PA-510) with their work as the PATH HOCM and is a member of Homeless Support Network. CSG's President is a board member of LCCEH. All these activities meet quarterly.

Collaboration with Local Community Organizations – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH-eligible clients, and describe the coordination of activities and

policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

Partnerships include:

1. Lancaster County Coalition to End Homelessness (Lancaster General Hospital) – Coordination of the homeless system
2. Lancaster County Behavioral health and Developmental Service – county agency for mental health and intellectual disabilities.
3. Tabor Community Services – Supportive housing, budget and credit counseling
4. Recovery Insights – Peer support services
5. Mid Penn Legal Services – Legal services to obtain entitlement and benefit income
6. Office of Vocational Services – vocational services and funding
7. Keystone Service Systems – mental health rehabilitation and long term housing support
8. The Lodge Life Services– homeless outreach, HUD permanent housing, long term housing support, representative payee
9. Water Street Rescue Mission – homeless shelter, drug and alcohol services, medical and dental services, furniture, clothing and food banks
10. Salvation Army - Furniture and clothing bank
11. Goodwill – vocational services, furniture and clothing
12. Behavioral Healthcare Corp – mental health treatment and social rehabilitation services
13. Southeast Clinic – medical services
14. Ephrata Area Rehabilitation – vocational
15. Lancaster County Housing Authority – housing subsidy
16. Lancaster City Housing Authority – housing subsidy
17. Arch Street Center – mental health drop-in center
18. ICAN of Lancaster – mental health drop-in center
19. Council of Churches – food bank, emergency winter shelter
20. Philhaven Hospital – mental health treatment services, mental health diversion program
21. Lebanon Veterans Administration – Federal veteran services
22. Lancaster County Veteran Affairs Office – Local government veteran assistance office
23. Various Landlords in the community
24. Community Basics – housing development
25. Housing Development Corp – housing development
26. Lancaster County Drug and Alcohol Commission – drug and alcohol services
27. Compass Mark – drug and alcohol services
28. Various housing development companies
29. Lancaster County Probation and Parole – criminal justice services
30. Lancaster County Prison – local jail
31. Re-Entry Management of Lancaster – criminal justice reentry program
32. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing

33. Ingermen Housing Development – low income housing development

LCBHDS organizes several stakeholder meetings and other opportunities for networking with other outreach teams and community and natural resources. LCBHDS's Housing Specialist maintains an email listserv that allows communication across the entire mental health system of different resources to those who are being served.

Service Provision – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

The PATH HOCM funds a 0.8 FTE outreach case manager and a 0.1 case management supervisor who also works in the field. These positions will work with people experiencing homelessness that have a serious mental illness to access the mental health system. This includes supporting the person in obtaining a mental health case manager; applying for benefits including income, medical and other social service benefits, link the person to employment resources and to build relationship with people to increase their participation in social services that could benefit them.

The service include: Outreach Case Management

a. How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless.

PATH HOCM will assist people in obtaining mental health supports that are literally homeless. PATH HOCM will be assisting people with accessing the mental health system, obtain benefits and link to housing services, especially those in the transitional age group and other vulnerable populations.

b. Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services.

PATH HOCM can leverage funds and services from several non-profit and faith based organizations which include, food banks, clothing banks, rental assistance, furniture banks, medical services and dental services. PATH HOCM will encourage and assist people with mental illness to be referred to LCBHDS to be able to access the wide array of services and resources that the county agency has to offer.

c. Gaps that exist in the current service systems.

A gap identified in Lancaster is that people experiencing homelessness lack street outreach that would engage them in moving toward mental health and addictions recovery. People who are homeless are not thinking about treatment of their mental illness, they are trying to survive by whatever means they have. This

can include behaviors that would increase the negative symptoms of mental illness which could include self-medication with drugs and/or alcohol, developing poor relationships, remaining on the fringe of society where services are not available and committing minor crimes.

d. Brief description of the services available to clients who have both a serious mental illness and a substance use disorder.

People who are opened with LCBHDS through the PATH HOCM will have access to the mental health services contracted with LCBHDS which includes supported housing, vocational rehabilitation, treatment services, social rehabilitation, Drop-in Centers and advocacy and self help programs. With the initiation of the HSBG program, Lancaster County now has some flexibility in moving funds to services that are needed by the residents of the county. Medicaid expansion has supported more people getting into drug and alcohol services. Lancaster has also seen a significant increase in PATH participants eligible for Medicaid through the Medicaid expansion initiated last fiscal year. Getting more people with disabilities enrolled in Medicaid has allowed a decrease need for HSBG funds for treatment services and those funds can be shifted to mental health and substance abuse services and other resources to support the person's recovery.

e. How the local provider agency, pays for or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support migration of PATH data into HMIS.

Community Services Group's PATH funded employees have attend the SOAR training conducting by Mid Penn Legal Services.

LCBHDS Housing Specialist coordinates HMIS for PATH purposes and has program director rights to the new system to provide training of PATH provider staff in the use of HMIS. Lancaster migrated to a new HMIS system, July 1, 2015, Case Worthy. This new system is still being worked through for the PATH data points. All PATH funded positions have computer tablets and field access to the internet and databases to better serve individuals and input data in real time. LCBHDS is working with LCCEH (HMIS Lead Agency) in developing policies and procedures to include recommending an online training manual for Case Worthy. LCBHDS is working with LCCEH (HMIS Lead Agency) in developing policies and procedures and recommending an online training manual for Case Worthy. CSG fully uses HMIS for data entry for their PATH services as of July 1, 2016.

f. Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

CSG is not drug and alcohol service provider and is not required to follow the 42 CFR Part 2 regulations.

g. Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)

CSG is active with the criminal justice system under the guidance of LCBDHS. CSG opened the Transition to Community program in May 2017 that will serve people who are being released from incarceration but need continued mental health treatment but not in an inpatient setting. Lancaster criminal justice related services for those with mental illness and/or drug and alcohol addictions include: Mental Health Forensic Case Manager, Mental Health Crisis Intervention Police Liaison, Mental Health Court, Drug Court, Veteran Court, Crisis Intervention Training to the local and state police agencies, Re-entry Management Program, Special Offenders Probation Parole Services, provide Mental Health groups and treatment in the local jail, Day Reporting Center at Career Link, Master Leasing Program for those discharged from local jail, MISA Group which includes coordination between LCBHDS, Lancaster County Prison, District Attorney, Probation Parole and the County Commissioners and serving on state committees that target prison reform and diversion for those with mental illness. These services, supports and planning activities are in coordination with local social service agencies, local jail, District Attorney's Office, Probation and Parole and elected officials. CSG Outreach at times will see people in local jail but most these outreach services are performed by LCBHDS's Forensic Case Manager.

LCBHDS is working with Lancaster Housing Opportunity Partnership to educate landlords, property manager and housing development companies about the realities of those with criminal histories who have a serious mental illness. This education will hopefully allow landlords to give people with criminal convictions an opportunity to rent from them.

Data – Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff.

LCBHDS is integrally involved with HMIS having both PATH and HUD grants. The County of Lancaster is providing funding to the Lead Agency through HSBG funding and will continue in a lead role with the LCCEH. Michael Foley from LCCEH is the HMIS Lead and responsible for the HMIS system. Lancaster migrated to a new HMIS system, July 1, 2015 that will better accommodate the new PATH data points. All PATH staff have been trained in using HMIS being utilized by Lancaster County. LCBHDS is recommending that there will be on-going training for current staff, training new staff and providers as they enter the system. LCBHDS will work with the HMIS Lead Agency to encourage them to develop policies and procedures for training the staff and to include developing a training manual and online training. Each contract with the PATH providers requires the entry of data in HMIS as part of the service provision.

LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. As of July 1, 2016, Lancaster PATH providers were fully utilizing HMIS for the PATH programs as developed by the software vendor.

Alignment with PATH goals – – Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Lancaster County has identified gaps in the service system to the most vulnerable adults who are literally homeless and meeting chronic at times. The PATH HOCM is meeting with people on the streets, at free meals, at MH drop-in centers and other locations that have literally homeless adults. The program is designed to develop relationships with those people who are literally homeless with a serious mental illness and/or substance abuse disorder. As relationships are developed, the PATH HOCM attempts to get the adults to engage in treatment and social services.

Alignment with State Comprehensive Mental Health Services Plan – Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS)identified in their PATH state plan in targeting adults who are in the category of transitional age, aged 18-30, and literally homeless as a priority group. Lancaster has dedicated several resource specific to PATH funding and specific to all adults in this category. CSG'S HOCM works with several people who are PATH eligible and in the transitional age population. LCBHDS has alos identified CSG's PATH HOCM in their Olmstead Plan as a resource to reduce a person with mental illness's likelihood of needing long term institutional care, becoming incarcerated and supporting them from homeless emergency shelters. LCBHDS has utilized several long term subsidized units through the HUD PSHP. LCBHDS has also dedicated first month's rent, security deposits and bridge subsidies to this group who are literally homeless and have an income to sustain their own housing. Lancaster submit PATH HOCM in the Human Services Block Grant plan submitted to the state every year outlining the service and programs planned for the next fiscal year including some outcomes. This is how the state provides updates on their initiatives and whether the counties are following their direction.

Alignment with State Plan to End Homelessness – Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans

PATH Intended Use Plan FY 2017-18
Lancaster County

PATH HOCM is integral in meeting the state's plan to end homelessness, through the outreach to those who are literally homeless. The PATH HOCM is meeting people on the street, at the free meals, mental health drop-in centers and at the emergency shelters, to encourage people with mental illness and/or substance abuse disorders in engaging with social services to obtain housing, treatment service, community services and resources and taking personal responsibility to improve their situation. The PATH HOCM has been very involved in linking people up to mental health and/or substance abuse services by attending intakes with the person, attaining and providing clinical documentation for those intakes and supporting the person through the process. Being open with LCBHDS does increase available resource and/or services a person may have access to. LCBHDS has been dedicating a vast amount of resources to those literally homeless for many years in order to reduce the burden on the homeless system and to properly serve people with mental illness.

Lancaster County has not historically and does not current have a significant number of chronically homeless adults ((6, 2016 PIT Count; 7, 2015 PIT Count). This is because of the array of services, both public and private that are provided to those in need. While affordable housing is an issue in Lancaster, people seem to find places to live, whether with family, friends, natural and community supports or faith based options. LCBHDS has 47 HUD PSHP units that are dedicated to those people with serious mental illness and no income who are HUD defined homeless. Managing these resources for the most vulnerable population that has no natural resources and no income or ability to attain an income in a short period of time has been successful in reducing the number of people in long term homelessness or with multiple episodes.

Each agency is required to have an emergency/disaster preparedness plan for those who they serve. As part of their plan, the agencies test and modify these plans as needed in order to be ready for a local or national emergency. Lancaster has a local Emergency Management agency that is responsible for directing the local community in what actions to take during an emergency/disaster. This system is tested regularly to assure the community is ready for an emergency/disaster. The supportive housing programs teach each person how to they would be alerted through this system and informed about their options during an emergency/disaster.

Other Designated Funds – Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

CSG PATH HOCM can access any of the resources/services through LCBDHS if the person meets criteria for mental health services and is willing to receive services. While none of these funds are dedicated to PATH services specifically, these funds have direct impact on those people who are receiving PATH funded services.

PATH Intended Use Plan FY 2017-18
Lancaster County

Programmatic and Financial Oversight –In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

The state of Pennsylvania provide both PATH federal and state PATH match funds to Lancaster County through the Human Services Block Grant. These funds are categorized as PATH and are only used by CSG for the OPATH HOCM as submitted though he PATH intended use plan. CSG, as a contrct provider with LCBDH, funds PATH HOCM through a program funding method of payment for the PATH services. CSG provides an invoice that details all the expenses for PATH HOCM the month prior. CSG submits an annual budget, a service description, quality assurance plan and goals and other supportive documentation. The contract specifies that PATH funds can only be used for approved expenses as required by the PATH regulations. CSG is responsible to provide LCBDHS with a 6 month, 9 month and annual profit/loss statement. CSG submits their annual single audit to LCBHDS. Included CSG's contract is LCBHDS's right to audit the CSG as needed. LCBHDS provides the state with how the funds were expensed through the annual Human Services Block Grant report, which shows which categorical the funds were expensed.

<u>SSI/SSDI Outreach, Access, Recovery (SOAR)</u> – Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. For the grant year 2016-2017, include all of the following data:

1. **The number of staff trained in SOAR**
2. **The number of staff who provided assistance with SI/SSDI applications using the SOAR model;**
3. **The number of consumers assisted through SOAR**
4. **Application eligibility results (i.e., approval rate on initial application, average time to approve the application)**
5. **The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]**

As March 31, 2017, two of the two supportive service staff funded by PATH have attended the SOAR training provided by Mid Penn Legal Services, Valerie Case. There were 16 consumers supported by PATH HOCM with a SOAR application in 2015-2016. Lancaster estimates that 20-25 people could be SOAR eligible who have been enrolled with the PATH HOCM program. CSG does not have any staff dedicated to doing SOAR, it is integrated in Mental Health Case Manager's jobs for those that have been trained.

PATH Intended Use Plan FY 2017-18
Lancaster County

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

PATH HOCM program will not be providing or subsidizing housing for people. They will partner with housing programs that will utilize their expertise of the housing to find and link the person to safe affordable housing in the community in which the person would hold the lease in their name and/or link the person to subsidized housing opportunities based on eligibility of the person. All non LCBHDS housing resources are managed through the homeless system's coordinated entry program.

Coordinated Entry – Indicate if/how your organization is engaged with the local coordinated-entry processes of your CoC. Please also describe the roles of key partners in the CoC.

CSG PATH HOCM participate in the coordinated entry program developed for the homeless system. The process includes calling the United Way 211 system to request support if a person is experiencing homelessness. If the person is assessed on the phone as meeting HUD defined homelessness, they are then referred to Tabor's Coordinated Housing Assessment Referral Team (CHART), for an intake worker to provide an intake and determine what homeless services a person might be eligible for. LCCEH oversees the contract with Tabor for CHART and is responsible for monitoring and governing under a contract with the County of Lancaster.

PATH HOCM utilize the system when homeless services and/or resources are needed for people they support who are not open with LCBHDS. LCBHDS has invested in a vast array of resources for housing and/or resources for people open with LCBHDS. LCBHDS has relied less on the homeless system to serve the people open with the agency, this reduces the burden on the homeless system. Lancaster 2016 PIT count reflects this investment, in that only 16.3% of those counted reported a mental illness, while Pennsylvania is at 25.2% and the United States is at 19.6%. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's mental health case manager or LCBHDS's Housing Specialist.

Justice Involved – Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

PATH HOCM works with a significant number of people who are currently in the criminal justice system or have convictions that could present barriers to obtaining housing. Pennsylvania has a Unified Justice Portal, in which any person has access, including landlords and property managers, so being upfront of criminal history has been very important in developing relationships with the landlords and property managers. The other issue with criminal background is that with Low Income Tax Credit Properties, the housing development companies and property managers have set very strict criteria on criminal history and understanding what a person's barriers to those units and how to appeal the rejection of the person's application is very important.

PATH Intended Use Plan FY 2017-18
Lancaster County

PATH HOCM works closely with the local courts, prison and probation/parole services to improve a person's chance of being successful in reentry back into their community. Lancaster has a great number of jail diversion and justice related programs for those with mental illness and/or substance abuse disorders. These programs include Mental Health Court, Drug Court, Special Offenders Probation and Parole Services for those with mental health and/or intellectual disabilities, Mental Health Forensic Case Management, and Mental Health Hospital/Forensic Intake Worker. In addition, LCBDHS has developed tools that help the justice system in determining the best course of action for someone who is being released from jail and has no permanent housing to return too.

LCBHDS estimates that nearly 80% of the people working with the PATH programs have some sort of criminal history. It is estimated that 25% have felonies. The group that Lancaster has found to have the greatest barrier to finding permanent housing are people with convictions that would place them on the Sexual Offender's list, arson, multiple convictions of aggravated assault, manufacture/sales/distribution of controlled substances and domestic violence.

Staff Information –

- **Describe the demographics of staff serving the clients**
- **Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients**
- **Discuss the extent to which staff are receptive to differences of clients**
- **Identify the extent to which staff receive periodic training in cultural competence and health disparities**

PATH HOCM has a 0.8 FTE outreach case manager and a 0.1 FTE case management supervisor who provide PATH HOCM services. Both are female, Caucasian and under 50. LCBHDS requires in their contracts that provider address how to provide services that address culturally competency issues which include age, gender, disability, race, ethnicity, national origin, religious beliefs and other status protected by law. Staff from PATH HOCM will attend Pennsylvania's PATH Conference in June.

Client Information –

- **Describe the demographics of the client population**
- **Project the number of adult clients to be contacted**
- **Identify expected number of adult clients to be enrolled**
- **Give estimated percentage of adult clients served using PATH funds to be literally homeless**

The PATH homeless Outreach Case Manager will serve any person who is experiencing homelessness and has mental health issues. They will connect people to the appropriate services that would include for adults, culturally or other specialized services for people.

PATH Intended Use Plan FY 2017-18
Lancaster County

The projected number of contacted clients that will receive PATH HOCM services for FY 2017-2018 is 220 people. The PATH HOCM will enroll an estimated 140 clients. Estimated percent of the clients to be literally homeless is 100%.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix I "Guidelines for Consumer and Family Participation".

Community Services Group is committed to involving families and consumers in their strategic planning and other advisory roles. This is evident by having two family members and one consumer on their Advisory Board. Community Services Group has supported the local NAMI affiliate and the NAMI Director is on their Board of Directors. They send employees to several of the consumer driven group including Community Support Program and the Lancaster County Stake holder meeting. Community Services Group provides an annual satisfaction survey to people receiving their services and their community partners to get feedback about the programs they provide.

Health Disparities Impact Statement – Please identify efforts to support the Transition Age Youth (TAY) disparity population by providing the following:

- **The unduplicated number of TAY individuals who are expected to be served using PATH funds**
- **The total amount of PATH funds expected to be expended on services for the TAY population**
- **The types of services funded by PATH that are available for TAY individuals**
- **A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population**

PATH HMHOC will serve approximately another 30 people within this subpopulation based on the percentage who are homeless within this age range. We project that the total amount expended on this subpopulation will be approximately $38,880 for Tabor's PATH CTI and $7,164 for CSG's PATH HOCM. These services will include outreach and supportive housing services but will be able to access any of the additional services and/or resource offered by LCBHDS if opened with the office. We will work with LCBHDS's and CSG's Transitional Age Case Mangers in linking these young adults to PATH services and other mental health and/or drug and alcohol services. If the young adult is identified as homeless and with mental illness and/or drug and alcohol issues, CSG's PATH HOCM will attempt to engage with them and linking them to community and public services. These contacts will be tracked in HMIS through entry exit and service provision entries.

PATH Intended Use Plan FY 2017-18
Lancaster County

Limited English Proficiency – Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es

Under LCBHDS contract, CSG is required to provide services to limited English proficiency people. CSG uses a language line for non-English speaking and will access Deaf and Hard of hearing service for sign.

PATH Intended Use Plan FY 2017-18
Lancaster County

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.

Personnel:
Cost associated with a portion of the salary for the Case Manager who will provide the direct service provision. This line item includes the following breakdown: $25,955 in Federal PATH, $8,652 in State PATH and $0 in other funding for a total of $34,606.

Fringe Benefits (37.5%):
Cost associated with a portion of fringe benefits that include employer shared taxes, physical health, dental and optical insurance, employer shared retirement plans, worker compensation insurance and unemployment insurance for the above funded position. This is based on the same allocation methodology used by the provider for the current contract with LCBHDS. This line item includes the following breakdown: $3,973 in Federal PATH, $1,324 in State PATH and $0 in other funding for a total of $5,297.

Travel:
Provide mileage reimbursement to employee for utilizing their own vehicles to provide services to participants in the PATH funded program within the community. This line item includes the following breakdown: $1,767 in Federal PATH, $589 in State PATH and $0 in other funding for a total of $2,356.

Equipment:
Cost of replacement and/or maintenance of existing equipment in supporting PATH funded positions and services. This line item includes the following breakdown: $225 in Federal PATH, $75 in State PATH and $0 in other funding for a total of $300.

Supplies:
Costs associated with office supplies needed to do day to day business of the PATH program. This line item includes the following breakdown: $450 in Federal PATH, $150 in State PATH and $0 in other funding for a total of $600.

Other:
Staff training with provide for cost associated with training and education to increase the competencies of the staff to provide services to the participants of the PATH funded program. Communication cost would include telephone, cell telephone and internet access associated with direct service provision. Insurances would include professional liability, umbrella, property insurance and other liability insurance. Administrative costs would be allocated indirect costs associate with implementing the PATH funded program. These include salaries and benefits of the indirect or support staff and rent, utilities, communication, purchased services, supplies and equipment allocated in administrative support of the PATH funded program. This

line item includes the following breakdown: $3,452 in Federal PATH, $1,151 in State PATH and $0 in other funding for a total of $4,603.

In – Kind Supports:

The participants who meet serious mental illness criteria for county mental health will have access to mental health services provided through county funding to include treatment, psychiatric rehabilitation, vocational, social rehabilitation, case management, housing supports and advocacy/self help services.

***See Sample Budget Table below**
***Please add additional rows as necessary**

PATH Intended Use Plan FY 2017-18
Lancaster County

Community Services Group
2017-18 Budget
Lancaster County

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Outreach Case Managers	$29,790	0.8 FTE	$29,790	$29,790
Outreach CM Supervisor	$48,000	0.1 FTE	$4,800	$4,816
sub-total	**$77,790**	**.9 FTE**	**$34,606**	**$34,606**
Fringe Benefits				
Outreach Case Managers				$3,743
Outreach CM Supervisor				$1,554
sub-total				**$5,296**
Travel				
Local Travel for Outreach				$2,356
sub-total				**$2,356**
Equipment				
Replacement and/or maintenance of existing equipment				$300
sub-total				**$300**
Supplies				
Office Supplies				$600
Consumer-related items				$0
sub-total				**$600**
Other				
Staff training				$400
Communication				$1,000
Admin Costs				$2,953
Insurance				$250
sub-total				**$4,603**
Total Community Services Group PATH Budget			**$47,761**	

31. Lancaster County - Tabor Community Services

308 E King St

Lancaster, PA 17602

Contact: Ann Linkey

Contact Phone #: 7173589391

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-051

State Provider ID: 4251

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Tabor Community Services will receive a total of $73,703 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 220

Estimated Number of Persons to be Enrolled: 140

Estimated Number of Persons to be Contacted who are Literally Homeless: 220

Number staff trained in SOAR in grant year ending in 2017: 1

Number of PATH-funded consumers assisted through SOAR: 1

Tabor Community Services
Critical Time Intervention Program
PATH Intended Use Plan FY 2015-16
Lancaster County

Local Provider Description – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

Tabor Community Services is a non-profit community services organization that specializes in supportive housing, credit counseling, homeless services and community development. Tabor receives $77,760 for their PATH services. This is broke down as $55,277 in PATH Federal funds, $18,426 in State PATH funds and $4,057 in other funding to provide the PATH Critical Time Intervention service (PATH CTI).

Tabor Community Services
308 E King St
PO Box 1676
Lancaster, PA 17608
717-397-5182

PDX Name – PA-051 Lancaster: Tabor Community Services

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the areas where PATH operates.

Tabor is a member of the Lancaster County Coalition to End Homelessness (LCCEH) (HUD CoC PA-510), HUD Continuum of Care and Homeless Provider Network. Tabor receives HUD funding for coordinated entry, transitional housing, rapid rehousing and permanent supportive housing. On August 1, 2013, Tabor began to provide the Coordinated Housing and Referral Team (CHART) program which essentially is the single point of entry for Lancaster County's homeless system and Rapid Rehousing service through HUD CoC funding. Tabor is a leading agency within the coalition in designing programs that meet the community needs regarding homelessness. Tabor's President is on LCCEH Leadership Council and they participate in all levels of planning with the CoC.

Collaboration with Local Community Organizations – Provide a brief description of partnerships and activities with local community organizations that provide key services

(e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

Tabor understands the importance of partnering with different community services that support people in need. The CTI model takes these partnerships to another level by assessing and planning with people to assure the available supports have been identified and who is responsible for supporting the person in accessing them. Partnerships include:

Partnerships include:

1. Lancaster County Coalition to End Homelessness (Lancaster General Hospital) – Coordination of the homeless system
2. Community Services Group mental health treatment, rehabilitation and case management including PATH Case Manger dedicated to serving the people experiencing homelessness
3. Lancaster County Behavioral Health and Developmental Service – county mental health and developmental agency
4. Recovery Insights – Peer support services
5. Mid Penn Legal Services – Legal services to obtain entitlement and benefit income
6. Office of Vocational Services – vocational services and funding
7. Keystone Service Systems – mental health rehabilitation and long term housing support
8. The Lodge Life Services– homeless outreach, HUD permanent housing, long term housing support, representative payee
9. Water Street Rescue Mission – homeless shelter, drug and alcohol services, medical and dental services, furniture, clothing and food banks
10. Salvation Army - Furniture and clothing bank
11. Goodwill – vocational services, furniture and clothing
12. Behavioral Healthcare Corp – mental health treatment and social rehabilitation services
13. Southeast Clinic – medical services
14. Ephrata Area Rehabilitation – vocational
15. Lancaster County Housing Authority – housing subsidy
16. Lancaster City Housing Authority – housing subsidy
17. Arch Street Center – mental health drop-in center
18. ICAN of Lancaster – mental health drop-in center
19. Council of Churches – food bank, emergency winter shelter
20. Philhaven Hospital – mental health treatment services, mental health diversion program
21. Lebanon Veterans Administration – Federal veteran services
22. Lancaster County Veteran Affairs Office – Local government veteran assistance office

23. Various Landlords in the community
24. Community Basics – housing development
25. Housing Development Corp – housing development
26. Lancaster County Drug and Alcohol Commission – drug and alcohol services
27. Compass Mark – drug and alcohol services
28. Various housing development companies
29. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
30. Ingermen Housing Development – low income housing development

Tabor provides homeless outreach services through the CoC and coordinates with other outreach services.

Service Provision – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

Critical Time Intervention is on SAMHSA's National Registry of Evidence-based Programs and Practices as an effective model to work with people who are either homeless or institutionalized and are experiencing a serious mental illness. As cited by SAMHSA's National Registry of Evidence-based Programs and Practices, CTI is time limited case management "designed to prevent homelessness and other adverse outcomes among persons with severe mental illness. It aims to enhance continuity of care during the transition from institutional to community living". The CTI model is a nine month program after housing but the PATH CTI worker will be developing important relationships with people prior to housing to encourage people to access health and human services, community and natural supports. CTI is a very structured set of expectations for the PATH CTI worker and the person in the program which include specific timeframes of accomplishments. The PATH CTI worker will be responsible for supportive housing, housing search, linking to non-mental health community and natural supports and teaching the person and their service/treatment team skills to work effectively together.

The services include: housing support to include housing search, community service and resource linkage.

a. How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless.

The PATH CTI program is a medium term supportive housing service to support a person in identifying and accessing the community and natural supports a person has identified for their success in housing. The PATH CTI worker will provide this guidance during the nine months and once the team is establish, the PATH CTI worker will back out to allow the longer terms supports to continue to engage the person. While the referrals are received and reviewed by LCBHDS's Housing Specialist for meeting criteria and to assure that the person is in need of this

intensive short term service based on the person's lack of housing options in the community, history of housing stability, skills the person to obtain and maintain housing in the community and mental health needs of the person.

b. Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services.

Tabor's PATH CTI program participants have access to the resources LCBHDS has leveraged and allocated for supportive housing resources and all LCBHDS funded mental health services. Tabor leverage funds and services from several non-profit and faith based organizations which include, food banks, clothing banks, rental assistance, furniture banks, medical services and dental services.

c. Gaps that exist in the current service systems.

A gap in services to those experiencing homelessness in Lancaster County is meeting the exact criteria of HUD's definition of homelessness. People who are homeless are not thinking about meeting a criterion; they are trying to survive by whatever means they have. This can include doing things that would make them ineligible for HUD funded services like doubling up with family or friends temporally, renting a motel or hotel room until their financial means are expended, moving into transitional housing that does not meet HUD definition of Transitional Housing or renting a room that far exceeds their ability to pay which results in them becoming homeless for a portion of each month due to using all their financial means. The PATH CTI can support people who fall into one of these gaps to support them in attaining permanent safe and affordable housing.

An additional gap people open with LCBHDS have are services to support people who are in time limited residential programs and state institutions find safe and affordable housing. Housing search and developing relationships with landlords is a specialized set of skills. We have found that a good housing agency can work with landlords on behalf of the person in services to negotiate rent or utility reductions, special accommodations and other amenities that are a necessity to the success of many of the people who receive these mental health services. The housing agency can be the place the landlord can access when there are issues with the tenant versus the landlord starting the eviction process immediately

The last gap recently identified by Lancaster County are those who are homeless or at risk of homelessness that are transitional age, Lancaster identifies this group as 18-24. In the first year of focusing on this group has in theory significant results. In 2016, this age group represented 6.5% (2015 PIT 10%) of those who were in emergency shelter and 5.4% (2015 PIT 6.4%) were in a homeless transitional housing program were 18-24. This group represent 8.7% (2014 PIT 6.2%) of the total HUD defined homeless population in Lancaster County. This also represents a 33.3% decrease of those 18-24 who are experiencing homelessness from the 2015 PIT count to the 2016 PIT count. The total decrease of those people

experiencing homelessness in Lancaster County and City CoC was 5.8%. With LCBHDS's targeting of this population, we believe these specialized services and supports is having an impact on the transitional age homeless population decrease over the last three years. LCBHDS has worked with the transitional age populations with mental illness through specialized programs to include targeted case management, residential rehabilitation and support groups. PATH CTI will continue to focus half the caseload on those in the transitional age group who are literally homeless or at significant risk of homelessness.

d. Brief description of the current services available to clients who have both a serious mental illness and a substance use disorder

People in the PATH CTI program will have access to the mental health services contracted with LCBHDS which includes supported housing, vocational rehabilitation, treatment services, social rehabilitation, Drop-in Centers and advocacy and self-help programs. In addition, the mental health case managers have experience in linking people who have substance abuse disorders to those services that are available to them. With the initiation of the HSBG program, Lancaster County now has some flexibility in moving funds to services that are needed by the residents of the county. Medicaid expansion has supported more people getting into drug and alcohol services. Lancaster has also seen a significant increase in PATH participants eligible for Medicaid through the Medicaid expansion initiated last fiscal year. Getting more people with disabilities enrolled in Medicaid has allowed a decrease need for HSBG funds for treatment services and those funds can be shifted to mental health and substance abuse services and other resources to support the person's recovery.

e. How the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data in HMIS.

The CTI or Critical Time Intervention program is a SAMHSA evidence-based practice to support people who are experiencing homelessness and have a mental illness. The program uses the CTI manual as a guide for the service delivery and LCBHDS is in the process of investigating some resources to support the CTI program to improve. Tabor PATH CTI funded employees have attended the SOAR training conducting by Mid Penn Legal Services. Tabor utilizes a Housing First model for housing services and/or resources. Housing First does not put treatment or service requirements on a person who is in need of housing to obtain those housing services and/or resources. LCBDHS does require a person to open with one of Lancaster's level of mental health case management to access LCBDHS funded services and/or resources.

Each agency has a staff development budget to send PATH funded employees to trainings that are pertinent to their work. Tabor sends their Direct Service Professional to the annual Pennsylvania PATH Conference in June. Trainings that have been utilized in the past include motivational interviewing,

homelessness, housing first, mental health disorders, local services and clinical approaches.

LCBHDS Housing Specialist coordinates HMIS for PATH purposes and has program director rights to the new system to provide training of PATH provider staff in the use of HMIS. Lancaster migrated to a new HMIS system, July 1, 2015, Case Worthy. This new system is still being worked through for the PATH data points. All PATH funded positions have computer tablets and field access to the internet and databases to better serve individuals and input data in real time. LCBHDS is working with LCCEH (HMIS Lead Agency) in developing policies and procedures to include recommending an online training manual for Case Worthy.

f. Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

Tabor is not drug and alcohol service provider and is not required to follow the 42 CFR Part 2 regulations.

g. Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)

Tabor participates in several of the areas outlined below, with the support of LCBDHS. Lancaster criminal justice related services for those with mental illness and/or drug and alcohol addictions include: Mental Health Forensic Case Manager, Mental Health Crisis Intervention Police Liaison, Mental Health Court, Drug Court, Veteran Court, Crisis Intervention Training to the local and state police agencies, Re-entry Management Program, Special Offenders Probation Parole Services, provide Mental Health groups and treatment in the local jail, Day Reporting Center at Career Link, Master Leasing Program for those discharged from local jail, MISA Group which includes coordination between LCBHDS, Lancaster County Prison, District Attorney, Probation Parole and the County Commissioners and serving on state committees that target prison reform and diversion for those with mental illness. These services, supports and planning activities are in coordination with local social service agencies, local jail, District Attorney's Office, Probation and Parole and elected officials.

LCBHDS is now targeting PATH CTI to work with some of the people referred to the MISA (mental Illness Substance Abuse) group. These people are currently incarcerated with high barriers to being released to include no housing, significant behaviors and/or symptoms of mental illness and/or consistent drug and/or alcohol use, few or no positive natural supports, constant negative interaction with law enforcement and other issues that cause them to be incarcerated repeatedly or for long periods of time. PATH CTI will work to find immediate permanent housing for them while they are still incarcerated, utilizing resources and funds by

LCBHDS. Once released, the PATH CTI worker will engage with them frequently along with their other supports to increase their success in the community. The ultimate goal is for the person to reduce or eliminate negative interactions with law enforcement and incarceration.

LCBHDS is also working with Lancaster Housing Opportunity Partnership to educate landlords, property manager and housing development companies about the realities of those with criminal histories who have a serious mental illness. This education will hopefully allow landlords to give people with criminal convictions an opportunity to rent from them.

Data – Describe the provider's status on the HMIS transition plan, with accompanying timeline, to collect PATH data by fiscal year 2017. If providers are fully utilizing HMIS for PATH services, please describe plans for continued training and how providers will support new staff.

Tabor defers issues and coordination with HMIS to LCBHDS. LCBHDS is integrally involved with HMIS having both PATH and HUD grants. The County of Lancaster is providing funding to the Lead Agency through HSBG funding and will continue in a lead role with the LCCEH. Michael Foley from LCCEH is the HMIS Lead and responsible for the HMIS system. Lancaster migrated to a new HMIS system, July 1, 2015 that will better accommodate the new PATH data points. All PATH staff have been trained in using HMIS being utilized by Lancaster County. LCBHDS is recommending that there will be on-going training for current staff, training new staff and providers as they enter the system. LCBHDS will work with the HMIS Lead Agency to encourage them to develop policies and procedures for training the staff and to include developing a training manual and online training. Each contract with the PATH providers requires the entry of data in HMIS as part of the service provision. LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. As of July 1, 2016, Lancaster PATH providers were fully utilizing HMIS for the PATH programs as developed by the software vendor.

Alignment with PATH goals – Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Tabor's PATH CTI program prioritizes people who are literally homeless with a target of half the caseload working with adults 18-24 who are literally homeless or at significant risk of homelessness. We have also started targeting people who are currently incarcerated who do not have permeant housing upon release from local jail. This group can historically be released to temporary housing, including homelessness which increases their risk of recidivism and/or reincarceration.

Alignment with State Mental Health Services Plan – Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS)identified in their PATH state plan in targeting adults who are in the category of transitional age, aged 18-30, and literally homeless as a priority group. Lancaster has dedicated several resource specific to PATH funding and specific to all adults in this category. Tabor's PATH CTI program has at least half their caseload dedicated to working with this priority group. In addition, several resources have been dedicated to assist those transitional age adults in obtain housing, utilizing the housing first model, while setting expectations on them in working toward become self-sustaining through attaining income, both competitive work and/or benefits/entitlements and learning how to be a good tenant, neighbor and member of their community. LCBHDS has utilized several long term subsidized units through the HUD PSHP. LCBHDS has also dedicated first month's rent, security deposits and bridge subsidies to this group who are literally homeless and have an income to sustain their own housing.

In addition to the state PATH goals, LCBHDS has also included both PATH programs as part of their Olmsted Plan submitted. These programs provide critical supports to reduce the need for those with mental illness for long term institutionalization, including state mental health hospitals, long term homeless shelters and transition housing and other setting that are not integrating them into our community. Lancaster submit PATH CTI in the Human Services Block Grant plan submitted to the state every year outlining the service and programs planned for the next fiscal year including some outcomes. This is how the state provides updates on their initiatives and whether the counties are following their direction.

Alignment with State Plan to End Homelessness – Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

70% of Tabor's PATH CTI program enrollees are literally homeless and provides supportive housing case management services to them. Lancaster County has not historically and does not current have a significant number of chronically homeless adults (6, 2016 PIT Count; 7, 2015 PIT Count). This is because of the array of services, both public and private that are provided to those in need. While affordable housing is an issue in Lancaster, people seem to find places to live, whether with family, friends, natural and community supports or faith based options. LCBHDS has 47 HUD PSHP units that are dedicated to those people with serious mental illness and no income who are HUD defined homeless. Managing these resources for the most vulnerable population that has no natural resources and no income or ability to attain an income in a short period of time has been successful in reducing the number of people in long term homelessness or with multiple episodes.

Tabor is required to have an emergency/disaster preparedness plan for those who they serve. As part of their plan, the agencies test and modify these plans as needed in order to be ready for a local or national emergency. Lancaster has a local Emergency

Management agency that is responsible for directing the local community in what actions to take during an emergency/disaster. The supportive housing programs teach each person how to they would be alerted through this system and informed about their options during an emergency/disaster.

Other Designated Funds – Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

Tabor PATH CTI participants have full access to LCBHDS services and/or resources as they are open with the county agency. Tabor receives funds through the CoC to provide coordinated assessment, rapid rehousing, permanent supportive housing and outreach services dedicated to those who are HUD defined homeless. While none of these funds are dedicated to PATH services specifically, these funds have direct impact on those people who are receiving PATH funded services. LCBHDS allocates an additional $4,057 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded for Tabor's services $77,760. The state and federal allocation is $73,703.

Programmatic and Financial Oversight –In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

Tabor is a contracted provider with LCBHDS for the PATH grant funds. The state of Pennsylvania provide both PATH federal and state PATH match funds to Lancaster County through the Human Services Block Grant. These funds are categorized as PATH and are only used for PATH CTI as submitted through he PATH intended use plan. LCBHDS contracts with Tabor through as a fee for service program for the PATH services. Tabor bills LCBDHS based on a contracted rate developed by the approved budget for only services provided. As part of the contacting process, LCBDHS requires tabor to submit an annual budget, a service description, quality assurance plan and goals and other documentation. Tabor's contract specifies that PATH funds can only be used for approved expenses as required by the PATH regulations. Tabor is responsible to provide LCBDHS with a 6 month, 9 month and annual profit/loss statement. Tabor provides an annual single audit to include how the PATH funds were spent. Included in Tabor's contract is LCBHDS's right to audit the provider as needed. LCBHDS provides the state with how the funds were expensed through the annual Human Services Block Grant report, which shows which categorical the funds were expensed.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. For the grant year 2016-2017, include all of the following data:

- **The number of staff trained in SOAR**
- **The number of staff who provided assistance with SI/SSDI applications using the SOAR model;**
- **The number of consumers assisted through SOAR**
- **Application eligibility results (i.e., approval rate on initial application, average time to approve the application)**
- **The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]**

As March 31, 2017, the CTI worker funded by PATH has attended the SOAR training provided by Mid Penn Legal Services, Valerie Case. There were 1 consumers through PATH CTI program with a SOAR application in 2015-16. We estimate that around 1 person per year could be SOAR eligible, as 60% the caseload is for those who are HUD defined homeless but majority of the people enrolled will have income due to changes in how LCBHDS administers their HUD PSH programs with changes in CoC funding and match requirements. Tabor has no staff solely dedicated to SOAR and does not use the OAT system at this time. All SOAR information is stored in HMIS.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Tabor's PATH CTI program will not be providing or subsidizing housing for people. This program will be a Housing First model program and will utilize the expertise of Tabor to find and link the person to safe affordable housing in the community in which the person would hold the lease in their name and/or link the person to subsidized housing opportunities based on eligibility of the person. The reason for contracting with Tabor was that they are the housing experts, with nearly 300 landlords in Lancaster County they work with in order to link housing up with people who are homeless or at risk of becoming homeless. Tabor does provide Rapid Rehousing services and the PATH participants might utilize those resources in accessing funds. Tabor will also work with Lancaster County's Local Lead Agency, Lancaster Housing Opportunity Partnership, to access LIHTC set asides for those with disabilities and the PHFA 811 PSH program funds.

Coordinated Entry – Indicate if/how your organization is engaged with the local coordinated-entry processes of your CoC. Please also describe the roles of key partners in the CoC.

Tabor is the provider of the coordinated entry and assessment program for the homeless system in Lancaster County. The process includes calling the United Way 211 system to request support if a person is experiencing homelessness. If the person is

assessed on the phone as meeting HUD defined homelessness, they are then referred to Tabor's Coordinated Housing Assessment Referral Team (CHART), for an intake worker to provide an intake and determine what homeless services a person might be eligible for. LCCEH oversees the contract with Tabor for CHART and is responsible for monitoring and governing under a contract with the County of Lancaster.

PATH CTI is not directly receiving referrals from CHART because of the requirement of being open with LCBHDS. LCBHDS has invested in a vast array of resources in housing and/or resources for people open with LCBHDS and has relied less on the homeless system to serve the people open with the agency. Lancaster 2016 PIT count reflects this investment, in that only 16.3% of those counted reported a mental illness, while Pennsylvania is at 25.2% and the United States is at 19.6%. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's Mental Health Case Manager or LCBHDS's Housing Specialist.

Justice Involved – Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

Tabor work with a significant number of people who are currently in the criminal justice system or have convictions that could present barriers to obtaining housing. LCBHDS's Housing Specialist provides a full housing assessment of a person referred to Tabor's PATH CTI that include a full criminal background check to assist the person's team to work through potential barriers to housing. Pennsylvania has a Unified Justice Portal, in which any person has access, including landlords and property managers, so being upfront of criminal history has been very important in developing relationships with the landlords and property managers.

Tabor works closely with the local courts, prison and probation/parole services to improve a person's chance of being successful in reentry back into their community. Lancaster has a great number of jail diversion and justice related programs for those with mental illness and/or substance abuse disorders. These programs include Mental Health Court, Drug Court, Special Offenders Probation and Parole Services for those with mental health and/or intellectual disabilities, Mental Health Forensic Case Management, and Mental Health Hospital/Forensic Intake Worker. In addition, LCBDHS has developed tools that help the justice system in determining the best course of action for someone who is being released from jail and has no permanent housing to return too.

Tabor estimates that nearly 80% of the people working with the PATH programs have some sort of criminal history. It is estimated that 25% have felonies. The group that Lancaster has found to have the greatest barrier to finding permanent housing are people with convictions that would place them on the Sexual Offender's list, arson, multiple convictions of aggravated assault, manufacture/sales/distribution of controlled substances and domestic violence.

Staff Information – Describe the demographics of staff serving the clients

- **Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients**

- **Discuss the extent to which staff are receptive to differences of clients**
- **Identify the extent to which staff receive periodic training in cultural competence and health disparities**

Tabor PATH CTI has one FTE supportive housing case manager who leads the CTI process and the team leader who supervises the case manager. Of the two employees being funded with PATH funds, the demographics include two females, two are Caucasian with the ethnicity of two non-Hispanic. One person is Spanish/English bilingual. There are several opportunities to PATH staff to receive training on cultural competency through internal trainings and conferences they attend. The direct service professionals, provider supervisors and LCBHDS's Housing Specialist will attend the annual Pennsylvania PATH Conference.

Client Information –

- **Describe the demographics of the client population**
- **Project the number of adult clients to be contacted**
- **Identify expected number of adult clients to be enrolled**
- **Give estimated percentage of adult clients served using PATH funds to be literally homeless**

PATH CTI will target people who are experiencing homelessness or are at risk of becoming homeless. The demographics will include any person residing in Lancaster County who is 18 years and over and of any race, gender, ethnicity, religious belief and meets the OMHSAS Serious Mental Illness criteria, which is defined as a person who has a diagnosis of psychotic NOS disorder, schizophrenia, major depression, mood disorder and/or borderline personality disorder and has a secondary history that impedes their ability to function in the community successfully. In addition, the person must agree to be open in LCBHDS's services for PATH CTI services. LCBHDS is dedicating half of the PATH CTI worker's caseload to those 18-24 years old.

Everyone who will be targeted will need to meet the OMHSAS Serious Mental Illness criteria and agree to be open in LCBHDS services. The number of contacted clients for PATH CTI services will be 35 and the projected number of enrolled clients that will receive PATH CTI services for FY 2017-2018 is 30. Half of those people will be the targeted priority group of transitional age 18-24. Estimated percent of the clients to be literally homeless is 60%.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix I "Guidelines for Consumer and Family Participation".

Tabor has hired people who have experienced homelessness in their own life for direct service professionals and support staff. Tabor is required to have a person who had

or is experiencing homelessness on their board as per HUD. Tabor frequently utilizes client satisfaction and follow up surveys where a client has the opportunity to share new ideas for the program.

Health Disparities Impact Statement – Please identify efforts to support the Transition Age Youth (TAY) disparity population by providing the following:

- **The unduplicated number of TAY individuals who are expected to be served using PATH funds**
- **The total amount of PATH funds expected to be expended on services for the TAY population**
- **The types of services funded by PATH that are available for TAY individuals**
- **A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population**

Tabor's PATH CTI will have at least 50% of their caseload dedicated to the TAY population. Tabor expects to serve 15 people in this subpopulation. We project that the total amount expended on this subpopulation will be approximately $38,880 for Tabor's PATH CTI. These services will include supportive housing services but will be able to access any of the additional services and/or resource offered by LCBHDS. Tabor will work with LCBHDS's and CSG's Transitional Age Case Mangers in linking these young adults to PATH services and other mental health and/or drug and alcohol services. These contacts will be tracked in HMIS through entry exit and service provision entries.

Limited English Proficiency – Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.

Under the contract with LCBHDS, Tabor is required to provide services to limited English proficiency people. Tabor accesses a language line for interrupting services, relies on Deaf and Hard of Hearing for sign language and the one direct service professional is bi-lingual in Spanish.

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.

Personnel:
Cost associated with a portion of the salaries for the Critical Time Intervention Worker who will provide the direct service provision. Cost associated with a portion of the Team Leader who provide direct supervision to the CTI Worker. This line item includes the following breakdown: $28,574 in Federal PATH, $9,525 in State PATH and $2,023 in other funding for a total of $40,121.

Fringe Benefits:
Cost associated with a portion of fringe benefits that include employer shared taxes, physical health, dental and optical insurance, employer shared retirement plans, worker compensation insurance and unemployment insurance for each of the above funded position. This is based on the same allocation methodology used to calculate the portion of the PATH grant that fund the salaries of each position. This line item includes the following breakdown: $$8,594 in Federal PATH, $2,865 in State PATH and $560 in other funding for a total of $12,019.

Travel:
Provide mileage reimbursement to employees for utilizing their own vehicles to provide services to participants in the CTI program within the community or at their home in Lancaster County. This line item includes the following breakdown: $2,434 in Federal PATH, $811 in State PATH and $55 in other funding for a total of $3,300.

Equipment:
Cost of replacement and/or maintenance of existing equipment in supporting PATH funded positions and services. This line item includes the following breakdown: $335 in Federal PATH, $112 in State PATH and $0 in other funding for a total of $446.

Supplies:
Costs associated with office supplies needed to do day to day business of the CTI program. This line item includes the following breakdown: $464 in Federal PATH, $155 in State PATH and $0 in other funding for a total of $618.

Other:
Staff training with provide for cost associated with training and education to increase the competencies of the staff to provide services to the participants of the PATH funded program. Building and equipment maintenance is for contract for equipment upkeep like copiers and scanners and for office building upkeep. Purchased services would be the professional services the organization need to maintain their computer technology associated with direct service provision, audits required by contract and regulations and other outsourced services to support the program under the agency. Protective Payee Services is a service offered to the participants of the PATH funded program to support them in managing their income to assure timely payment of rent, bills and other cost associated with maintaining a home. Communication cost would include telephone, cell

telephone and internet access associated with direct service provision. Utilities are costs that include electric, gas, oil, trash removal, water and sewer associated to the office space used by the direct service staff. Office rent is the rent allocated to the program for space utilized by the direct service staff. Insurances would include professional liability, umbrella, property insurance and other liability insurance. Administrative costs would be allocated indirect costs associate with implementing the PATH funded program. These include salaries and benefits of the indirect or support staff and rent, utilities, communication, purchased services, supplies and equipment allocated in administrative support of the PATH funded program. This line item includes the following breakdown: $14,878 in Federal PATH, $4,959 in State PATH and $1,419 in other funding for a total of $21,256.

Lancaster County
Tabor Community Service
Critical Time Intervention PATH Program
FY 2016-17 Total Budget

*Please add additional rows as necessary

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
CTI Worker	$35,460	1 FTE	$35,460	$35,460
Team Leader	$51,790	0.09 FTE	$4,661	$4,661
sub-total	**$87,250**	**1.09 FTE**	**$40,121**	**$40,121**
Fringe Benefits				
CTI Worker				$10,589
Team Leader				$1,431
sub-total				**$12,019**
Travel				
Local Travel for Outreach				$3,300
sub-total				**$3,300**
Equipment				
Replacement and/or maintenance of existing equipment				$446
sub-total				**$446**
Supplies				
Office Supplies				$618
sub-total				**$618**
Other				
Staff training				$300
Building and Equip Maintenance				$900
Purchase Services				$3,474
Protective Payee Services				$1,800
Communication				$1,400
Utilities				$600
Admin Costs				$11,766
Office Rent				$616

Insurance				$400
sub-total				**$21,256**
Total Tabor PATH Budget	**$77,760**			

32. Lehigh County - Lehigh County MH/ID/D&A/HealthChoices Program

17 South 7th Street

Allentown, PA 18101

Contact: Wendy Mingora

Contact Phone #: 6107823135

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-014

State Provider ID: 4214

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 51,680	$ 17,227	$ 68,907	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 51,680	$ 17,227	$ 68,907	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 51,680	$ 17,227	$ 68,907	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 51,680	$ 17,227	$ 68,907	

Source(s) of Match Dollars for State Funds:

Lehigh County will receive a total of $68,907 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 125

Estimated Number of Persons to be Enrolled: 40

Estimated Number of Persons to be Contacted who are Literally Homeless: 31

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Lehigh County MH/ID/D&A PATH Intended Use Plan
FY 2017-2018

Local Provider Description

Lehigh County MH/ID/D&A/HealthChoices Program is the sole recipient of PATH funding. Lehigh County MH, Lehigh County Government Center, 17 South Seventh Street, Allentown, PA 18101. In PDX we are listed as: Lehigh County Mental Health/Intellectual Disabilities. The Mental Health Program manages federal, state, and local funds to provide comprehensive, community-based, recovery-oriented services. These services include, but are not limited to: outpatient, partial hospitalization, residential, vocational, and specialized case management for individuals with a severe mental illness. The region served is Lehigh County, which includes the City of Allentown, part of the City of Bethlehem and numerous smaller municipalities. Lehigh County will receive a federal allocation of $51,680 and a state match of $17,227 for a total of $68,907 for the fiscal year 2017/2018.

Collaboration with HUD Continuum of Care (CoC) Program

Lehigh County staff attend and are active participants in the RHAB (Regional Housing Advisory Board) meetings. RHAB is a subdivision under our local HUD CoC. These meetings utilize the combined wealth of experience and knowledge of each member/agency to seek out better ways to serve the homeless community and provide more comprehensive interventions for the conditions leading to homelessness. Lehigh County participates quarterly in the CoC meetings held at Wernersville State Hospital. Lehigh County actively participates in the Homeless Intervention & Client Case Planning (HICCP) meeting. We track all outreach referrals received through Homeless Support Services. Additionally, The Lehigh County Reinvestment Housing Plan entails a comprehensive plan to address the need for decent, safe, and affordable housing for mental health individuals in our community. Consumer representatives actively participate in the planning process.

Collaboration with Local Community Organizations

The County of Lehigh works and partners with many community organizations that provide services to our PATH eligible individuals. These services may include outreach, primary health care, behavioral health services, housing supports, and employment and/or life skills services. The agencies providing these services include: local hospitals, hospital programs, food banks, outpatient clinics, shelters, vocational programs, etc. Lehigh County currently has a caseworker that attends our local soup kitchen on a weekly basis. She is working with local agencies to connect individuals with housing resources including PATH funding.

Service Provision

The PATH staff routinely meets with key agencies to coordinate, develop and preserve relationships to benefit the homeless with mental illness/co-occurring disorders. Individuals are referred to the appropriate agency for specific needs identified by the individual during the assessment process and are monitored through the case management process.

The Lehigh County Housing Case management staff work closely with the agencies in our community that are doing outreach and working with the literally homeless population. We have developed relationships with these agencies and have made them aware of the availability of PATH funds. Conference of Churches targets street outreach. Our priority at initial contact is to provide case management services which may include other case managers in our agency working closely with our housing staff to discuss situations when they have an individual who is homeless. Our county case managers work with the Conference of Churches housing Clearinghouse case manager to provide maximum use of PATH money and other available resources.

There are many gaps in our current service systems. We struggle to work effectively with transitional age youth that often have no income and have to endure homelessness to be eligible for Social Security benefits. There is not enough housing that is affordable for individuals with Social Security incomes. We are in great need of Section 8 housing vouchers. Our Section 8 wait list has been long for years. Housing eligibility requirements can limit people's access to housing including individuals with criminal records being barred from site-based subsidies. We do not have programs/resources to support people experiencing a financial or personal crisis that may cause them to lose their housing. Individuals with Mental Illness and chronic homelessness may struggle to maintain a steady source of income. There is a lack of furnished single room occupancies (SROs) that are affordable.

The PATH program provides case management, screening, and referral to individuals with mental illness and/or substance abuse disorders who are homeless or in danger of becoming homeless. Additionally, there are many community programs that we refer to. Some of those include: Step-by-Step – which offers a dual program where individuals can access treatment and case management services; The Lehigh Valley D&A Intake Services – which assesses individuals with co-occurring disorders, makes recommendations regarding D&A treatment or rehabilitation placement, and provides intensive case management services, this is done through various agencies in our county; The Allentown Rescue Mission – which offers a D&A residential program in addition to shelter services; and outpatient clinics such as Hispanic American Organization and Haven House – which have programs and groups which include Drug & Alcohol treatment components. Lehigh County maximizes the use of PATH funds by leveraging use of other available funds for PATH services. Agencies we connect individuals with include but are not limited to: Goodwill, Office of Vocational Rehabilitation, Recovery Education, D&A services, Clubhouse, Daybreak, Drop In Centers, Food Banks, Veterans Affairs, Clearinghouse, Conference of Churches, Furniture Depot, Soup Kitchens, VNA

nurses, Health Clinics, Street Medicine, Specialized Case Management, Partial Hospitalization Programs, Peer supports, Valley Housing, Section 8, Overlook Housing Authorities, Social Security, Department of Public Welfare, Unemployment Compensation, Domestic Relations, Turning Point, Pathways, Homeless Support Services, Representative Payee, Guardianship……

Our PATH staff are tracking information on our PATH individuals in HMIS. We also support the community agencies that are entering data into HMIS systems. These agencies include but are not limited to Conference of Churches, the Allentown Rescue Mission, Valley Housing Development Corporation and the Veteran's Administration. The agencies work directly with people who are "literally" homeless and provide outreach. PA HMIS trainings are free and HMIS Technical Assistance Conferences are free through the website.

Lehigh County follows the Health Insurance Portability & Accountability Act of 1996 (HIPAA). We notify each individual of what the Act means and their rights under the Act.

Lehigh County offers several programs to directly assist individuals with criminal justice involvement. We offer MISA, Re-Entry and SPORE. Team MISA has an initial goal of diverting low risk MH offenders from incarceration or in the very early stages of incarceration. The meetings are scheduled weekly as a "think tank" for the involved parties to streamline processes and expedite appropriate releases from jail. The success of the group hinges on collaboration and ensuring that there are decision makers, as well as front line staff, at the table. The team meets weekly to discuss new referrals and any updates on "old" referrals. Each team member collects all information from their respective office, has information releases signed when necessary, and collectively, the team discusses the most appropriate and expeditious approach to manage the case. Recommendations for any type of release do not require unanimous agreement; however, if any member believes that the defendant presents a threat to self or others, the release is tabled. Plans of action are developed. The Re-entry Committee is a multi-disciplinary team that meets every other week to discuss and develop re-entry plans for inmates who have a variety of needs including mental health and/or intellectual disabilities. S.P.O.R.E. is a joint program that supervises those offenders that have mental illness and/or mental retardation that have received a county term of probation or parole. S.P.O.R.E. integrates the criminal justice system of Lehigh County and the Mental Health/Intellectual Disability systems of Lehigh County. This collaborative effort combines the resources of two systems in order to provide a greater positive impact on behalf of the client. Adult S.P.O.R.E. can provide two main functions; one being a diagnostic function and the other a case management/supervision function.

Data

Our PATH staff are entering all PATH individuals in the PA HMIS system. Our case managers work with each other on being sure individuals are led to access any available applicable services for them. Lehigh County will continue to participate in any web trainings available for the HMIS system. DCED is the PA HMIS Administrator.

Alignment with PATH goals

Lehigh County is providing housing case management to our individuals that are most vulnerable risk for homelessness. We currently have a case manager that is stationed at the soup kitchen program to work with individuals and refer them to programs such as PATH. PATH services are a priority in our office. Our case managers are available to immediately meet with individuals and can enroll them in the PATH program on the same day they are presenting to our office.

Alignment with State Mental Health Services Plan

Our PATH program supports the efforts to reduce/eliminate chronic homelessness in the state by providing and linking to all services in our community that are available. Our goal in Lehigh County is to house the most chronically homeless and mentally ill. Some of the programs helping individuals are through Seneca House and our MISA programs. PATH integrates with the Continuum of Care (CoC) planning through RHAB. The CoC also provides housing (subsidies, master leases) for people who are homeless. In regards to disaster preparedness, Lehigh County meets with the City of Allentown and County of Lehigh Emergency Management staff as part of the homeless, winter sheltering workgroup. PATH can be used to house people who are displaced and become homeless in an emergency. We work with prioritizing the Transitional Age Youth (TAY) population that is homeless.

Alignment with State Plan to End Homelessness

At Lehigh County, Case management is available immediately whether that would occur at our office, the Government Center, or in the community, at an agency such as our soup kitchen at St. Paul's church. Our housing case managers will meet with individuals after, between and in concert with connecting individuals with other case management and services in the community.

Other Designated Funds

In Lehigh County we have a Mental Health Block Grant. PATH funding and services are not a part of the Block Grant. PATH funding is only used for PATH services.

SSI/SSDI Outreach, Access, Recovery (SOAR)

In Lehigh County we work with staff at Conference of Churches in order to assist individuals in the SOAR application process. PATH staff directly assist individuals in reviewing their individual situation in order to help them apply for benefits they may qualify for. At this time we do not have any workers completing the SOAR process.

Housing

PATH funds are utilized for security deposits and rental assistance to prevent eviction. The Lehigh County PATH case managers maintain an extensive list of landlords and constantly update lists of available housing. Lehigh County has used reinvestment dollars to fund housing programs partnering with PHFA, Allentown Housing Authority and Pennrose Management. We have been able to provide and maintain about 40 individuals in subsidized housing units. The Fountain Street Bridge Program continues to offer a transitional housing program and allows individuals the ability to have access to decent, safe and affordable housing on a short-term basis while waiting for a permanent housing option. The PATH case managers work with each individual Case Manager to ensure that housing goals are met.

Coordinated Entry

Lehigh County is going to be a site for Coordinated Entry for Homeless Services. Individuals will come to our Information and Referral office. By coordinating entry we can prioritize housing and services for families and individuals based on vulnerability and severity of need. We do consider housing for the most needy person first. We screen within our agency. Only outdoor homeless and individuals living in shelters are eligible for some of our available programs.

Justice Involved

In Lehigh County, almost half of our enrolled PATH individuals are criminally involved and or have a criminal history. We have a program called Team MISA (Mental Illness Substance Abuse). Team MISA is comprised of a variety of disciplines within the County, including the District Attorney's Office, Lehigh Valley Pre-Trial Services, MH/ID, SPORE, D&A, Lehigh County Prison (treatment, administration, and case managers), Probation/ Parole and the Public Defender's Office. The meeting is chaired by the first Assistant DA. The success of the group results from the collaboration and participation of department heads, as well as front line staff, at the table. The team meets weekly to discuss new referrals and any updates on ongoing cases that are involved in the criminal justice system. Members collect and present pertinent information from their office which the team discusses to develop the most appropriate plan to most appropriately address the individual's situation in the most clinically appropriate manner.

Staff Information

Staff serving the PATH individuals at the county and at the various community organizations are of both sexes, a variety of ethic backgrounds and between the same age ranges as the individuals they serve. Our PATH staff are involved in ongoing trainings offered through the county, community and most recently through webinars. PATH staff provides services sensitive to age, gender, racial/ethnic diversity by being seasoned workers who have been trained in gender/age/cultural competency. We have the ability to use other case managers to do translating and to use a telephone service that allows us to communicate with a person speaking any language. We have paperwork that is printed in English and Spanish, as those are the languages that are most consistent with the population we serve. Staff have received training in cultural competency and sensitivity and are encouraged to attend "refresher" courses on an annual basis. PATH staff are well versed on the unique needs of people with a mental illness and are able to assist staff of other agencies in their sensitivity working with all populations.

Client Information

In FY 2017/18, we project serving around 125 individuals. We project enrolling about 40 individuals. From recent years, we have found that about 25% of the individuals served with PATH funds are "literally" homeless, 80% of individuals enrolled by PATH were Caucasian, 15% were Hispanic/Latino/Black or African American, with many individuals falling into more than one category.

All individuals served were between the ages of 18 to 64 years, 85% were 35 years of age or older, and both females and males are served close to equally.

Consumer Involvement

Persons who are homeless and have serious mental illness and family members are involved in the planning, implementation, and evaluation of PATH funded services through active participation in Mental Health Planning process. Individuals and/or family members are represented on the Mental Health and HealthChoices Advisory Boards and are well represented on the Mental Health Planning Committee. Individuals will continue to provide the actual direction of the Reinvestment Plan Housing Initiatives by identifying their needs and collaborating with the stakeholders regarding their services.

Health Disparities Impact Statement

We work with many subpopulations in working with the Serious Mentally Ill population. One of the subpopulations we are working with is the Transitional Age Youth (TAY) Population. Based on previous years, we would predict serving around 10 TAY this year. Last year about 5% of the people serviced were in our Transitional Age Youth group. The funds expected to be used for them would therefore be around $700. An individual in the TAY population may need PATH funds for security deposit or rental assistance. We

are attempting to make the community aware of the availability of PATH funds for individuals in the TAY population.

Limited English Proficiency

Lehigh county staff are called upon in order to provide direct Bi-Lingual services to individuals when they come in the Government Center. We have a diverse speaking group of staff who are willing to act as an in person translator when needed. If a translator is not available, we use Propio Language Services to get a translator on the phone line whether we are in the community or in the main office building. We have paperwork that is written in English and Spanish. We connect individuals to ongoing services in their native language. This might include case management, therapy, doctors, etc.

Lehigh County MH/ID Program
PATH Budget
FY 2017-2018

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Sr. Case Manager 3	$69,685	.5 FTE	$22,648	$22,648
Sr. Case Manager 2	$60,216	.2 FTE	$7,828	$7,828
Sr. Case Manager 2	$60,216	.1 FTE	$3,914	$3,914
Program Specialist/Supervisor	$81,058	.1 FTE	$5,269	$5,269
sub-total				**$39,659**
Fringe Benefits				
Case Mngr Benefits	$24,717		$3,708	$3,708
Case Mngr Benefits	$21,359		$1,282	$1,282
Case Mngr Benefits	$21,359		$641	$641
Prog Spec Benefits	$28,751		$863	$863
sub-total				**$6,494**
Travel				
Travel-train/workshps/mtgs				$200
sub-total				**$200**
PATH Assistance Payments				
Rental Assistance				$6,755
Security Deposits				$13,664
Utility Payments				$2,000
Sub-Total				**$22,419**
Other				
Postage				$35
Trainings				$100
Sub-total				**$135**
Total PATH Budget				**$68,907**

Lehigh County MH/ID/D&A – Budget Narrative
FY 2017-18

Personnel:
A portion of the 3 Senior Housing Case Managers and of the 1 Program Specialist/Supervisor's salaries are PATH funded.

Travel:
Our travel expense is used mainly for traveling to meet with possible PATH eligible individuals. It would also include: Travel to housing meetings and to give presentations at provider meetings and other community agencies.

Rental assistance:
The rental assistance is used to assist eligible PATH individuals for the purpose of preventing eviction and subsequent homelessness.

Security Deposits:
The security deposit assistance is used to make a one-time payments directly to the landlord or housing manager.

Utility Assistance:
Utility Assistance is used to make a one-time payment directly to a utility company in the case where the individual would have been evicted due to utility non-payment. This would be the case in which an individual got behind but is now able to show how continued payment will occur in the future.

Postage:
The postage expense is used to send out information on the PATH program. This may include: mailing rental and security deposit checks, sending correspondence to individuals, and mailing housing grant information.

Training:
The training expense includes covering the registration costs accrued as the housing case manager attends necessary workshops, trainings and conferences that will enhance the ability of the housing case manager to provide PATH effective services.

33. Luzerne-Wyoming County - Community Counseling Services

110 S Pennsylvania Ave

Wilkes-Barre, PA 18701

Contact: Beth Hollinger

Contact Phone #: 5705526000

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID: PA-053

State Provider ID: 4253

Geographical Area Served: Northeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 51,680	$ 17,227	$ 68,907	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 51,680	$ 17,227	$ 68,907	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 51,680	$ 17,227	$ 68,907	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 51,680	$ 17,227	$ 68,907	

Source(s) of Match Dollars for State Funds:

Luzerne/Wyoming will receive a total of $68,907 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 450

Estimated Number of Persons to be Enrolled: 125

Estimated Number of Persons to be Contacted who are Literally Homeless: 90

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 16

2017-2018 PATH IUP

Local Provider Description – Community Counseling Services 110 South Pennsylvania Ave. Wilkes Barre PA 18701– PDX: Luzerne/Wyoming: Community Counseling- a community mental health center offering clinical and case management services. Community Counseling Services is a large community mental health center offering clinical and case management services to upper Luzerne County and all of Wyoming County. Community Counseling Services has staff with great knowledge of community resources and cooperative relationships with other community organizations. These links to the community offer access to resources above and beyond funding expectations. Funding is expected to be $68907.

Collaboration with HUD Continuum of Care (CoC) Program – The Luzerne County CoC is the CoC for Luzerne County. The Luzerne County CoC meets monthly to advance the coordination of services for the homeless. Community Counseling Services participates with the Commission on Economic Opportunity and the Luzerne County Office of Community Development in developing the Continuum of Care Programs for Luzerne County. The Continuum of Care goals are part of the work of the Luzerne County Homeless Coalition, in which CCS is an active participant. Community Counseling also works regularly with Community Development agencies who also participate in the LHOT to develop and locate housing options for disabled persons in the community. These agencies are part of an "Emergency Planning and Intervention Team" that meets as needed to resolve difficult problems with clients at risk for homelessness, legal problems, or physical debilitation as a result of being mentally ill. Community counseling is also a key partner with the Luzerne County Office of Human Services Shelter Plus Care program; offering a full range of in kind services for up to eleven participants.

Collaboration with Local Community Organizations –

Mental Health:

Community Counseling Services – home agency – full service community mental health agency, ability to facilitate rapid involvement in services.

Northeast Counseling Services – community mental health agency in southern Luzerne County – provide coordination when their consumers are in shelters in our area, also provide SOAR consultations to case managers when needed.

Housing:

Step By Step – Community Residential Rehab and Supported Living provider – Mutual referrals based on consumer needs.

Mother Theresa's Haven – Men's emergency shelter – outreach at the shelter to identify residents who request or need mental health services

Commission on Economic Opportunity (housing assistance) – HUD funded permanent supported housing programs; rental, mortgage and utility assistance; medication purchase

assistance – outreach to CEO when a consumer presents who requests or appears to need mental health services.

Local Housing Authorities (permanent Housing) – Section 8 and subsidized housing – outreach as needed to tenants or applicants who may be in danger of becoming homeless

Ruth's Place – Women's emergency Shelter – weekly outreach to the shelter to meet with residents and involvement in weekly planning meeting.

Health:

Wilkes-Barre General Hospital – outreach at the request of nurse case managers to patients who are homeless and in need of services and community resources

Geisinger Wyoming Valley Hospital - outreach at the request of nurse case managers to patients who are homeless and in need of services and community resources

McKinney Clinic – Healthcare for the Homeless provider – outreach at the request of clinic staff to patients who are homeless and in need of services

Volunteer in Medicine Clinic – Clinic for working individuals with no insurance - outreach at the request of clinic staff to patients who are homeless and in need of services

Substance Abuse:

Choices Drug & Alcohol Services (inpatient and outpatient) – mutual referrals based on consumer need

Wyoming Valley Drug & Alcohol Services (outpatient and intensive outpatient) - mutual referrals based on consumer need

Luzerne County Drug and Alcohol Case Management – SCA - mutual referrals based on consumer need

Employment:

Office of Vocational Rehabilitation – Local OVR office has a representative at Community Counseling Services who is available for rapid enrollment into services

Step-by-Step – Supported employment – referrals to for supported employment

The Greenhouse – Clubhouse Model – TEPs, supported employment, Psychiatric Rehabilitation – mutual referrals based on consumer need

Service Provision– PATH funds are used to fund a Homeless Advocate, whose primary responsibility is to engage

with homeless individuals and provide case management services in order to link these individuals with all necessary services, housing, entitlements, and educational and vocational opportunities. These linkages allow consumers to take advantage of programs above and beyond what they may be offered through PATH or Community Counseling. Community Counseling Services is also the lead SOAR agency for the county, coordinating training and offering consultative assistance to other agencies with SOAR eligible consumers

- The Homeless Advocate has10 years of experience and relationship building which serve PATH clients well. Her tenacity in seeking out resources fills gaps that may appear as a person transitions from homelessness to housed. Having the Homeless Advocate embedded in a community mental health setting makes connecting consumers to services seamless. Trainings in evidenced based practices and other PATH related topics are found through Drexel, CCBH (our local MCO), Luzerne/Wyoming County MH/DS. Any costs are absorbed by the agency.

- The services listed on the previous page have worked well together for the past several decades. However, the increasing numbers of homeless people accompanied with the often difficulty problems of mental illness and substance abuse have created challenges for the existing system. Many people have difficulty following treatment recommendations, taking medication to reduce behavioral symptoms, or attending counseling services to deal with the emotional and substance abuse problems with plague many people in the counties. Many residential providers, both subsidized and non-subsidized, have strict requirements on behaviors that prevent many severely ill people from finding adequate housing. The Local Housing Options Team has joined with provider agencies and business groups to pursue a permanent shelter for men and women, with vital services provided at the site.

- All Community Counseling Services consumers are assessed for both Mental Health and Substance Abuse issues. This can occur at Intake, Crisis Evaluation, or upon outreach by the Homeless Advocate. Referrals to appropriate Substance Abuse Services are made on a regular basis to agencies referenced above. Individuals with both substance abuse and mental health disorders benefit from a wide range of services available through Community Counseling Services itself and its affiliate CHOICES. Detox, inpatient rehab, intensive outpatient, individual outpatient and methadone/suboxone are all available through CHOICES. Community Counseling Services offers a dual diagnosis inpatient unit, substance abuse tracks in both partial and psych rehab, and co-occurring case management. Individuals also have access to case management through Luzerne County Drug and Alcohol and Wyoming Valley Drug and Alcohol Treatment Services.

- Community Counseling Services are not required to follow 42 CFR Part 2 regulations.

Data – Arrangements have been made for the 3 PATH funded staff to receive training on the CLARITY HMIS system utilized by the Luzerne County CoC. Once the 3 hour training is completed we will be able to access and start to use CLARITY to enter data into HMIS. Manual data collection will continue through this year with the first year of HMIS data being fiscal year 2017. The Commission on Economic Opportunity is the lead HMIS agency and Roderick Blaine is the HMIS director.

Alignment with PATH goals – The Homeless advocate will go to wherever there are reports of homeless individuals often with representatives of other CoC participating agencies to ensure meeting the diverse needs of the individual or family.

Alignment with State Comprehensive Mental Health Services Plan –

Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

Alignment with State Mental Health Services Plan – The Homeless Advocate working in accordance with the Luzerne County CoC to meet the needs of homeless individuals we encounter. The agencies of the CoC have long used the 'no wrong door' approach to prevent shuttling vulnerable clients from agency to agency. The county's service providers work together on Shelter + Care, permanent supported housing, rapid re-housing programs to decrease interruptions in the lives of homeless individuals and families. Outreach is conducted at programs which serve the homeless and to areas where the homeless can be found begin to form relationships which can turn into successful engagement and enrollment. Community Counseling Services actively participates in Luzerne County emergency preparedness programs and drills. We work with both Luzerne County Emergency Management Agency and the CoC in the planning and implementation of drills for a number of natural disasters i.e. flooding, wildfires. Our participation is to help with rumor control hot line and to make sure that the specific needs of those with SMI and the homeless.

Other Designated Funds – While PATH funds are used exclusively for the outreach and engagement of homeless individuals, many homeless individuals connect with Community Counseling Services through self-referral, Crisis Services, and other methods. Direct referrals to traditional Case Management bypass the Homeless Advocate. These entries into service are funded through county base dollars as well as Health Choices. There are no other funds specifically earmarked for PATH use.

Programmatic and Financial Oversight –

In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Since July 2015 10 SOAR applications have been completed with 9 positive results. We have consulted with other agencies on 6 applications with positive results. We have worked with both the CoC and the Luzerne County Reentry Committee to recruit staff from other agencies to complete the new online SOAR training. We will continue to act in a consultative capacity as other agencies complete the training. Within Community Counseling Services we will train at least 50% of the Case Management Department before the end of 2017.

Housing – Referrals to housing run the gamut from PCBH to CRR's, Transitional Housing, Permanent Supported Housing, Shelter Plus Care, subsidized housing, private housing, and home ownership, based on participant wishes and needs. Agencies include personal care providers, Step by Step, Commission on Economic Opportunity, Housing Development Corporation, Luzerne County Office of Human Services, Public Housing Authorities, Private Subsidized Providers, and private landlords. Rental assistance is available through the Commission on Economic Opportunity.

Coordinated Entry – Development and implantation of a Coordinated Entry System in the Luzerne County is the key focus of the CoC this year. Gathering useful data which eliminates clients retelling their stories will be balanced with privacy and safety concerns raised by medical, psychiatric, substance abuse, and domestic violence providers.

Justice Involved – Approximately 40% of PATH participants have some criminal background. Consumers with a criminal background are presented with challenges when attempting to find permanent housing. Working with the Reentry Committee to identify landlords with favorable histories has been an effective technique. Community Counseling Services provides the Case Management component for the county's Mental Health Court. A key component to the Mental Health Court is a Master Leasing program which allows consumers to gather a good landlord reference after their involvement in the program is completed.

Staff Information – The staff funded through PATH are white, female and over age 50. Many opportunities exist for ongoing training in Cultural Competence through Drexel University.

Client Information – In the 2015 PATH report Community Counseling Services reported 384 individuals contacted through outreach of the PATH funded Homeless Advocate and 143 linked with services at Community Counseling Services or any other community mental health center. Of these individuals 171 were in emergency shelter or living outdoors. Based on past years encounters we would anticipate 2015-16 outreach contacts to total @450 individuals with a linkage rate into services of 25% which would translate to 125 enrolled. Approximately 20% will be staying in emergency shelter or outdoors. The average age of the individuals is 37 and consistent with the make-up of Luzerne and Wyoming Counties the majority will be Caucasian. The sex of individuals is split about 56% female, 43% male, less than 1% identifying as transgendered.

Consumer Involvement – Consumers and families participate in initial planning and development of all services. Each year the county holds many public hearings to accept input for development of the annual plan. Families, consumers and interested parties are able to provide their comments that are included in development of services.

Additionally, the county has an ongoing Mental Health Planning Committee that meets on a regular basis to discuss family and consumer ideas about existing services and their ideas about development of new services. This special group was developed several years ago to give special recognition and opportunity to consumers and families so they are more directly involved in services planning and implementation.

Health Disparities Impact Statement – Efforts to support the Transition Age Youth (TAY) Disparity population by providing the following:

- Expected number of TAY to be contacted is 80, enrolled is 30
- Approximately 8% of PATH funds or $5200
- The types of services funded by PATH that are available for TAY individuals include outreach, screening, linkage, and case management.
- CCS works closely with Children's Service Center and Northeast Counseling (adolescent Mental Health providers) to ensure seamless transition in housing and treatment. We also work with Valley Youth House and Manna House who provide transitional housing to homeless TAY to connect with appropriate services.

Limited English Proficiency –
Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.

Budget Narrative - The entirety of PATH funds is used to fund the Homeless Advocate and a portion of supervisory time for 2 supervisors including SOAR administration time. $33,000 pays the salary of the Homeless Advocate and 29, 499 pays 33% of 2 supervisors salaries. The supervisors participate in CoC meetings, and other meetings related to homeless topics such as the Re-entry Meetings, CJAB meetings, etc. One supervisor is the lead SOAR contact for our agency as well as other providers in the county who need assistance. The Homeless Advocate and Supervisors are located at Community Counseling Services. Total request for salaries is $62499.

There are no requests for fringe benefits, travel, supplies, or other.

Community Counseling Services
PATH Program

FY 2016-2017 Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Housing Case Manager	$33000	1.0		$33000
2 Supervisors	$88497	.3		$29499
sub-total				$62499
Fringe Benefits				
FICA Tax				
Unemployment				
Retirement				
Life Insurance				
sub-total				
Travel				
Local Travel for Outreach				
Travel to training and workshops				
sub-total				
Supplies/Equipment				
Consumer-related items				
sub-total				
Other				
Staff training				
One-time rental assistance				
Security deposits				
sub-total				
Total PATH Budget				**$62499**

34. Mercer County

8362 Sharon-Mercer Road

Mercer, PA 16137

Contact: Anna Shears

Contact Phone #: 7246621550

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID:

State Provider ID:

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 56,180	$ 18,727	$ 74,907	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 56,180	$ 18,727	$ 74,907	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 56,180	$ 18,727	$ 74,907	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 56,180	$ 18,727	$ 74,907	

Source(s) of Match Dollars for State Funds:

Mercer Co will receive a total of $74,907 federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

Estimated Number of Persons to be Contacted who are Literally Homeless: 0

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Mercer County
Comprehensive PATH Intended Use Plan
FY 2017-2018

Local Provider Description

The provider organization receiving the PATH funds within Mercer County is the Mercer County Behavioral Health Commission, Inc (MCBHC). The MCBHC was originally incorporated by the Mercer County Board of Commissioners in 1979 to administer the county's substance abuse services and later to include the mental health and intellectual disability services. As the initial point of contact for the three programs, the MCBHC provides administrative oversight, centralized program intake functions, case management services, mental health emergency crisis services, peer support services, mobile psychiatric nursing services, early intervention services, and prevention education programs. For 38 years the MCBHC has outreached, engaged, intervened, and been a partner in recovery with the targeted population. The MCBHC is a private, non-profit organization that administers the county's Mental Health, Developmental Services, and Substance Abuse services. The organization has long-standing experience and a positive track record of involvement with the targeted population. The region served by the Behavioral Health Commission is Mercer County.

The MCBHC also serves as the Single County Authority (SCA) for drug and alcohol program funding through the PA Department of Drug and Alcohol Programs. As the SCA, the MCBHC is responsible for planning, administering, funding and evaluating the drug and alcohol service programs within Mercer County.

The MCBHC will receive a federal allocation of $56,180 and a state allocation of $18,727 totaling $74,907. The attached line item budget reflects the detail funding for MCBHC. MCBHC subcontracts with one in county provider for PATH funded services and supports. Community Counseling Center (CCC) will receive a federal allocation of $35,000 to support PATH funded services. This is reflected within the attached budget detail under "*Contracts/Purchase Services*" line item.

Mailing Address:
Mercer County Behavioral Health Commission
8406 Sharon-Mercer Road
Mercer, PA 16137

The MCBHC is identified in PDX as "PA-016 Mercer: Mercer County MH/MR, Mercer Co. Behavioral Health Commission"

Community Counseling Center (CCC) is a non-profit agency providing comprehensive community behavioral health services since 1957. Community Counseling Center provides mental health and substance use disorder treatment, rehabilitation and support services through a wide range of services for children, adults, and families. There are service locations throughout Mercer County. A large area of focus for CCC is providing services to individuals with mental illness who are experiencing homelessness or to prevent homelessness. Community Counseling Center assists individuals through Supported Housing, Community Residential Rehabilitation,

Fairweather Lodges, and Enhanced Personal Care Boarding Homes. Please refer to CCC individual IUP for more comprehensive information.

Mailing Address:
Community Counseling Center of Mercer County
2201 East State Street
Hermitage, PA 16148

Community Counseling Center is identified in PDX as "PA-005 Mercer: Community Counseling"

Collaboration with HUD Continuum of Care Program

It is recognized that the Pennsylvania Continuum of Care (CoC) identified goal is to reduce homelessness by 50% by the year 2022. The Housing Coordinator within the Mercer County Behavioral Health Commission has participated in the Western Region Continuum of Care meetings within the 2016-2017 fiscal year. This has provided the agency an opportunity to be a resource of information for the staff within the MCBHC, as well as to the local Housing Coalition. The Housing Coordinator is also an active member and vice-chair of the local Housing Coalition.

Mercer County participates in the monthly Northern Regional Housing Advisory Board meetings. Mercer County will be starting a coordinated entry process, using the coordinated assessment, by 6/30/17. The single-point of entry will allow for an easier flow of assisting homeless individuals within the county.

Additionally, the Housing Coordinator within BHC participates as often as possible in the webinars provided by SAMHSA. This allows the BHC to maintain alignment with not only the state goals, but also with federal expectations.

Collaboration with Local Community Organizations

The local efforts for reducing homelessness within Mercer County are driven by the Housing Coalition. The Mercer County Housing Coalition meets monthly to discuss planning activities, program coordinator initiatives, updates within each organization, and other concerns. The current roster of participants at the Housing Coalition meetings are: Area Agency on Aging, Adult Probation and Parole, AWARE, Behavioral Health Commission, Community Action Partnership of Mercer County, Community Counseling Center, Mercer County Housing Authority, Primary Health Network, Prince of Peace Center, the Self Determination Project, Southwest Legal Services, local Realtors, Wahlberg Family Pharmacy, and Veterans Services.

One of the main functions that the Mercer County Behavioral Health Commission provides is case management. It is imperative that the case management staff is aware of the local community organizations which provide housing supports. The Housing Coordinator within the organization is an additional resource for the case management staff when housing issues arise. Additionally, within the 2016-2017 fiscal year, BHC began a Utilization Review and authorization process for some housing related services. This allows greater oversight to

providers who receive funding from the county for the housing related services and ensures that the dollars received are being utilized effectively.

Below are the key services provided by local community organizations throughout Mercer County which the MCBHC collaborates and coordinates with regularly:

Primary Health Providers

The Mercer County Assistance Office links eligible persons to benefits in order to access health care services in Mercer County. The county has two Federally Qualified Health Centers: Primary Health Network and Sharon Community Health Center. Each provides quality primary care services and access to specialty care to meet the needs of the individuals. The federally qualified health centers offer free services or sliding scale fees to persons who are deemed eligible. Primary Health Network also has Certified Health Care Navigators on staff to assist individuals in applying for medical benefits. Often, individuals who are homeless do not have insurance for medical needs. Having staff that is able to assist with applying for benefits helps to eliminate the barrier to treatment. Additionally, Primary Health Network has received special grant funding specific for providing physical health, behavioral health, and dental services to individuals who are homeless. This grant allows the homeless individual to receive any necessary treatment, transportation to appointments, and may cover costs of medications. The staff is able to connect the homeless individuals with other housing, mental health, drug and alcohol services and supports that may be needed. The Primary Health Network staff who determines eligibility for this grant program is also a Certified Health Care Navigator and is an active member and participant on the Mercer County Housing Coalition meetings.

Mental Health Providers

The MCBHC continues to provide Intake and Assessment, Blended Case Management, Certified Peer Specialist, Crisis Intervention, and Mobile Psychiatric Nursing to persons in need of mental health services. Upon completion of an assessment and level of care determination, individuals are referred to appropriate agencies. Currently, Mercer County's only inpatient mental health provider is Sharon Regional Health System (SRHS). The SRHS inpatient hospital has both children and adult units. Sharon Regional Health System's Behavioral Health Services offer partial programs for children, adolescents, and adults. Outpatient mental health medication management is also provided by Sharon Regional and serves as one of four licensed providers. The three other remaining licensed providers of outpatient mental health services are: Associates in Counseling and Child Guidance, Community Counseling Center, and Paoletta's Counseling Service. Although these providers do not receive PATH funding, with the exception of Community Counseling Center, services are available for persons eligible for PATH.

Substance Abuse Providers

MCBHC continues to provide Intake and Assessment, Case Coordination services, and Recovery Specialist services to persons seeking substance abuse treatment. For those individuals identified as needing a higher level of care than partial hospitalization, a referral is made to an out of county contracted provider for inpatient care. Upon completion of inpatient treatment, the MCBHC Case Coordinator assists in arranging aftercare within the community setting. MCBHC also provides Recovery Specialist services.

Mercer County has two licensed providers of Outpatient and Intensive Outpatient substance abuse treatment. Community Counseling Center, a PATH recipient, and Gaudenzia provides these levels of care for substance abuse treatment. Mercer County also has two licensed Methadone providers. Discovery House, located in Hermitage, PA, and Rainbow Recovery Center, located in Mercer, PA.

Housing

Mercer County has multiple agencies providing a variety of housing supports and services. All of the services, supports, and programs are available to eligible PATH recipients.

MCBHC collaborates with all the supports in the community in order to meet the needs of the individuals. MCBHC specifically provides case management services in order to link, coordinate and monitor services for individuals with mental health, drug and alcohol, and intellectual disabilities. The case management departments are made aware of the community supports through training opportunities, departmental meetings and collaboration with providers.

Community Counseling Center (CCC) offers a wide variety of housing programs. The services specific to housing include: supportive housing services, respite rooms, Enhanced Personal Care Boarding Home, Fairweather Lodges, and full and partial Community Residential Rehabilitation programs. All programs are designed to meet the individuals need and are intended to be structured and recovery oriented. CCC is a recipient of PATH funding to support the housing programs that they offer. Please refer to CCC's Intended Use Plan for more specific details of the housing supports offered.

Other county organizations that offer housing services and supports, but are not subcontracted to provide PATH funded services and supports, include: AWARE, City of Sharon, Good Shepherd Center, Housing Authority, and Joshua's Haven, Mental Health Association, Prince of Peace, and the Shenango Valley Urban League. All individuals served within the other organizations may be eligible for PATH funded assistance and programming as well.

AWARE provides emergency shelter for women, men, and children fleeing from domestic violence situations. The organization partners with schools, allied health, medical and mental health, law enforcement and justice systems, and faith institutions, as part of their larger mission to prevent domestic/sexual violence victims. The Shirley Bursey House can accommodate up to 13 people, and the Williams House can accommodate up to 9 people. Community Action Partnership of Mercer County also leases the Legacy House, a four unit complex, to AWARE for the provision of transitional housing for victims of domestic violence. Residents may stay up to 18 months and are provided services enabling them to move into stable and permanent housing.

The City of Sharon oversees the Community Developmental Block Grant (CDBG) funds. The city of Sharon offers a Housing Rehabilitation Program which provides a low interest installment loan of up to $10,000 for qualified individuals to improve the safety and sanitary conditions of their home.

The Community Action Partnership of Mercer County (CAPMC) offers a wide variety of housing supports and services. Currently there is one housing counselor who assists with housing counseling, senior housing, special needs housing, and single family rental housing.

The agency owns and/or manages 275 units of senior housing at ten locations. This program is for independent living for income qualified seniors ages 62 and older. Additionally, the agency owns and manages 22 units of special needs housing at five locations. Such special needs housing includes: Florence Street Apartments, Independence Park, and Permanent Supported Housing for Persons with Serious Mental Illness inclusive of eight units at two locations in which Community Counseling Center provides the supportive services. Additional mental health housing consists of nine units at four locations for persons with mental health issues. This project was developed with financial support from the MCBHC. Single Family Rental Housing is yet another housing option provided by CAPMC offering decent, safe, and affordable housing for five families. Rents are subsidized and based on household income. Further, CAPMC is a certified HUD Housing Counseling Agency and provides such services under contract with the Mon Valley Initiative, the PA Housing Finance Agency, and the City of Sharon.

Additionally, CAPMC assists military veterans who are experiencing a housing crisis. CAPMC employs a veteran who does street outreach, assists veterans in navigating the VA, and links veterans to additional supports offered by the VA.

The Good Shepherd Center addresses the physical needs of the economically challenged in the greater Greenville area. Greenville is located in the Northern part of Mercer County. Services offered include: food pantry, thrift store, hot meals program, free medical clinic, and limited emergency housing/utility assistance. The medical clinic serves Greenville community members who have no Medical Assistance or other insurance and fall within the income guidelines. If an individual goes to the Good Shepherd Center and is in a housing crisis, Good Shepherd Center can pay for lodging for one night and works with other agencies to coordinate housing services.

Mercer County Housing Authority (MCHA) administers the Homeless Prevention and Rapid Re-Housing program. MCHA also oversees Section 8 and public housing. To date there are 19 housing units available throughout the county which are managed by the Housing Authority.

Joshua's Haven City Mission serves as the only emergency and temporary shelter in Mercer County for homeless men. Joshua's Haven provides warm meals, hygiene facilities, counseling, a Christian-based environment, skill building programs, vocational assistance, individual case management, transportation, and referrals.

The Mental Health Association of Mercer County has been a long standing community agency providing Representative Payee services for individuals with mental illness. The organization has expanded their program to include housing services. They currently have two locations which provide a shared living situation where individuals have their own bedrooms and share the living areas, bathrooms and kitchen. One location has three bedrooms and the other currently has five. They are still in the process of expanding the one location to house more individuals as well. Additionally, Mental Health Association offers four individual apartments. Three of which are Section 8 approved.

Prince of Peace provides emergency services, Family Supportive Services (FSS), thrift store, and food services. One service provided to the community is the AWESOME (Assistance With Education, Shelter, Organization, Money management, and Employment) program. The program provides the attendees with educational classes on a wide array of topics, including

proper nutrition, financial planning, and informed decision making. When an individual successfully completes the class, they are awarded $125.00 to be put towards a utility bill or rent.

The Shenango Valley Urban League exists to ensure equal access and opportunity for African Americans and others in need. The Urban League provides comprehensive housing counseling services as they are a Certified HUD Counseling Agency. The Urban League assists in locating decent, affordable housing and provides rental education, delinquent/default counseling, and budget counseling. Additional housing services provided include, but are not limited to: Homeowners Emergency Mortgage Assistance Program (HEMAP), Emergency Shelter Program, and can assist with one month rent or security deposit.

Youth Advocate Program (YAP) is offering two mental health housing support services: Mental Health Habilitation, and Mental Health Chore and Homemaker Services. One of the identified needs for housing supports was for a "hands on" approach in order to assist individuals in maintaining independent living. The MH Chore and Homemaker service helps an adult with mental health challenges maintain their home in a clean, sanitary, and safe condition. This service may include: washing floors, windows and walls; yard maintenance; moving heavy furniture which may be blocking exits; and other needs that the individual identifies.

The Mental Health Habilitation Service assists adults with mental health challenges in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the home and community.

Employment Providers

Mercer County Career Link provides a variety of career services to job seekers including, but not limited to: resume preparation, job searching resources, employment advocates, and unemployment compensation applications. The Office of Vocational Rehabilitation, Veterans Affairs, and Aging Division of Employment services also exist.

An employment provider is CCC, a recipient of PATH dollars. After an individual completes the assessment through the Office of Vocational Rehabilitation, they can be referred to CCC for employment services. CCC provides Employment Resource Specialists (ERS). ERS is an employment placement service benefitting both the potential employee and the potential employer. ERS will assist with interviewing candidates, provide on the job training and educate potential employers about the benefits of hiring individuals with disabilities. CCC's vocational services assist individuals with disabilities to find and maintain gainful employment. The largest disability group served is behavioral health consumers; however, also served are the blind or visually impaired, deaf and hard of hearing, physically disabled, and developmentally disabled. Services vary depending on the client's needs. Services are delivered based on need and include, but are not limited to: Pre-Vocational Training, Job Development, and Job Coaching.

Other employment providers within Mercer County include Youth Advocate Program and St. Anthony's Point. Both providing Pre-Vocational Training, Job Development, and Job Coaching services for individuals with disabilities. Those providers are not recipients of PATH dollars, but are available for individuals who are eligible for PATH services.

Service Provision

PATH funded services are provided to those deemed literally homeless and to those who are in danger of being evicted which may result in homelessness. Housing services related to planning of housing, costs associated with matching eligible homeless persons with appropriate housing situations, technical assistance in applying for housing assistance, improving the coordination of housing services, re-establishment of utility services, and one-time only assistance with security deposits or first month's rent are PATH funded services provided to individuals who meet criteria of "literally homeless" and those at "imminent risk of homelessness" as a priority population. PATH funds are never paid directly to the PATH individual, but are paid directly to the vendor.

The MCBHC maximizes the use of PATH funds for the individuals being served because they are also receiving services and supports of Mental Health Blended Case Management, Mental Health Certified Peer Specialist, Drug and Alcohol Case Coordination, and/or Drug and Alcohol Certified Recovery Specialist services. The funds that support those programs are provided by the Managed Care Organization and base funds from both the Mental Health and the Department of Drug and Alcohol Programs.

When a consumer receiving services through MCBHC is also experiencing a housing crisis, a referral to the PATH program is made. During the time of determining PATH eligibility, the PATH Coordinator will meet with the staff person who is making the referral in order to discuss additional supports that the individual may benefit from. Examples of additional services would be educational classes provided by a variety of organizations or suggested linkages with other housing supports within Mercer County. The case manager would assist the individual with applying for those classes or making referrals for additional housing supports.

Gaps existing within the current service system include emergency housing specific to: women with children, men with children, and entire family units, as well as, single women. A sub-committee of the Mercer County Housing Coalition has been pursuing funding to address the family unit issue. At this time, the committee continues to search for a suitable building and location for this project. Historically, one barrier for identifying a location is the lack of local community support for a homeless shelter. The community members' statement continues to be that they are aware there is a concern about homelessness, but they do not want a shelter by their own home.

A second identified gap is reaching the transitional age youth as they appear to fall between the cracks as they age out of the adolescent mental health system and make the decision to drop out of services as they reach adulthood. As they attempt to survive independently, on many occasions they meet obstacles in achieving a self-sufficient, healthy and satisfying life. In regards to housing, this priority population begins to "couch surf"- living in households in which their name does not appear on the lease. Due to HUD changing the definition of homelessness, couch-surfing is no longer considered being homeless. Therefore, those individuals would not qualify for HUD homeless housing services.

Finally, securing housing for individuals with mental health diagnosis and having criminal histories (felonies and sex offenders) remains problematic.

Services for individuals with co-occurring disorders of mental health and substance abuse are available at a variety of providers throughout Mercer County. Individuals experiencing a co-occurring mental illness and substance abuse disorder can access appropriate treatment through the Base Service Unit of MCBHC, also known as the Central Intake Unit. MCBHC remains the gatekeeper and initial point of contact for persons in need of such services. The assessment process is conducted to ensure that individuals with co-occurring needs have access to services in a full continuum of care by identifying, referring, and authorizing appropriate levels of care. The Central Intake Unit provides intake, evaluation, and referrals. As previously mentioned, MCBHC does have Certified Recovery Specialist services and Drug and Alcohol Case Coordination for drug and alcohol services in addition to the mental health services available. The staff are cross trained in both substance abuse and mental health co-occurring disorders in order to be better prepared to address the specific needs of this population. The case management supervisors are also cross-trained and supervise both mental health and drug and alcohol staff. This cross-training allows the staff and supervisors the knowledge of resources available and knowledge of skills in working with the dually diagnosed populations. MCBHC works collaboratively with Community Counseling Center which is the only local provider with a dual license for providing outpatient drug and alcohol services and mental health services. Additionally, the MCBHC contracts with multiple co-occurring residential treatment providers. All of those providers are outside of Mercer County.

The Housing Coordinator at MCBHC participates regularly in the webinars made available through the Homeless and Housing Resource Network in order to keep apprised of new services, issues and programs. MCBHC was awarded a grant to provide training of Motivational Interviewing. This evidence-based practice training was offered throughout all of the Human Service agencies within Mercer County. One of the goals of having this training is to gain a "universal language" in which we work with individuals receiving services. Having a 'universal language' can support the work of changing attitudes and behaviors in order to improve quality of lives.

Additional trainings that are offered by the Department of Drug and Alcohol Programs, as well as the Office of Mental Health and Substance Abuse Services are offered to MCBHC staff and providers throughout the year. Examples of trainings include areas such as: Dual Diagnosis, PTSD and Addiction, and Forensics and Addiction.

Staff monitors the websites for upcoming trainings and register for them as they become available.

The MCBHC is an agency required to follow 42 CFR Part 2 Regulations governing the confidentiality of patient records and information. Client confidentiality is a crucial part of the daily activities of the staff working with the substance abuse populations. Confidentiality is maintained by the use of valid consent forms which captures all the required elements as per the Department of Drug and Alcohol Programs Treatment Manual, Section 9.10. Additionally, client records, service notes, and treatment plans are maintained within an encrypted electronic health records system called Susquehanna.

Within the 2016-2017 fiscal year, the MCBHC has begun coordinating with individuals being released from the county prison who meet the criteria for Vivitrol. A Vivitrol van comes to the MCBHC twice a month in order to provide the Medical Assisted Treatment and link individuals

with ongoing outpatient treatment within the community. Because the van is located at the MCBHC, the individuals are able to have immediate access to the Central Intake Unit where additional referrals can be made to other community mental health, drug and alcohol, and community resources in order to have a continuity of care.

Mercer County recognizes that there are a large number of inmates incarcerated within the county jail who have mental health and/or drug and alcohol concerns. In working to address this, the President Judge requested an increase in supportive services to reduce the number of individuals in the jail who have committed crimes because of unaddressed mental health and/or drug and alcohol conditions. Subsequently, a new Jail Pilot program was developed. Mercer County Behavioral Health Commission (MCBHC), in conjunction with the probation and parole office and the county jail, has been increasing supports within the 2016-2017 fiscal year. The pilot program works to ensure that a full continuum of services and supports are in place prior to release from prison. The team, consisting of a case manager, peer specialist, recovery specialist, and a probation officer, meets with the identified inmate one month prior to release from jail. The team ensures that outpatient appointments are scheduled and begins the enrollment process for Medical Assistance benefits prior to release to the community. Once released, the team maintains close contact with the individual to support him or her within the community.

The MCBHC continues to provide co-occurring MH/DA intervention within the county prison. The Forensic Intervention Specialist conducts mental health and drug and alcohol evaluations per court orders, mental health psycho-educational groups, coordinates mental health hearings, as needed, at the jail for involuntary commitments, and is able to make referrals prior to release from the jail for outpatient services, case management, peer support, and other supportive services that are available. For fiscal year 2015-2016, a total of 273 inmates were assessed. The breakdown of assessment types provided is: 159 Drug and Alcohol, 32 Driving while Under the Influence, 30 Mental Health, and 52 Dual. In addition to the assessments, psycho educational groups were provided. A total of seven Drug and Alcohol psycho-educational groups were provided. There were a total of 56 participants in those seven groups.

Data

The MCBHC has been entering data into HMIS since December 2011. CCC is also an established user of HMIS. All PATH eligible individuals are entered into the HMIS system, currently using ClientTrack. The Housing Coordinator at MCBHC has been trained on entering data in ClientTrack. As additional training for updates occur the Housing Coordinator participates in order to stay apprised of any new requirements or updates to the system.

Alignment with PATH goals

The MCBHC does not currently provide street outreach. A large part of the homeless population of rural Mercer County is not on the street, but rather couch-surfing.

Individuals who are receiving Mental Health Blended Case Management, Drug and Alcohol Case Coordination, Drug and Alcohol Recovery Specialist, and Mental Health Peer Specialist services through the MCBHC are eligible to receive PATH funded services, if they meet the PATH eligibility criteria. The Case Management department staff are aware of PATH funded

services being available. The Case Managers meet with the PATH Coordinator and will make a referral for PATH assistance in order to provide support to the individual who may be at risk of homelessness, or who is homeless.

Alignment with State Comprehensive Mental Health Services Plan

Services provided within Mercer County related to housing are consistent with the State Comprehensive Mental Health Services Plan. The housing agencies available within the county coordinate services and promote targeting the resources available. Additionally, assessing the effectiveness of the current housing services is completed on a regular basis. The Housing Coalition supports all the local efforts to end homelessness. The collaborative agencies are always engaging in efforts to work towards ending homelessness to a functional zero. Additionally, all mental health and drug and alcohol housing services provided in Mercer County are recovery-oriented. Those recovery-oriented services are fostering empowerment of the individual to understand what recovery means and how stable housing promotes and builds their personal recovery.

The Housing Coordinator within the Mercer County Behavioral Health Commission plays a major part in the coordinating, planning, and writing of the mental health services plan section within the Mercer County Human Services Plan. Because of this, the narrative of the mental health section is all inclusive of housing supports provided in Mercer County including PATH funds. It is widely known that the Housing First approach is the most effective way to improve individual mental health recovery. As case managers meet with mental health consumers, housing is always at the forefront of service planning and coordination of services in order to ensure that individuals are receiving the housing supports needed.

Alignment with State Plan to End Homelessness

The Mercer County Behavioral Health Commission (MCBHC) provides multiple services and supports which are consistent with the state initiatives to prevent or reduce homelessness. The PATH Coordinator/Housing Coordinator and the case management departments link homeless individuals, or individuals who are at imminent risk of homelessness, with supports and services that exist within the county. The support provided is to encourage the individuals and family's to not cycle back into the same situation of facing a housing crisis. Additional support that is provided by MCBHC is direct financial assistance for individuals who are facing eviction, or who are currently homeless. The financial assistance is never paid directly to the individual, but rather to the vendor. This financial assistance is most frequently used for first month's rent, rental assistance to prevent an eviction, or utility assistance.

The staff providing the services through MCBHC are providing case management services and are able to identify homeless, or at risk of homelessness, individuals throughout their daily work functions. When individuals are identified as possibly qualifying for PATH services, the MCBHC staff will meet with the PATH Coordinator in order to make that determination and referral.

Individuals and families are referred to other providers who may be offering classes, such as: building budgeting skills, tenant/landlord agreements, or how to find an apartment. The campaign of United Way of Mercer County is "Lifting Families Out of Poverty". The organizations throughout Mercer County who receive funding from the United Way are encouraged to provide learning sessions. Those sessions are geared to promote financial stability and independence. By providing ongoing learning sessions and educational opportunities, people within the community, both those with mental health conditions, and those without, will be less likely to become homeless or to face eviction. The Behavioral Health Commission has been a long-standing member of the United Way and supports those efforts.

MCBHC has an excellent collaborative and working relationship with the Mercer County Department of Public Safety and that Program Director. The PATH Coordinator has met with the Director of Public Safety in order to discuss the County disaster response plan and what the response would be for homeless individuals. Mercer County has 76 emergency shelter locations throughout the county. In the event of a disaster where evacuation would be needed, the Red Cross would identify which location(s) would be opened for accepting evacuees. The police officers and other public safety staff would assist with identifying individuals who are at the most risk of needing assistance, which includes those who are homeless, and would provide that assistance to secure safety. When needed, the Department of Public Safety would coordinate services and activities related to disaster response with the PA Disaster Mental Health and Human Services Coordinator, Natalie Herberg.

The MCBHC also has representation on the County Emergency Operations Center and participates within those planning meetings and efforts in order to provide behavioral health, substance abuse, and intellectual disability representation. The county often utilizes and calls upon the MCBHC Critical Incident Response Team (CIRT). The team is often called out to situations within the county where behavioral health intervention may be needed. As a sub-group of CIRT is the Disaster Crisis Outreach and Response Team (DCORT). This state trained team is utilized for more specific disasters and would be utilized as part of the County Disaster plan, if needed. The PATH Coordinator at MCBHC is trained and actively serves on both CIRT and DCORT. Additionally, one employee at the Community Counseling Center serves on both CIRT and DCORT.

There are multiple individuals, groups, organizations, and churches who participate and are trained for CIRT. As of 5/10/17, there are 20 individuals trained in the basic National Organization for Victim Assistance (NOVA), 8 have the advanced NOVA training, 14 DCORT trained, 13 Psychological First Aid, and 55 in Grief and Bereavement. The PATH/Housing Coordinator at the MCBHC has received all trainings listed above.

Community Counseling Center provides regular emergency drills within their housing programs. This will be enhanced within the upcoming year to include additional emergency situations. This allows the residents within the variety of homes an opportunity to learn about emergency preparedness and practice it. As those individuals move to the community and to lesser restrictive settings, they have been afforded those educational and practice opportunities.

Other Designated Funds

Mercer County is not a Block Grant county. As stated previously, the MCBHC maximizes the use of PATH funds for the individuals being served because these individuals are also receiving services and supports of Mental Health Blended Case Management, Certified Peer Specialist, Drug and Alcohol Case Coordination, and Certified Recovery Specialist services. The funds that support these other programs are provided by the Managed Care Organization and base funds from both the Mental Health and the Department of Drug and Alcohol Programs, but are not earmarked for PATH services specifically.

MCBHC also receives federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars. Those funds are used for Case Coordination, Prevention and Intervention/Treatment of alcohol and drug use. Those funds are not earmarked for PATH services specifically.

Programmatic and Financial Oversight

Within the MCBHC, financial oversight is provided to the program. Housing and PATH related service expenditures are coded to a separate cost center to enable the financial information for this program to be tracked and monitored. Additional oversight is provided by the Chief Financial Officer who reviews and approves PATH dollars needed to support PATH referrals for services.

Mercer County Behavioral Health Commission is familiar with the services CCC is providing to their supported living/housing program related to PATH individuals. Monthly invoices and their annual audit are reviewed. Please refer to Community Counseling Center's (CCC) IUP for additional information related to how that agency monitors the utilization of PATH dollars.

Additional programmatic and financial oversight is provided by the State PATH Coordinator. An annual on-site monitoring is completed for all the PATH recipient organizations in Mercer County.

SSI/SSDI Outreach, Access, Recovery (SOAR)

There are currently five known Mercer County staff trained in SOAR. The MCBHC PATH Coordinator received the certification on 12/26/14. To date, there were no PATH funded consumers assisted using SOAR at the MCBHC because all the PATH funded individuals receive SSI or SSDI, and/or are employed.

SOAR can be very time burdensome. The staff who are currently employed at the MCBHC are unable to take on additional responsibilities to successfully complete SOAR applications. Unfortunately, due to this reason, MCBHC has not had any SOAR applications completed.

Housing

PATH funded staff are kept apprised of the various housing services available within Mercer County. Staff is able to make appropriate referrals and linkages based on the information they are provided and knowledge of the local county housing providers which are listed in the "Collaboration with Local Community Organizations" section of the Intended Use Plan. Both

agencies that receive PATH funds actively attend and participate in the monthly Housing Coalition meetings which allow everyone to be kept apprised of other housing agencies, projects and programs in the area. Please refer to the above information for specific agencies providing housing services and supports within Mercer County.

Coordinated Entry

Mercer County is a part of the Northern Regional Housing Advisory Board. Beginning 6/30/17, Mercer County will be utilizing a Coordinated Entry Program as a part of the CoC. Within the next month further information and processes will be developed related to this new system.

An additional human services resource that has been available in Mercer County is "211". This United Way funded service provides individuals who call in resources available within the county related to the identified need. One of the most frequently requested service is related to housing needs.

Justice Involved

The Criminal Justice Advisory Board (CJAB) of Mercer County was awarded funding for Crisis Intervention Team (CIT) training. The grant dollars will be available through PCCD in order to cover the cost of staff time for the training. At this time, a sub-committee of CJAB has received the template for the training curriculum and will be designing it to be specific to Mercer County.

Staff information

Specific to MCBHC, PATH is administered by one individual housed within the MCBHC. There is a total of 92 part-time and full-time staff employed by the MCBHC. 82% of the workforce is comprised of women and 18% men. Regarding race, 99% of the staff are Caucasian and 1% are Black. Please reference CCC's Intended Use Plan for the respective staff demographics.

The PATH organizations provide their staff with regular trainings to keep up to date of the changing culture and to maintain cultural sensitivity. At least one Mercer County PATH staff is registered with the Think Cultural Health in order to stay apprised of upcoming trainings and ensure that agency staff that is serving the targeted population is able to address any health disparities and maintain cultural competency.

Trainings are made available to staff through a variety of venues that include: on site trainings, conferences, regional meetings, webinars, PATH technical center, etc. Training opportunities on effective outreach such as being person-centered, recovery oriented, and highly informed on trauma, as well as gender, age, and cultural competency are highly valued within the MCBHC.

Client information

The individuals served in the PATH program will have either a mental health disorder, or a co-occurring substance abuse and mental health disorders. The age range of PATH clients being served are those 18 and over. Clients served by PATH funds are typically at imminent risk of homelessness. They are generally either "couch surfing", doubled-up living arrangement where

their name is not on a lease, living in condemned/substandard dwelling and have no other place to live, living in temporary or transitional housing that has time limits for length of stay, received an eviction notice, or those being discharged from health care facility or criminal justice institution without a place to live. Others served are those considered "literally homeless". This refers to individuals who are staying in a temporary shelter, or those who are in transitional housing.

It is estimated the total number of individuals to be contacted, or to contact BHC and CCC will be 115. The organizational breakdown of the total number contacted is:
Behavioral Health Commission- 20
Community Counseling Center- 95

It is estimated that the total number of individuals in Mercer County who will become enrolled in PATH services in the upcoming fiscal year will be around 73. Estimating that of those 73 clients, 75% will be literally homeless. The organizational breakdown of the total number is:
Behavioral Health Commission-28
Community Counseling Center- 45

The unduplicated number of individuals (18 and older) enrolled in Blended Case Management, Peer Specialist, Drug and Alcohol Case Coordination, and Drug and Alcohol Recovery Specialist services within the 2016-2017 fiscal year (enrolled through 5/10/17) is 459. Of the individuals enrolled in the services identified above provided by the Mercer County Behavioral Health Commission, 26 individuals were enrolled in the PATH program. This equals 6% of individuals served at MCBHC received PATH funded services.

Demographics of PATH individuals (26 individuals) served through the BHC from 2016-2017 fiscal year (enrolled through 5/10/17):

Age:		**Race:**		**Ethnicity:**		**Gender:**	
18-45	58%	**Black or African American**	12%	**Non-Hispanic/Non-Latino**	96%	**Male**	38%
46-62	35%	**White**	85%	**Refused**	4%	**Female**	62%
63+	8%	**Refused**	4%				

Consumer involvement

The New Freedom Initiative (NFI) is Mercer County's Community Support Program. The local committee is comprised of 50% of individuals in recovery from mental health disorders and/or co-occurring disorders. NFI is partly responsible for developing the local Human Service Plan where housing is a component within the plan and is a well-known problem area for many of the individuals receiving services. Many of the individuals who participate in the monthly NFI meetings have had housing crisis experiences. These lived experiences can assist with providing that unique and specific perspective. NFI reports to the county Administrative Entity and to the Behavioral Health Commission administrator any proposals, concerns, areas of need, etc. that would assist in the recovery of individuals with mental health and/or co-occurring disorders.

Additionally, local Mercer County mental health consumers attend the Western Regional Community Support Program (WRCSP) monthly. One of the committee's formed within the WRCSP is a group addressing homelessness and looking at ways to end homelessness. The ideas and suggestions shared at the WRCSP are shared at the local NFI committee. There is also representation at the WRCSP meetings by OMHSAS who are also able to hear what the mental health consumer's ideas and planning efforts and thoughts are.

Health Disparities Impact Statement

It is estimated that the unduplicated number of Transition-Age Youth (TAY) served using PATH funds in Mercer County is expected to be three. The MCBHC estimates the amount of PATH funds used to assist the TAY individuals to be $800.00. The PATH funded services for TAY are the same services provided to non-TAY: first month's rent, security deposit and utility assistance. Additional services are referrals to other agencies to provide assistance with obtaining and maintaining independent living. Supports offered through other agencies include supportive housing, housing counseling, outreach services, staff training, psychiatric rehabilitation, referrals to community mental health services, which may include case management, and additional housing supports. All services are used in order to prevent homelessness, or to establish housing and are never paid directly to the individual.

A sub-committee of NFI is the Transition-Age Workgroup (TAWG). TAWG was developed many years ago in effort to identify and address the needs faced by the Transition-Age Youth population. This has proven to be very challenging for the committee and involved agencies. One major area of difficulty is getting individuals within the ages of 14-26 to participate and attend any meetings in order to share their specific needs. TAWG has proposed a number of options to address needs of this population. Some of the suggestions are: Big Brother/Big Sister program, Youth Peer Specialist, or Transition Age Coordinator.

TAWG developed a resource directory of services available within Mercer County for this population. This resource directory is being distributed in multiple places throughout the county, including, but not limited to: mental health providers, schools, churches, and libraries. It is also posted on the MCBHC website. The use and availability of the resource directory is one effort completed by this workgroup.

The most recent work completed by TAWG was a Needs Assessment. This assessment was completed separately by schools, providers, and individual TAY. There were 17 respondents between the ages of 14-26 who completed the survey. Below are the responses related to housing by the TAY:

1. Most respondents live with their family (10).
2. Three respondents live in a group home and three live in a CRR.
3. The living situation for most respondents in the past is with family (9).
4. Most respondents (8) have received some type of assistance with living situation.
5. Most common problem in obtaining/finding a place to live was due to income/employment.
6. Three respondents identified having no problems with finding a place to live.
7. Most respondents (9) do NOT want help finding place to live.

Below are the needs identified by the schools and providers:

Category Need	School	Provider	Total
Continuing education/volunteer/employment	41%	50%	47%
Independent Living Skills/Housing	18%	63%	47%
Assistance with services/TAY Coordinator	29%	43%	38%
Transportation	18%	23%	21%
Autism	0	23%	15%
Mentoring program	24%	0	9%
MH/ID	0	13%	9%

There are ongoing efforts by local administrations for identifying how to address the specific needs for the transition age youth population. The data provided by the Needs Assessment has been one strategy for guiding this process.

Limited English Proficiency

At this time, Mercer County has not required the need for assistance in providing meaningful access to limited English proficient persons within the PATH program. All individuals served speak English as their first language or when it is not, are proficient in speaking and understanding English. If the need does develop, resources available include Mango. This is a translating service which is free, or Language-Line, which is a fee for service cost. Additionally, for individuals who may be in need of sign-language, Community Counseling Center (a PATH recipient) is able to provide American Sign Language interpreters.

Budget Narrative - 2017-2018

The money received through the contract with Behavioral Health Commission (BHC) will be used for salaries and benefits of the case workers who will be assisting the persons referred for services. Within BHC, a portion of PATH funds are also utilized for one-time rental payment, special needs, or security deposit to prevent eviction. The PATH coordinator at MCBHC will also ensure that referrals are being made to local agencies, as needed and accepted, for such areas as budgeting skills, independent living skills, mental health services, drug and alcohol services, etc. The overall budget consists of: $56,180-federal allocation and $18,727-state match allocation. The budget does not include local match required for state portion of the budget.

Personnel & Employee Benefits

This line item includes the cost of salaries for two individuals. One individual works as an intake case manager who assists with homeless outreach activities. The other position is the PATH Coordinator who coordinates housing/path related items in the County and works with providers to assist the system at large. Employee Benefits include the costs associated with the two individuals listed under the salary line item. These are based on actual costs and our listed out in detail.

Travel

This line includes travel at .40 cents per mile which is our current agency reimbursement rate for use of personal vehicles. If an agency vehicle is used the rate is 53.5 cents per mile, which is the 2017 government reimbursement rate. This line item includes attending meetings for our PATH Coordinator.

Contracts/Purchase Services

MCBHC will be contracting with one local provider for PATH funded services for 2017/2018.

Community Counseling Center – Supported Housing Services for this population are funded with Path dollars. Community Counseling Center is estimating contacting 95 individuals in the upcoming fiscal year. Of those individuals, estimating that 45 individuals will become enrolled in PATH.

Supplies

Office Supplies – Basic supplies to run the program and to provide training material.

Other

Habilitative Supplies – This line item addresses the needs of homeless individuals to assist in various housing needs to prevent homelessness. These items include: one time rental payments, transportation, temporary overnight respite, and security deposits.

Program Development – special events including in-house trainings

Occupancy

This line item includes work space for employees attributed to the PATH Program.

Mercer County
FY 2017-2018 PATH Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Housing Coordinator	43,979	.30 FTE	$13,194	$13,194
Case Manager	36,206	.16 FTE	5,793	5,793
sub-total			**18,987**	**18,987**
Fringe Benefits				
FICA Tax			1,453	1,453
Health Insurance			8,837	8,837
Retirement			1,329	1,329
Life, Disability & Misc. Benefits			340	340
PA Unemployment			147	147
Workmen's Compensation			126	126
sub-total			**12,232**	**12,232**
Travel				
Travel to trainings and meetings			567	567
sub-total			**567**	**567**
Contracts/Purchase Services				
Community Counseling Services			35,000	35,000
sub-total			**35,000**	**35,000**
Supplies				
Office Supplies			705	705
sub-total			**705**	**705**
Other				
One-time rental assistance			5,791	5,791
Occupancy			1,625	1,625
sub-total			**7,416**	**7,416**
Total PATH Budget				**$74,907**

35. Mercer County - Community Counseling Center

2201 E State St

Hermitage, PA 16148

Contact: Fran Billen

Contact Phone #: 7249816193

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID: PA-005

State Provider ID: 4205

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**$ 0**	**$ 0**	**$ 0**	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0**	**$ 0**	**$ 0**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0**	**$ 0**	**$ 0**	

No Data Available

d. Equipment	**$ 0**	**$ 0**	**$ 0**	

No Data Available

e. Supplies	**$ 0**	**$ 0**	**$ 0**	

No Data Available

f. Contractual	**$ 0**	**$ 0**	**$ 0**	

No Data Available

g. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Community Counseling Center will receive a total of $35000 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 95

Estimated Number of Persons to be Enrolled: 45

Estimated Number of Persons to be Contacted who are Literally Homeless: 71

Number staff trained in SOAR in grant year ending in 2017: 1

Number of PATH-funded consumers assisted through SOAR: 0

Local Provider Description

Community Counseling Center of Mercer County is a Comprehensive Mental Health Non-Profit agency. It is located at 2201 East State Street, Hermitage, Pa. 16148. We are identified in the PDX as Community Counseling Center. The agency has been providing community services to persons with mental illness for 60 years. The Residential Services specifically Permenent Supportive Housing was started in the late 1990's. Community Integration Services were available in the early 1980's with its Community Residential Program. All services are available to any resident of Mercer County with housing services provided in both the urban and rural areas. Annually the agency receives $35,000 in PATH Funding. This funding is used to provide housing services to individuals with mental illness living in the county who are homeless or at risk of being homeless. The funds are used to maintain staff members that assist eligible individuals locate and secure safe affordable housing. If unable to provide services to any individual, the staff member will complete a referral to an agency that could provide those services. Also, the staff members provide Outreach Services through the members of the local Housing Coalition, the churches and other local contacts in the county.

Community Counseling Center of Mercer County is able to provide these services through a contract with the Behavioral Health Commission of Mercer County

.

Collaboration with HUD Continuum of Care (CoC) Program

The Community Integration Services Administrator of Community Counseling Center is a member of the Governance Board of the Western Region CoC 601. The Governance Board meets quarterly to discuss relevant issues. As a member of the CoC, the administrator represents the Mental Health component of the Northwest Region. The Coc has been working on the Coordinated Entry and Assessment Process. A pilot program had been started last year in 5 counties within the Western Coc. This year by June 30, 2017 each county must identify which agency in that county will be conducting the Coordinated Entry Assessment.

As a member of the Northwest RHAB board, the CIS Administrator attends the monthly meetings either by phone or in person at Stairways in Erie, Pa. Locally, the CIS Administrator is the Treasurer of the Mercer County Housing Coalition. The local

Housing LHOT for Disabilities is a sub-committee of local coalition and meets on a as needed basis. As part of her responsibilities as a member of the Coc , she is to relay information from the RHAB and Coc to the local coalition as well as keeping them updated of relevant posting to the state website and training available. The administrator is keeping the regional entities updated on the activities of the Mercer County Housing Coalition that affect the Coc and housing opportunities.

Collaboration with Local Community Organizations

The local housing coalition has an active membership which includes the following agencies: Community Counseling Center, The Behavioral Health Commission, Veterans Services out of Butler, Pa., Community Action Partnership of Mercer County, AWARE, Prince of Peace Center, Adult Probation and Parole, Primary Health Care, the Self Determination Project, the Mercer County Housing Authority, Northwest Legal Services and local Realtors.
The coalition provides the opportunity for agencies to network and share resources that are available. Through the membership, documentation of the number of homeless individuals being served in the Mercer County area monthly is distributed and discussed. Also provided at the meeting is information from the RHAB and CoC regarding new funding, additional housing options and trainings. Discussion will occur at this meeting to determine which agency can best fullfill the Coordinated Entry Assessment duties and position.

Because of the relationship amongst the members of the Coalition, when an agency has a person that they are unable to service, that agency is able to make an appropriate referral. The outreach of one agency provides referrals to other services to ensure that an individual has access to assistance from all resources in the area. Referrals can be made to Community Counseling Center for Mental Health Services, or Domestic Abuse Victims for shelter through AWARE, and others such as those seeking Veterans Services will be made to Community Action Partnership' for their specialized programs. This network of agencies coordinates referrals to assist those in need to navigate the multi resources with less frustration. 211 is also utilized in the area to refer individuals for appropriate services.

Service Provision

Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

How the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless

Through the use of PATH funds, Community Counseling Center of Mercer County is able to support the staff needed to do the outreach into the community to locate and assist those who are have a Mental Health Diagnosis and are homeless. Our staff is able to meet the individual wherever they are as transportation is limited especially in the more rural parts of the county. Once the staff have completed the initial contact with the individual and have determined their eligibility into the program their needs can be assessed and the necessary referrals completed. We can also arrange for Emergency Housing if available and needed.

PATH funds are used to support the staff assigned to the Emergency Shelter unit and the 30 day Respite Rooms for Mental Health individuals who are homeless. The staff are able to assess the needs of the persons and make the needed referrals. They are able to start the process to help them find and secure safe affordable housing and to access the resources available in the community. Once enrolled in the Supportive Housing Program, County Base Funding for Mental Health Services is used to support the person. Also Medicaid dollars will be access to provide therapy and medication management as well as other rehabilitation services.

Specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services

Community Counseling Center of Mercer County has been contracted as the Sub-Grantee in four HUD grants with the first starting in 1999. We have provided the Outreach Services with use of PATH Dollars to support the staff in the following ongoing projects:

- Permanent Housing with Supports for 8 single individuals with Mental Illness with Community Action Partnership of Mercer County.
- 16 Shelter Plus Vouchers with the Mercer County Housing Authority to provide housing for individuals with Mental Illness and their families.
- The 811 project built through the Community Action Partnership of Mercer County. This project is for individuals with mental illness. The

project is 8 single apartments and 2 two bedroom apartments for those with families.

- Housing Now is a collaboration with CHAPPS of Crawford County to provide housing for five Chronically Homeless Persons with Mental Illness. This is a master leasing project.

Gaps that exist in the current service systems

Over the past years, the housing gap in Mercer County has not changed. We continue to experience an increasing number of homeless families and individuals without the shelter beds to accommodate them. It has been the goal of the housing coalition to establish a shelter for these individuals with no success due to the lack of funding and an agency willing to assume the liability. Today we also are dealing with a large number of individuals in the Criminal Justice System, who are both Homeless and Mentally Ill. Because of the crime or crimes they have been convicted of, it limits their options for housing.
At the present time, Community Counseling Center has one efficiency apartment designated as a 30 days shelter for families and individuals. We also have two respite rooms located at our Mercer Community Residential Rehabilitation Facility which are a 30 day stay. AWARE has two shelters in the county but they are only for Domestic Violence. We have three private shelters for men in the county. Many agencies or faith based communities, have small amounts of money that can be used to shelter a homeless family or individual for a night or two at the local hotel but that money is quickly spent.
To address the needs of those in the Criminal Justice System, the Community Integration Services Administrator of CCC has joined the CJAB of Mercer County and heads the Integration Sub-committee for housing.

Brief description of the current services available to clients who have both a serious mental illness and a substance use disorder

The Community Counseling Center offers a variety of services designed for those with both a serious mental illness and a substance abuse disorder. These services are:

Intensive Outpatient groups and Individual sessions are available for individuals with substance abuse disorders to address their specific issues. Along with the group and individual sessions, the individual is assigned a psychiatrist for Medication Checks and evaluations to address their mental health needs.

The Community Residential Rehabilitation Program is used by individuals as a stepping stone between the hospital and their re-integration into the community. The group homes provide a highly structured setting for the residents who have been diverted from the local psychiatric unit or from the community as opposed to going to the state hospital or a Drug and Alcohol Rehab Facility. Many of these individuals were homeless upon admission. The program provides training and assistance in all daily life skills and allows the residents to progress at their own level and ability.

Respite Rooms which are located within the group homes are used to house individuals who have a dual diagnosis and who are homeless. Individuals can remain in the respite program for 30 days while seeking other permanent housing with the assistance of the PATH staff.

The Supportive Housing Program helps individuals with Mental Illness and Substance Abuse to locate, secure and maintain safe affordable housing in Mercer County. All services are provided in the community or in the consumer's home. This is a voluntary program and the person must be willing to accept the services before they are provided. Many of the referrals to the program come from the Emergency Shelter Unit or the Respite rooms.

The Emergency Shelter is located within the ECHO Center owned by the Community Counseling Center. It is an efficiency unit which has the capacity to house from one individual or a family of four or less. The length of stay at the shelter is 30 days and can be utilized by an individual or family once per year. The Caseworker assigned to the unit is supported by PATH Funding. They assist the individuals to find permanent housing and assist in the access of mainstream resources.

How the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support

collection of PATH data in HMIS

Community Counseling Center is able to provide training and support evidenced based practices through several other funding sources. Through our partnership with other agencies to provide Supportive Services in several HUD projects, we receive funding to support the staff and the evidence based services they provide their participants. We also receive MH Base Funding through the county which supports training for the staff and activities associated with the collection of PATH data in the HMIS System. Lastly, we provide evidenced-based practices such as Psychiatric Rehabilitation Services which are billable services through Value, the MCO.

Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

Community Counseling Center is required to follow the 42 CFR part 2 regulations and has developed a specific policy and procedures to ensure the confidentiality of those participants. Access to client records is limited to clinical and support staff on a need to know basis. Also there is firewall protection and password protocols in place to provide security.

Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)

In Mercer County, the Behavioral Health Commission has a Staff member within the Criminal Justice System who makes the referrals to Community Counseling Center for housing and services. We have utilized both the Respite Room and the Emergency shelter to have the individual released from jail. Once in either location the staff work with the person to meet their housing needs and to refer them to other services such as therapy, Drug and Alcohol, medication management, employment and life skills development.
The challenge with this population is that the restrictions that apply when an individual has a criminal record. Many landlords will not rent to them and our Housing Authority doesn't rent to those who are on Probation or Parole, and who have prior drug convictions. In these cases, we utilize our Master Leasing Program, where we are the leasors and they are participants in that program. We also have admitted many individuals into our CRR Program to help them learn daily living skills and then transition them into the community.

Data

Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For *providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff*.

At the present time, we at Community Counseling Center of Mercer County are entering PATH data in the HMIS system on individuals who are entered into the PATH program. We are attempting to enter all of the outreach contacts that are made into HMIS. Unfortunately we had trouble with the system, and needed to contact the state administrator. We have been maintaining all of that information on paper. The data includes all contact information as well as all referrals made and attained by the program participants. At the present time, only one user is imputing the data and I am the local system manager for the area. I will be adding the Supportive Housing Supervisor as a manager also so that he will be able to run reports to insure that the data is entered timely and others are exited from the program. All of the users will view the needed trainings listed on the PA HMIS website through DCED to begin as well as attending all additional and updated training as needed. The new system manager will ensure that all data is being entered into the system by running monthly reports.

Alignment with PATH goals

Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Through the use of PATH funds, Community Counseling Center is able to provide the staff needed to do the outreach into the community to locate and assist those who are disabled and homeless which aligns with PATH goals. We are able to provide services to those who call because they have been evicted and are living in the streets or places not meant for human habitation. We often receive many referrals through HUD's annual Point in Time Survey since we outreach to the areas police departments and food pantries. Once that relationship is established it is utilized though out the year. Because transportation is limited especially in the rural areas, our staff will make arrangements to meet the person where is it convenient for them. Once the staff have met with the individual and have determined their eligibility into the program their needs can be assessed and the necessary referrals completed.

Alignment with State Comprehensive Mental Health Services Plan
Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

The State Comprehensive Mental Health Services Plan states that counties should have goals and objectives for preventing and ending chronic and episodic homelessness that reflect the state's commitment to the recovery model for all people with serious mental illness. Community Counseling Center implements the Evidence Based Model of Supportive Housing and embraces the CSP Principles of Recovery that are consistent with the state plan.

Alignment with State Plan to End Homelessness
Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

In Mercer County with the use of the PATH funding, Community Counseling Center is able to support staff which assists individuals to reduce the length of time that they are homeless and prevent an additional event of homelessness. We are also working toward the State Plan to End Homelessness to a position of Functional Zero.

The Supportive Housing Staff provides information through their life skills training program to the participants regarding disaster preparedness and emergency planning. For those in the emergency shelter, the staff discuss the location of the tornado shelter and the fire exits in the building. Similar discussion occur at the location of the respite rooms.
In both locations monthly fire drills are held as well as a tornado and natural disaster drills to ensure that the residents are familiar with the process. They discuss where the safe areas are and what to do in case of a natural disaster.
In the community, the staff talk about the living situation with the resident at each site, so each location would have different areas of safety. The staff also reviews what they should take with them if possible, such as medications, ID, and phone. They also review how the resident could get information regarding where they should go and what has happened in a natural disaster.
We encourage individuals to have the emergency alert app on their cell phones.

At Community counseling Center we have a staff member who is both a certified member of CERT and DCORT crisis teams for the county who is readily available for our participants.

Other Designated Funds
Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

Through two of the HUD grants that we are sub- recipient for, Permanent supportive Housing and Master Leasing for Chronically Homeless, we receive Supported Services dollars. These dollars are specific to dealing with the Homeless Individuals that are also eligible for PATH services. These dollars are not earmarked for PATH services specifically but enhance and expand the services that are provided to these individuals. We do utilize some Mental Health Block Grant dollars to support the staff in providing daily life skills training to those individuals with serious mental illness in the Supportive Housing Program who are also PATH eligible.

Programmatic and Financial Oversight
In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

The Community Counseling Center of Mercer County receives PATH monies through the Behavioral Health Commission on behalf of the county. The PATH monies are allocated as part of our Supportive Housing budget and is used to support the staff in that program. The state PATH Coordinator annually monitors the program through a site visit and review all charts for program participant and all eligible expenses.

SSI/SSDI Outreach, Access, Recovery (SOAR) –

Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. For the grant year 2016-2017, include all of the following data:

During the grant year 2016-17, we had one individual who was trained to complete the SOAR applications. She did not complete any applications as none of her participants required this service. During the upcoming grant year, we will be training an additional staff member so if needed they will be able to implement the SOAR process.

Housing
Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Community Counseling Center is able to offer a person eligible for PATH services several different housing options. This includes the Emergency Shelter at the ECHO Center or one of the two respite rooms available. These sites are available for 30 days while permanent housing is sought. If neither is available other agencies through the local housing coalition will be contacted to provide emergency shelter for the person. Other agencies such as the Prince of Peace Center, Salvation Army, and Aware may be able to assist with housing through their homeless programs. There are several men's shelters in the Mercer County Area, but no adequate shelters for families or single women. If no other option is available then housing through a faith based organization such as the Good Shephard Center is explored. They can offer funds to provide one or two nights stay at a local hotel/motel.

Once the immediate need has been met, the person will meet with the Caseworker to discuss their needs and what services are appropriate for them. If there is an opening in one of the three HUD projects, they will be referred if they meet the criteria. This year we have partnered with another member of the Coc to provide Rapid Re-housing for those individuals who are homeless. These individuals will receive rental assistance for up to 18 months but must have a plan or means to assume that amount once the grant period has expired.

If all of the projects are filled, then the caseworker will work with the individual to find a private landlord, or the Mercer County Housing Authority to find a housing situation that they can afford. If they meet the qualifications and need the services, a person can be referred to the Community Counseling Center's Community Residential Rehabilitation program.

Coordinated Entry –

Indicate if/how your organization is engaged with the local coordinated-entry processes of your CoC. Please also describe the roles of key partners in the CoC.

Mercer County is not part of a coordinated entry pilot program but as a member of the Coc Governance Board the CIS Administrator for Community Counseling Center is aware of the project and the need to implement the process. As of June 30, 2017, an agency in Mercer County will be identified as the Coordinated Entry Point of Contact and will conduct the assessment and enter the data into HMIS. Presently we do utilize "211" as often as possible.

Justice Involved

Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

In Mercer County, during the past year, there has been a great deal of movement toward educating the law enforcement of Mercer County. The CIS administrator for Community Counseling Center is part of the CIT committee to develop the training for the area. Mercer County CIT training will take place early in the fall of 2017. . At the present time very few individuals have been trained so I cannot give any feedback regarding its effectiveness.

Staff Information

The staff who are working in the program come from Mercer County with a variety of different backgrounds. They are hired on their ability to be flexible and sensitive to the cultural differences of the individuals they work with and to set their goals accordingly. They are required to attend 4 hours of Orientation training dealing with Cultural Competencies. The staff is also able to access Relias Learning, which is a web based educational site for additional training in these areas. The staff is expected to provide effective, equitable, understandable and respectful quality of care that is responsive to the diverse cultural health beliefs and practices of their participants. They will communicate in the person's preferred language and secure an interpreter if needed. As part of the staff's annual training, updated cultural competency

training are provided on site at the Community Counseling Center or in the community and staff are encouraged to attend.

Client Information

All of the persons served through the PATH Grant by the Community Counseling Center's Supportive Housing Program will be individuals with Mental Illness who are homeless in Mercer County. We are projecting to contact or be contacted by 95 individuals. Of the those individuals, 45 will be enrolled in the program and 100% of those enrolled will be literally homeless.

Consumer Involvement
Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be *meaningfully* involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix I "Guidelines for Consumer and Family Participation".

The Community Counseling Center of Mercer County believes strongly that persons with Mental Illness and their family members should be involved in the planning, implementation and evaluation of programming. The Programs and Services Advisory Board meets every other month to review existing programs and the possible expansion or addition of new programs. The board consists mainly of participants in the programs or family members, some staff and two board members, one of whom is a participant of services. Several of the persons sitting on this board entered the residential program after having been referred due to homelessness.

Also, the Governance Board of the Coc, has included in its membership, two individuals that have experienced homelessness. One from the Northern Rehab and one from the Southern Rehab have been identified.

PATH Grant Intended Use Plan 2017-18
Community Counseling Center of Mercer County

Health Disparities Impact Statement
Please identify efforts to support the Transition Age Youth (TAY) disparity population by providing the following:

During the grant year 2017-18, we expect to serve 5-10 individuals who are the Transition Age Youth. The PATH monies used to support these individuals will be proportional to the percentage of individuals in total served for the year. All services funded by PATH are available to the TAY individuals. These services include but are not limited to: assessment and referrals to mainstream resources, emergency and permenent housing location, referral to other agencies for services not provided by Community Counseling Center and general case management. Referrals will also be made for either employment services or aide in furthering their education.

During this past year, we have implemented a strategy to partner with Children and Youth Services to decrease the disparities in access, service use and outcomes with the TAY population. We used a master leasing program to help transition individuals out of the foster care system and to assist those individuals who were homeless due to their aging out of their placement. These individuals were 18 years old or older since we are unable to serve a younger population.

Limited English Proficiency –
Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.

During the past grant year, we did not have any participants who were limited English proficient. If we did experience such a person, we would contact individuals who would be able to assist in our communication with the individual. We would also use technology that would be available on the computers or cell phones to help with proper communication.

Budget Narrative

Provide a *descriptive* budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example: $10,000 federal allocation, $3,333 state match, $1000 PATH specific base fund match.

The PATH funds which are all federally funded will be used to support a portion of the Supportive Housing caseworker's salary and their Health Care Benefits who will work directly with PATH contacts to determine eligibility and to assess the needs of the individuals. Once eligibility is determined the caseworker will assist the individual to seek and secure either emergency or permanent housing if possible. They will also make the necessary referrals to the appropriate agencies for assistance that they cannot provide.

Included in the budget are monies for transportation, as stated in the narrative, the staff must go to where the person is due to the lack of public transportation. Mercer County is largely a rural county and traveling large distances could be a common occurrence. The county has a total area of 683 square miles

An additional budget expense are for electronic devices and their connection to the internet. The Supportive Housing staff each have a cell phone and IPAD to help with documentation and communication to assist the participants. Each device has a monthly charge and other basic office supplies are needed to provide services to the participants.

Community Counseling Center

PATH Grant Intended Use Plan 2017-18
Community Counseling Center of Mercer County

Mercer County- Community Counseling Center
PATH Program
FY 2017-2018 Budget

PERSONNEL Position	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Housing Case Manager	$37,800	.70	26,460	26,460
Outreach Liaison (Certified Peer Specialist)				
Outreach Liaison #2				
Resource Specialist				
sub-total	37,800	.70	26,460	26,460
FRINGE BENEFITS Position				
Housing Case Manager		Health care	3,704	3,704
Outreach Liaison (Certified Peer Specialist)				0
Outreach Liaison #2				0
Resource Specialist				0
sub-total				3,704
TRAVEL				
Local Travel for Outreach			3,250	3,250
Travel to training and workshops				0
sub-total				3,250
SUPPLIES/EQUIPMENT				
Consumer-related items				0
Office supplies			1,000	1,000
Cell Phone			586	586
sub-total				1,586
Other				
Staff training				0

One-time rental assistance				0
Security deposits				0
Client transportation				0
sub-total				0
Total PATH Budget				**$35,000**

36. Mercer County Behavioral Health Commission

8362 Sharon-Mercer Road

Mercer, PA 16137

Contact: Anna Shears

Contact Phone #: 7246621550

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-016

State Provider ID: 4216

Geographical Area Served: Western Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Mercer County Behavioral Health Commission will receive a total of $39,907 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 28

Estimated Number of Persons to be Enrolled: 28

Estimated Number of Persons to be Contacted who are Literally Homeless: 21

Number staff trained in SOAR in grant year ending in 2017: 5

Number of PATH-funded consumers assisted through SOAR: 0

Mercer County
Comprehensive PATH Intended Use Plan
FY 2017-2018

Local Provider Description

The provider organization receiving the PATH funds within Mercer County is the Mercer County Behavioral Health Commission, Inc (MCBHC). The MCBHC was originally incorporated by the Mercer County Board of Commissioners in 1979 to administer the county's substance abuse services and later to include the mental health and intellectual disability services. As the initial point of contact for the three programs, the MCBHC provides administrative oversight, centralized program intake functions, case management services, mental health emergency crisis services, peer support services, mobile psychiatric nursing services, early intervention services, and prevention education programs. For 38 years the MCBHC has outreached, engaged, intervened, and been a partner in recovery with the targeted population. The MCBHC is a private, non-profit organization that administers the county's Mental Health, Developmental Services, and Substance Abuse services. The organization has long-standing experience and a positive track record of involvement with the targeted population. The region served by the Behavioral Health Commission is Mercer County.

The MCBHC also serves as the Single County Authority (SCA) for drug and alcohol program funding through the PA Department of Drug and Alcohol Programs. As the SCA, the MCBHC is responsible for planning, administering, funding and evaluating the drug and alcohol service programs within Mercer County.

The MCBHC will receive a federal allocation of $56,180 and a state allocation of $18,727 totaling $74,907. The attached line item budget reflects the detail funding for MCBHC. MCBHC subcontracts with one in county provider for PATH funded services and supports. Community Counseling Center (CCC) will receive a federal allocation of $35,000 to support PATH funded services. This is reflected within the attached budget detail under "*Contracts/Purchase Services*" line item.

Mailing Address:
Mercer County Behavioral Health Commission
8406 Sharon-Mercer Road
Mercer, PA 16137

The MCBHC is identified in PDX as "PA-016 Mercer: Mercer County MH/MR, Mercer Co. Behavioral Health Commission"

Community Counseling Center (CCC) is a non-profit agency providing comprehensive community behavioral health services since 1957. Community Counseling Center provides mental health and substance use disorder treatment, rehabilitation and support services through a wide range of services for children, adults, and families. There are service locations throughout Mercer County. A large area of focus for CCC is providing services to individuals with mental illness who are experiencing homelessness or to prevent homelessness. Community Counseling Center assists individuals through Supported Housing, Community Residential Rehabilitation,

Fairweather Lodges, and Enhanced Personal Care Boarding Homes. Please refer to CCC individual IUP for more comprehensive information.

Mailing Address:
Community Counseling Center of Mercer County
2201 East State Street
Hermitage, PA 16148

Community Counseling Center is identified in PDX as "PA-005 Mercer: Community Counseling"

Collaboration with HUD Continuum of Care Program

It is recognized that the Pennsylvania Continuum of Care (CoC) identified goal is to reduce homelessness by 50% by the year 2022. The Housing Coordinator within the Mercer County Behavioral Health Commission has participated in the Western Region Continuum of Care meetings within the 2016-2017 fiscal year. This has provided the agency an opportunity to be a resource of information for the staff within the MCBHC, as well as to the local Housing Coalition. The Housing Coordinator is also an active member and vice-chair of the local Housing Coalition.

Mercer County participates in the monthly Northern Regional Housing Advisory Board meetings. Mercer County will be starting a coordinated entry process, using the coordinated assessment, by 6/30/17. The single-point of entry will allow for an easier flow of assisting homeless individuals within the county.

Additionally, the Housing Coordinator within BHC participates as often as possible in the webinars provided by SAMHSA. This allows the BHC to maintain alignment with not only the state goals, but also with federal expectations.

Collaboration with Local Community Organizations

The local efforts for reducing homelessness within Mercer County are driven by the Housing Coalition. The Mercer County Housing Coalition meets monthly to discuss planning activities, program coordinator initiatives, updates within each organization, and other concerns. The current roster of participants at the Housing Coalition meetings are: Area Agency on Aging, Adult Probation and Parole, AWARE, Behavioral Health Commission, Community Action Partnership of Mercer County, Community Counseling Center, Mercer County Housing Authority, Primary Health Network, Prince of Peace Center, the Self Determination Project, Southwest Legal Services, local Realtors, Wahlberg Family Pharmacy, and Veterans Services.

One of the main functions that the Mercer County Behavioral Health Commission provides is case management. It is imperative that the case management staff is aware of the local community organizations which provide housing supports. The Housing Coordinator within the organization is an additional resource for the case management staff when housing issues arise. Additionally, within the 2016-2017 fiscal year, BHC began a Utilization Review and authorization process for some housing related services. This allows greater oversight to

providers who receive funding from the county for the housing related services and ensures that the dollars received are being utilized effectively.

Below are the key services provided by local community organizations throughout Mercer County which the MCBHC collaborates and coordinates with regularly:

Primary Health Providers

The Mercer County Assistance Office links eligible persons to benefits in order to access health care services in Mercer County. The county has two Federally Qualified Health Centers: Primary Health Network and Sharon Community Health Center. Each provides quality primary care services and access to specialty care to meet the needs of the individuals. The federally qualified health centers offer free services or sliding scale fees to persons who are deemed eligible. Primary Health Network also has Certified Health Care Navigators on staff to assist individuals in applying for medical benefits. Often, individuals who are homeless do not have insurance for medical needs. Having staff that is able to assist with applying for benefits helps to eliminate the barrier to treatment. Additionally, Primary Health Network has received special grant funding specific for providing physical health, behavioral health, and dental services to individuals who are homeless. This grant allows the homeless individual to receive any necessary treatment, transportation to appointments, and may cover costs of medications. The staff is able to connect the homeless individuals with other housing, mental health, drug and alcohol services and supports that may be needed. The Primary Health Network staff who determines eligibility for this grant program is also a Certified Health Care Navigator and is an active member and participant on the Mercer County Housing Coalition meetings.

Mental Health Providers

The MCBHC continues to provide Intake and Assessment, Blended Case Management, Certified Peer Specialist, Crisis Intervention, and Mobile Psychiatric Nursing to persons in need of mental health services. Upon completion of an assessment and level of care determination, individuals are referred to appropriate agencies. Currently, Mercer County's only inpatient mental health provider is Sharon Regional Health System (SRHS). The SRHS inpatient hospital has both children and adult units. Sharon Regional Health System's Behavioral Health Services offer partial programs for children, adolescents, and adults. Outpatient mental health medication management is also provided by Sharon Regional and serves as one of four licensed providers. The three other remaining licensed providers of outpatient mental health services are: Associates in Counseling and Child Guidance, Community Counseling Center, and Paoletta's Counseling Service. Although these providers do not receive PATH funding, with the exception of Community Counseling Center, services are available for persons eligible for PATH.

Substance Abuse Providers

MCBHC continues to provide Intake and Assessment, Case Coordination services, and Recovery Specialist services to persons seeking substance abuse treatment. For those individuals identified as needing a higher level of care than partial hospitalization, a referral is made to an out of county contracted provider for inpatient care. Upon completion of inpatient treatment, the MCBHC Case Coordinator assists in arranging aftercare within the community setting. MCBHC also provides Recovery Specialist services.

Mercer County has two licensed providers of Outpatient and Intensive Outpatient substance abuse treatment. Community Counseling Center, a PATH recipient, and Gaudenzia provides these levels of care for substance abuse treatment. Mercer County also has two licensed Methadone providers. Discovery House, located in Hermitage, PA, and Rainbow Recovery Center, located in Mercer, PA.

Housing

Mercer County has multiple agencies providing a variety of housing supports and services. All of the services, supports, and programs are available to eligible PATH recipients.

MCBHC collaborates with all the supports in the community in order to meet the needs of the individuals. MCBHC specifically provides case management services in order to link, coordinate and monitor services for individuals with mental health, drug and alcohol, and intellectual disabilities. The case management departments are made aware of the community supports through training opportunities, departmental meetings and collaboration with providers.

Community Counseling Center (CCC) offers a wide variety of housing programs. The services specific to housing include: supportive housing services, respite rooms, Enhanced Personal Care Boarding Home, Fairweather Lodges, and full and partial Community Residential Rehabilitation programs. All programs are designed to meet the individuals need and are intended to be structured and recovery oriented. CCC is a recipient of PATH funding to support the housing programs that they offer. Please refer to CCC's Intended Use Plan for more specific details of the housing supports offered.

Other county organizations that offer housing services and supports, but are not subcontracted to provide PATH funded services and supports, include: AWARE, City of Sharon, Good Shepherd Center, Housing Authority, and Joshua's Haven, Mental Health Association, Prince of Peace, and the Shenango Valley Urban League. All individuals served within the other organizations may be eligible for PATH funded assistance and programming as well.

AWARE provides emergency shelter for women, men, and children fleeing from domestic violence situations. The organization partners with schools, allied health, medical and mental health, law enforcement and justice systems, and faith institutions, as part of their larger mission to prevent domestic/sexual violence victims. The Shirley Bursey House can accommodate up to 13 people, and the Williams House can accommodate up to 9 people. Community Action Partnership of Mercer County also leases the Legacy House, a four unit complex, to AWARE for the provision of transitional housing for victims of domestic violence. Residents may stay up to 18 months and are provided services enabling them to move into stable and permanent housing.

The City of Sharon oversees the Community Developmental Block Grant (CDBG) funds. The city of Sharon offers a Housing Rehabilitation Program which provides a low interest installment loan of up to $10,000 for qualified individuals to improve the safety and sanitary conditions of their home.

The Community Action Partnership of Mercer County (CAPMC) offers a wide variety of housing supports and services. Currently there is one housing counselor who assists with housing counseling, senior housing, special needs housing, and single family rental housing.

The agency owns and/or manages 275 units of senior housing at ten locations. This program is for independent living for income qualified seniors ages 62 and older. Additionally, the agency owns and manages 22 units of special needs housing at five locations. Such special needs housing includes: Florence Street Apartments, Independence Park, and Permanent Supported Housing for Persons with Serious Mental Illness inclusive of eight units at two locations in which Community Counseling Center provides the supportive services. Additional mental health housing consists of nine units at four locations for persons with mental health issues. This project was developed with financial support from the MCBHC. Single Family Rental Housing is yet another housing option provided by CAPMC offering decent, safe, and affordable housing for five families. Rents are subsidized and based on household income. Further, CAPMC is a certified HUD Housing Counseling Agency and provides such services under contract with the Mon Valley Initiative, the PA Housing Finance Agency, and the City of Sharon.

Additionally, CAPMC assists military veterans who are experiencing a housing crisis. CAPMC employs a veteran who does street outreach, assists veterans in navigating the VA, and links veterans to additional supports offered by the VA.

The Good Shepherd Center addresses the physical needs of the economically challenged in the greater Greenville area. Greenville is located in the Northern part of Mercer County. Services offered include: food pantry, thrift store, hot meals program, free medical clinic, and limited emergency housing/utility assistance. The medical clinic serves Greenville community members who have no Medical Assistance or other insurance and fall within the income guidelines. If an individual goes to the Good Shepherd Center and is in a housing crisis, Good Shepherd Center can pay for lodging for one night and works with other agencies to coordinate housing services.

Mercer County Housing Authority (MCHA) administers the Homeless Prevention and Rapid Re-Housing program. MCHA also oversees Section 8 and public housing. To date there are 19 housing units available throughout the county which are managed by the Housing Authority.

Joshua's Haven City Mission serves as the only emergency and temporary shelter in Mercer County for homeless men. Joshua's Haven provides warm meals, hygiene facilities, counseling, a Christian-based environment, skill building programs, vocational assistance, individual case management, transportation, and referrals.

The Mental Health Association of Mercer County has been a long standing community agency providing Representative Payee services for individuals with mental illness. The organization has expanded their program to include housing services. They currently have two locations which provide a shared living situation where individuals have their own bedrooms and share the living areas, bathrooms and kitchen. One location has three bedrooms and the other currently has five. They are still in the process of expanding the one location to house more individuals as well. Additionally, Mental Health Association offers four individual apartments. Three of which are Section 8 approved.

Prince of Peace provides emergency services, Family Supportive Services (FSS), thrift store, and food services. One service provided to the community is the AWESOME (Assistance With Education, Shelter, Organization, Money management, and Employment) program. The program provides the attendees with educational classes on a wide array of topics, including

proper nutrition, financial planning, and informed decision making. When an individual successfully completes the class, they are awarded $125.00 to be put towards a utility bill or rent.

The Shenango Valley Urban League exists to ensure equal access and opportunity for African Americans and others in need. The Urban League provides comprehensive housing counseling services as they are a Certified HUD Counseling Agency. The Urban League assists in locating decent, affordable housing and provides rental education, delinquent/default counseling, and budget counseling. Additional housing services provided include, but are not limited to: Homeowners Emergency Mortgage Assistance Program (HEMAP), Emergency Shelter Program, and can assist with one month rent or security deposit.

Youth Advocate Program (YAP) is offering two mental health housing support services: Mental Health Habilitation, and Mental Health Chore and Homemaker Services. One of the identified needs for housing supports was for a "hands on" approach in order to assist individuals in maintaining independent living. The MH Chore and Homemaker service helps an adult with mental health challenges maintain their home in a clean, sanitary, and safe condition. This service may include: washing floors, windows and walls; yard maintenance; moving heavy furniture which may be blocking exits; and other needs that the individual identifies.

The Mental Health Habilitation Service assists adults with mental health challenges in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the home and community.

Employment Providers

Mercer County Career Link provides a variety of career services to job seekers including, but not limited to: resume preparation, job searching resources, employment advocates, and unemployment compensation applications. The Office of Vocational Rehabilitation, Veterans Affairs, and Aging Division of Employment services also exist.

An employment provider is CCC, a recipient of PATH dollars. After an individual completes the assessment through the Office of Vocational Rehabilitation, they can be referred to CCC for employment services. CCC provides Employment Resource Specialists (ERS). ERS is an employment placement service benefitting both the potential employee and the potential employer. ERS will assist with interviewing candidates, provide on the job training and educate potential employers about the benefits of hiring individuals with disabilities. CCC's vocational services assist individuals with disabilities to find and maintain gainful employment. The largest disability group served is behavioral health consumers; however, also served are the blind or visually impaired, deaf and hard of hearing, physically disabled, and developmentally disabled. Services vary depending on the client's needs. Services are delivered based on need and include, but are not limited to: Pre-Vocational Training, Job Development, and Job Coaching.

Other employment providers within Mercer County include Youth Advocate Program and St. Anthony's Point. Both providing Pre-Vocational Training, Job Development, and Job Coaching services for individuals with disabilities. Those providers are not recipients of PATH dollars, but are available for individuals who are eligible for PATH services.

Service Provision

PATH funded services are provided to those deemed literally homeless and to those who are in danger of being evicted which may result in homelessness. Housing services related to planning of housing, costs associated with matching eligible homeless persons with appropriate housing situations, technical assistance in applying for housing assistance, improving the coordination of housing services, re-establishment of utility services, and one-time only assistance with security deposits or first month's rent are PATH funded services provided to individuals who meet criteria of "literally homeless" and those at "imminent risk of homelessness" as a priority population. PATH funds are never paid directly to the PATH individual, but are paid directly to the vendor.

The MCBHC maximizes the use of PATH funds for the individuals being served because they are also receiving services and supports of Mental Health Blended Case Management, Mental Health Certified Peer Specialist, Drug and Alcohol Case Coordination, and/or Drug and Alcohol Certified Recovery Specialist services. The funds that support those programs are provided by the Managed Care Organization and base funds from both the Mental Health and the Department of Drug and Alcohol Programs.

When a consumer receiving services through MCBHC is also experiencing a housing crisis, a referral to the PATH program is made. During the time of determining PATH eligibility, the PATH Coordinator will meet with the staff person who is making the referral in order to discuss additional supports that the individual may benefit from. Examples of additional services would be educational classes provided by a variety of organizations or suggested linkages with other housing supports within Mercer County. The case manager would assist the individual with applying for those classes or making referrals for additional housing supports.

Gaps existing within the current service system include emergency housing specific to: women with children, men with children, and entire family units, as well as, single women. A sub-committee of the Mercer County Housing Coalition has been pursuing funding to address the family unit issue. At this time, the committee continues to search for a suitable building and location for this project. Historically, one barrier for identifying a location is the lack of local community support for a homeless shelter. The community members' statement continues to be that they are aware there is a concern about homelessness, but they do not want a shelter by their own home.

A second identified gap is reaching the transitional age youth as they appear to fall between the cracks as they age out of the adolescent mental health system and make the decision to drop out of services as they reach adulthood. As they attempt to survive independently, on many occasions they meet obstacles in achieving a self-sufficient, healthy and satisfying life. In regards to housing, this priority population begins to "couch surf"- living in households in which their name does not appear on the lease. Due to HUD changing the definition of homelessness, couch-surfing is no longer considered being homeless. Therefore, those individuals would not qualify for HUD homeless housing services.

Finally, securing housing for individuals with mental health diagnosis and having criminal histories (felonies and sex offenders) remains problematic.

Services for individuals with co-occurring disorders of mental health and substance abuse are available at a variety of providers throughout Mercer County. Individuals experiencing a co-occurring mental illness and substance abuse disorder can access appropriate treatment through the Base Service Unit of MCBHC, also known as the Central Intake Unit. MCBHC remains the gatekeeper and initial point of contact for persons in need of such services. The assessment process is conducted to ensure that individuals with co-occurring needs have access to services in a full continuum of care by identifying, referring, and authorizing appropriate levels of care. The Central Intake Unit provides intake, evaluation, and referrals. As previously mentioned, MCBHC does have Certified Recovery Specialist services and Drug and Alcohol Case Coordination for drug and alcohol services in addition to the mental health services available. The staff are cross trained in both substance abuse and mental health co-occurring disorders in order to be better prepared to address the specific needs of this population. The case management supervisors are also cross-trained and supervise both mental health and drug and alcohol staff. This cross-training allows the staff and supervisors the knowledge of resources available and knowledge of skills in working with the dually diagnosed populations. MCBHC works collaboratively with Community Counseling Center which is the only local provider with a dual license for providing outpatient drug and alcohol services and mental health services. Additionally, the MCBHC contracts with multiple co-occurring residential treatment providers. All of those providers are outside of Mercer County.

The Housing Coordinator at MCBHC participates regularly in the webinars made available through the Homeless and Housing Resource Network in order to keep apprised of new services, issues and programs. MCBHC was awarded a grant to provide training of Motivational Interviewing. This evidence-based practice training was offered throughout all of the Human Service agencies within Mercer County. One of the goals of having this training is to gain a "universal language" in which we work with individuals receiving services. Having a 'universal language' can support the work of changing attitudes and behaviors in order to improve quality of lives.

Additional trainings that are offered by the Department of Drug and Alcohol Programs, as well as the Office of Mental Health and Substance Abuse Services are offered to MCBHC staff and providers throughout the year. Examples of trainings include areas such as: Dual Diagnosis, PTSD and Addiction, and Forensics and Addiction.

Staff monitors the websites for upcoming trainings and register for them as they become available.

The MCBHC is an agency required to follow 42 CFR Part 2 Regulations governing the confidentiality of patient records and information. Client confidentiality is a crucial part of the daily activities of the staff working with the substance abuse populations. Confidentiality is maintained by the use of valid consent forms which captures all the required elements as per the Department of Drug and Alcohol Programs Treatment Manual, Section 9.10. Additionally, client records, service notes, and treatment plans are maintained within an encrypted electronic health records system called Susquehanna.

Within the 2016-2017 fiscal year, the MCBHC has begun coordinating with individuals being released from the county prison who meet the criteria for Vivitrol. A Vivitrol van comes to the MCBHC twice a month in order to provide the Medical Assisted Treatment and link individuals

with ongoing outpatient treatment within the community. Because the van is located at the MCBHC, the individuals are able to have immediate access to the Central Intake Unit where additional referrals can be made to other community mental health, drug and alcohol, and community resources in order to have a continuity of care.

Mercer County recognizes that there are a large number of inmates incarcerated within the county jail who have mental health and/or drug and alcohol concerns. In working to address this, the President Judge requested an increase in supportive services to reduce the number of individuals in the jail who have committed crimes because of unaddressed mental health and/or drug and alcohol conditions. Subsequently, a new Jail Pilot program was developed. Mercer County Behavioral Health Commission (MCBHC), in conjunction with the probation and parole office and the county jail, has been increasing supports within the 2016-2017 fiscal year. The pilot program works to ensure that a full continuum of services and supports are in place prior to release from prison. The team, consisting of a case manager, peer specialist, recovery specialist, and a probation officer, meets with the identified inmate one month prior to release from jail. The team ensures that outpatient appointments are scheduled and begins the enrollment process for Medical Assistance benefits prior to release to the community. Once released, the team maintains close contact with the individual to support him or her within the community.

The MCBHC continues to provide co-occurring MH/DA intervention within the county prison. The Forensic Intervention Specialist conducts mental health and drug and alcohol evaluations per court orders, mental health psycho-educational groups, coordinates mental health hearings, as needed, at the jail for involuntary commitments, and is able to make referrals prior to release from the jail for outpatient services, case management, peer support, and other supportive services that are available. For fiscal year 2015-2016, a total of 273 inmates were assessed. The breakdown of assessment types provided is: 159 Drug and Alcohol, 32 Driving while Under the Influence, 30 Mental Health, and 52 Dual. In addition to the assessments, psycho educational groups were provided. A total of seven Drug and Alcohol psycho-educational groups were provided. There were a total of 56 participants in those seven groups.

Data

The MCBHC has been entering data into HMIS since December 2011. CCC is also an established user of HMIS. All PATH eligible individuals are entered into the HMIS system, currently using ClientTrack. The Housing Coordinator at MCBHC has been trained on entering data in ClientTrack. As additional training for updates occur the Housing Coordinator participates in order to stay apprised of any new requirements or updates to the system.

Alignment with PATH goals

The MCBHC does not currently provide street outreach. A large part of the homeless population of rural Mercer County is not on the street, but rather couch-surfing.

Individuals who are receiving Mental Health Blended Case Management, Drug and Alcohol Case Coordination, Drug and Alcohol Recovery Specialist, and Mental Health Peer Specialist services through the MCBHC are eligible to receive PATH funded services, if they meet the PATH eligibility criteria. The Case Management department staff are aware of PATH funded

services being available. The Case Managers meet with the PATH Coordinator and will make a referral for PATH assistance in order to provide support to the individual who may be at risk of homelessness, or who is homeless.

Alignment with State Comprehensive Mental Health Services Plan

Services provided within Mercer County related to housing are consistent with the State Comprehensive Mental Health Services Plan. The housing agencies available within the county coordinate services and promote targeting the resources available. Additionally, assessing the effectiveness of the current housing services is completed on a regular basis. The Housing Coalition supports all the local efforts to end homelessness. The collaborative agencies are always engaging in efforts to work towards ending homelessness to a functional zero. Additionally, all mental health and drug and alcohol housing services provided in Mercer County are recovery-oriented. Those recovery-oriented services are fostering empowerment of the individual to understand what recovery means and how stable housing promotes and builds their personal recovery.

The Housing Coordinator within the Mercer County Behavioral Health Commission plays a major part in the coordinating, planning, and writing of the mental health services plan section within the Mercer County Human Services Plan. Because of this, the narrative of the mental health section is all inclusive of housing supports provided in Mercer County including PATH funds. It is widely known that the Housing First approach is the most effective way to improve individual mental health recovery. As case managers meet with mental health consumers, housing is always at the forefront of service planning and coordination of services in order to ensure that individuals are receiving the housing supports needed.

Alignment with State Plan to End Homelessness

The Mercer County Behavioral Health Commission (MCBHC) provides multiple services and supports which are consistent with the state initiatives to prevent or reduce homelessness. The PATH Coordinator/Housing Coordinator and the case management departments link homeless individuals, or individuals who are at imminent risk of homelessness, with supports and services that exist within the county. The support provided is to encourage the individuals and family's to not cycle back into the same situation of facing a housing crisis. Additional support that is provided by MCBHC is direct financial assistance for individuals who are facing eviction, or who are currently homeless. The financial assistance is never paid directly to the individual, but rather to the vendor. This financial assistance is most frequently used for first month's rent, rental assistance to prevent an eviction, or utility assistance.

The staff providing the services through MCBHC are providing case management services and are able to identify homeless, or at risk of homelessness, individuals throughout their daily work functions. When individuals are identified as possibly qualifying for PATH services, the MCBHC staff will meet with the PATH Coordinator in order to make that determination and referral.

Individuals and families are referred to other providers who may be offering classes, such as: building budgeting skills, tenant/landlord agreements, or how to find an apartment. The campaign of United Way of Mercer County is "Lifting Families Out of Poverty". The organizations throughout Mercer County who receive funding from the United Way are encouraged to provide learning sessions. Those sessions are geared to promote financial stability and independence. By providing ongoing learning sessions and educational opportunities, people within the community, both those with mental health conditions, and those without, will be less likely to become homeless or to face eviction. The Behavioral Health Commission has been a long-standing member of the United Way and supports those efforts.

MCBHC has an excellent collaborative and working relationship with the Mercer County Department of Public Safety and that Program Director. The PATH Coordinator has met with the Director of Public Safety in order to discuss the County disaster response plan and what the response would be for homeless individuals. Mercer County has 76 emergency shelter locations throughout the county. In the event of a disaster where evacuation would be needed, the Red Cross would identify which location(s) would be opened for accepting evacuees. The police officers and other public safety staff would assist with identifying individuals who are at the most risk of needing assistance, which includes those who are homeless, and would provide that assistance to secure safety. When needed, the Department of Public Safety would coordinate services and activities related to disaster response with the PA Disaster Mental Health and Human Services Coordinator, Natalie Herberg.

The MCBHC also has representation on the County Emergency Operations Center and participates within those planning meetings and efforts in order to provide behavioral health, substance abuse, and intellectual disability representation. The county often utilizes and calls upon the MCBHC Critical Incident Response Team (CIRT). The team is often called out to situations within the county where behavioral health intervention may be needed. As a sub-group of CIRT is the Disaster Crisis Outreach and Response Team (DCORT). This state trained team is utilized for more specific disasters and would be utilized as part of the County Disaster plan, if needed. The PATH Coordinator at MCBHC is trained and actively serves on both CIRT and DCORT. Additionally, one employee at the Community Counseling Center serves on both CIRT and DCORT.

There are multiple individuals, groups, organizations, and churches who participate and are trained for CIRT. As of 5/10/17, there are 20 individuals trained in the basic National Organization for Victim Assistance (NOVA), 8 have the advanced NOVA training, 14 DCORT trained, 13 Psychological First Aid, and 55 in Grief and Bereavement. The PATH/Housing Coordinator at the MCBHC has received all trainings listed above.

Community Counseling Center provides regular emergency drills within their housing programs. This will be enhanced within the upcoming year to include additional emergency situations. This allows the residents within the variety of homes an opportunity to learn about emergency preparedness and practice it. As those individuals move to the community and to lesser restrictive settings, they have been afforded those educational and practice opportunities.

Other Designated Funds

Mercer County is not a Block Grant county. As stated previously, the MCBHC maximizes the use of PATH funds for the individuals being served because these individuals are also receiving services and supports of Mental Health Blended Case Management, Certified Peer Specialist, Drug and Alcohol Case Coordination, and Certified Recovery Specialist services. The funds that support these other programs are provided by the Managed Care Organization and base funds from both the Mental Health and the Department of Drug and Alcohol Programs, but are not earmarked for PATH services specifically.

MCBHC also receives federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars. Those funds are used for Case Coordination, Prevention and Intervention/Treatment of alcohol and drug use. Those funds are not earmarked for PATH services specifically.

Programmatic and Financial Oversight

Within the MCBHC, financial oversight is provided to the program. Housing and PATH related service expenditures are coded to a separate cost center to enable the financial information for this program to be tracked and monitored. Additional oversight is provided by the Chief Financial Officer who reviews and approves PATH dollars needed to support PATH referrals for services.

Mercer County Behavioral Health Commission is familiar with the services CCC is providing to their supported living/housing program related to PATH individuals. Monthly invoices and their annual audit are reviewed. Please refer to Community Counseling Center's (CCC) IUP for additional information related to how that agency monitors the utilization of PATH dollars.

Additional programmatic and financial oversight is provided by the State PATH Coordinator. An annual on-site monitoring is completed for all the PATH recipient organizations in Mercer County.

SSI/SSDI Outreach, Access, Recovery (SOAR)

There are currently five known Mercer County staff trained in SOAR. The MCBHC PATH Coordinator received the certification on 12/26/14. To date, there were no PATH funded consumers assisted using SOAR at the MCBHC because all the PATH funded individuals receive SSI or SSDI, and/or are employed.

SOAR can be very time burdensome. The staff who are currently employed at the MCBHC are unable to take on additional responsibilities to successfully complete SOAR applications. Unfortunately, due to this reason, MCBHC has not had any SOAR applications completed.

Housing

PATH funded staff are kept apprised of the various housing services available within Mercer County. Staff is able to make appropriate referrals and linkages based on the information they are provided and knowledge of the local county housing providers which are listed in the "Collaboration with Local Community Organizations" section of the Intended Use Plan. Both

agencies that receive PATH funds actively attend and participate in the monthly Housing Coalition meetings which allow everyone to be kept apprised of other housing agencies, projects and programs in the area. Please refer to the above information for specific agencies providing housing services and supports within Mercer County.

Coordinated Entry

Mercer County is a part of the Northern Regional Housing Advisory Board. Beginning 6/30/17, Mercer County will be utilizing a Coordinated Entry Program as a part of the CoC. Within the next month further information and processes will be developed related to this new system.

An additional human services resource that has been available in Mercer County is "211". This United Way funded service provides individuals who call in resources available within the county related to the identified need. One of the most frequently requested service is related to housing needs.

Justice Involved

The Criminal Justice Advisory Board (CJAB) of Mercer County was awarded funding for Crisis Intervention Team (CIT) training. The grant dollars will be available through PCCD in order to cover the cost of staff time for the training. At this time, a sub-committee of CJAB has received the template for the training curriculum and will be designing it to be specific to Mercer County.

Staff information

Specific to MCBHC, PATH is administered by one individual housed within the MCBHC. There is a total of 92 part-time and full-time staff employed by the MCBHC. 82% of the workforce is comprised of women and 18% men. Regarding race, 99% of the staff are Caucasian and 1% are Black. Please reference CCC's Intended Use Plan for the respective staff demographics.

The PATH organizations provide their staff with regular trainings to keep up to date of the changing culture and to maintain cultural sensitivity. At least one Mercer County PATH staff is registered with the Think Cultural Health in order to stay apprised of upcoming trainings and ensure that agency staff that is serving the targeted population is able to address any health disparities and maintain cultural competency.

Trainings are made available to staff through a variety of venues that include: on site trainings, conferences, regional meetings, webinars, PATH technical center, etc. Training opportunities on effective outreach such as being person-centered, recovery oriented, and highly informed on trauma, as well as gender, age, and cultural competency are highly valued within the MCBHC.

Client information

The individuals served in the PATH program will have either a mental health disorder, or a co-occurring substance abuse and mental health disorders. The age range of PATH clients being served are those 18 and over. Clients served by PATH funds are typically at imminent risk of homelessness. They are generally either "couch surfing", doubled-up living arrangement where

their name is not on a lease, living in condemned/substandard dwelling and have no other place to live, living in temporary or transitional housing that has time limits for length of stay, received an eviction notice, or those being discharged from health care facility or criminal justice institution without a place to live. Others served are those considered "literally homeless". This refers to individuals who are staying in a temporary shelter, or those who are in transitional housing.

It is estimated the total number of individuals to be contacted, or to contact BHC and CCC will be 115. The organizational breakdown of the total number contacted is:
Behavioral Health Commission- 20
Community Counseling Center- 95

It is estimated that the total number of individuals in Mercer County who will become enrolled in PATH services in the upcoming fiscal year will be around 73. Estimating that of those 73 clients, 75% will be literally homeless. The organizational breakdown of the total number is:
Behavioral Health Commission-28
Community Counseling Center- 45

The unduplicated number of individuals (18 and older) enrolled in Blended Case Management, Peer Specialist, Drug and Alcohol Case Coordination, and Drug and Alcohol Recovery Specialist services within the 2016-2017 fiscal year (enrolled through 5/10/17) is 459. Of the individuals enrolled in the services identified above provided by the Mercer County Behavioral Health Commission, 26 individuals were enrolled in the PATH program. This equals 6% of individuals served at MCBHC received PATH funded services.

Demographics of PATH individuals (26 individuals) served through the BHC from 2016-2017 fiscal year (enrolled through 5/10/17):

Age:		**Race:**		**Ethnicity:**		**Gender:**	
18-45	58%	**Black or African American**	12%	**Non-Hispanic/Non-Latino**	96%	**Male**	38%
46-62	35%	**White**	85%	**Refused**	4%	**Female**	62%
63+	8%	**Refused**	4%				

Consumer involvement

The New Freedom Initiative (NFI) is Mercer County's Community Support Program. The local committee is comprised of 50% of individuals in recovery from mental health disorders and/or co-occurring disorders. NFI is partly responsible for developing the local Human Service Plan where housing is a component within the plan and is a well-known problem area for many of the individuals receiving services. Many of the individuals who participate in the monthly NFI meetings have had housing crisis experiences. These lived experiences can assist with providing that unique and specific perspective. NFI reports to the county Administrative Entity and to the Behavioral Health Commission administrator any proposals, concerns, areas of need, etc. that would assist in the recovery of individuals with mental health and/or co-occurring disorders.

Additionally, local Mercer County mental health consumers attend the Western Regional Community Support Program (WRCSP) monthly. One of the committee's formed within the WRCSP is a group addressing homelessness and looking at ways to end homelessness. The ideas and suggestions shared at the WRCSP are shared at the local NFI committee. There is also representation at the WRCSP meetings by OMHSAS who are also able to hear what the mental health consumer's ideas and planning efforts and thoughts are.

Health Disparities Impact Statement

It is estimated that the unduplicated number of Transition-Age Youth (TAY) served using PATH funds in Mercer County is expected to be three. The MCBHC estimates the amount of PATH funds used to assist the TAY individuals to be $800.00. The PATH funded services for TAY are the same services provided to non-TAY: first month's rent, security deposit and utility assistance. Additional services are referrals to other agencies to provide assistance with obtaining and maintaining independent living. Supports offered through other agencies include supportive housing, housing counseling, outreach services, staff training, psychiatric rehabilitation, referrals to community mental health services, which may include case management, and additional housing supports. All services are used in order to prevent homelessness, or to establish housing and are never paid directly to the individual.

A sub-committee of NFI is the Transition-Age Workgroup (TAWG). TAWG was developed many years ago in effort to identify and address the needs faced by the Transition-Age Youth population. This has proven to be very challenging for the committee and involved agencies. One major area of difficulty is getting individuals within the ages of 14-26 to participate and attend any meetings in order to share their specific needs. TAWG has proposed a number of options to address needs of this population. Some of the suggestions are: Big Brother/Big Sister program, Youth Peer Specialist, or Transition Age Coordinator.

TAWG developed a resource directory of services available within Mercer County for this population. This resource directory is being distributed in multiple places throughout the county, including, but not limited to: mental health providers, schools, churches, and libraries. It is also posted on the MCBHC website. The use and availability of the resource directory is one effort completed by this workgroup.

The most recent work completed by TAWG was a Needs Assessment. This assessment was completed separately by schools, providers, and individual TAY. There were 17 respondents between the ages of 14-26 who completed the survey. Below are the responses related to housing by the TAY:

1. Most respondents live with their family (10).
2. Three respondents live in a group home and three live in a CRR.
3. The living situation for most respondents in the past is with family (9).
4. Most respondents (8) have received some type of assistance with living situation.
5. Most common problem in obtaining/finding a place to live was due to income/employment.
6. Three respondents identified having no problems with finding a place to live.
7. Most respondents (9) do NOT want help finding place to live.

Below are the needs identified by the schools and providers:

Category Need	School	Provider	Total
Continuing education/volunteer/employment	41%	50%	47%
Independent Living Skills/Housing	18%	63%	47%
Assistance with services/TAY Coordinator	29%	43%	38%
Transportation	18%	23%	21%
Autism	0	23%	15%
Mentoring program	24%	0	9%
MH/ID	0	13%	9%

There are ongoing efforts by local administrations for identifying how to address the specific needs for the transition age youth population. The data provided by the Needs Assessment has been one strategy for guiding this process.

Limited English Proficiency

At this time, Mercer County has not required the need for assistance in providing meaningful access to limited English proficient persons within the PATH program. All individuals served speak English as their first language or when it is not, are proficient in speaking and understanding English. If the need does develop, resources available include Mango. This is a translating service which is free, or Language-Line, which is a fee for service cost. Additionally, for individuals who may be in need of sign-language, Community Counseling Center (a PATH recipient) is able to provide American Sign Language interpreters.

Budget Narrative - 2017-2018

The money received through the contract with Behavioral Health Commission (BHC) will be used for salaries and benefits of the case workers who will be assisting the persons referred for services. Within BHC, a portion of PATH funds are also utilized for one-time rental payment, special needs, or security deposit to prevent eviction. The PATH coordinator at MCBHC will also ensure that referrals are being made to local agencies, as needed and accepted, for such areas as budgeting skills, independent living skills, mental health services, drug and alcohol services, etc. The overall budget consists of: $56,180-federal allocation and $18,727-state match allocation. The budget does not include local match required for state portion of the budget.

Personnel & Employee Benefits

This line item includes the cost of salaries for two individuals. One individual works as an intake case manager who assists with homeless outreach activities. The other position is the PATH Coordinator who coordinates housing/path related items in the County and works with providers to assist the system at large. Employee Benefits include the costs associated with the two individuals listed under the salary line item. These are based on actual costs and our listed out in detail.

Travel

This line includes travel at .40 cents per mile which is our current agency reimbursement rate for use of personal vehicles. If an agency vehicle is used the rate is 53.5 cents per mile, which is the 2017 government reimbursement rate. This line item includes attending meetings for our PATH Coordinator.

Contracts/Purchase Services

MCBHC will be contracting with one local provider for PATH funded services for 2017/2018.

Community Counseling Center – Supported Housing Services for this population are funded with Path dollars. Community Counseling Center is estimating contacting 95 individuals in the upcoming fiscal year. Of those individuals, estimating that 45 individuals will become enrolled in PATH.

Supplies

Office Supplies – Basic supplies to run the program and to provide training material.

Other

Habilitative Supplies – This line item addresses the needs of homeless individuals to assist in various housing needs to prevent homelessness. These items include: one time rental payments, transportation, temporary overnight respite, and security deposits.

Program Development – special events including in-house trainings

Occupancy

This line item includes work space for employees attributed to the PATH Program.

Mercer County
FY 2017-2018 PATH Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Housing Coordinator	43,979	.30 FTE	$13,194	$13,194
Case Manager	36,206	.16 FTE	5,793	5,793
sub-total			**18,987**	**18,987**
Fringe Benefits				
FICA Tax			1,453	1,453
Health Insurance			8,837	8,837
Retirement			1,329	1,329
Life, Disability & Misc. Benefits			340	340
PA Unemployment			147	147
Workmen's Compensation			126	126
sub-total			**12,232**	**12,232**
Travel				
Travel to trainings and meetings			567	567
sub-total			**567**	**567**
Contracts/Purchase Services				
Community Counseling Services			35,000	35,000
sub-total			**35,000**	**35,000**
Supplies				
Office Supplies			705	705
sub-total			**705**	**705**
Other				
One-time rental assistance			5,791	5,791
Occupancy			1,625	1,625
sub-total			**7,416**	**7,416**
Total PATH Budget				**$74,907**

37. Montgomery County - Access Services, Inc.

500 West Office Center Drive, Suite 100

Fort Washington, PA 19034

Contact: Kara Savastio

Contact Phone #: 215-540-2150

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-077

State Provider ID: 4277

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 79,998	$ 26,666	$ 106,664	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 79,998	$ 26,666	$ 106,664	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 79,998	$ 26,666	$ 106,664	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 79,998	$ 26,666	$ 106,664	

Source(s) of Match Dollars for State Funds:

Montgomery County will receive a total of $106,664 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 250

Estimated Number of Persons to be Enrolled: 125

Estimated Number of Persons to be Contacted who are Literally Homeless: 25

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Access Services, Inc.
500 W. Office Center Drive
Suite 100
Fort Washington, PA 19034
Phone – 215-540-2150
Fax – 215-540-2165

2017-2018 PATH IUP

Local Provider Description

The provider name listed in the PATH Data Exchange is Access Services, Inc. Access Services is a 501(c)(3) non-profit social services agency operating in ten counties in Pennsylvania. This year, JRS received $93,828 in PATH funding.

In Montgomery County, Access Services offers the following programs:

- Montgomery County Mobile Crisis – Montgomery County's 24/7 mobile crisis response team providing crisis support services to the entire county. MCMC also provides support through the Teen Talk Line (anonymous talk and text line for teens in Montgomery County operated by trained peers) and the Peer Support Talk Line (warm line operated by Certified Peer Specialists)
- Starting Point – Mobile psychiatric rehabilitation program providing support in the community to adults with chronic mental illness.
- Justice Related Services – ***JRS is the county recipient of PATH funds*****.** Access Services recently acquired the JRS contract with services starting on 01/01/2017. JRS provides blended case management services for adults with Serious Mental Illness who are involved with the criminal justice system. The program works to divert charges, shorten sentences, facilitate re-entry to the community, and reduce recidivism for people with a diagnosed SMI.
- In-Home Supports – IHS provides individualized in-home care and support for adults and children with developmental disabilities by setting personal goals and learning the basic skills of day-to-day living
- Lifesharing – The Lifesharing program supports individuals with developmental disabilities living with qualified, trained, host families. As host families welcome individuals into their lives, offering support and guidance, individuals with developmental disabilities become fully participating members of their communities and are empowered to reach for and achieve their goals and aspirations
- Respite Services – Our respite program provides a temporary home with qualified providers for adults and children with behavioral health challenges to allow for their daily caregivers to strike a balance between time spent caring for others and time spent caring for themselves.
- Life Day Program – The Life Day Program helps adults with developmental disabilities develop functional skills and discover their talents through volunteer work and engaging social activities. Individuals in the Life Day Program learn social, community, personal, and vocational skills.

Collaboration with HUD Continuum of Care (CoC) Program

Currently, Your Way Home is Montgomery County's unified homeless crisis response system, part of the HUD Continuum of Care. JRS utilizes YWH which fully embraces HUD policy of prioritizing rapid re-housing and permanent supportive housing, using a Housing First model. The entire JRS team has attended Service Prioritization Decision Assistance Tool (SPDAT) training so our coordinators are familiar with the prioritization tool used by YWH intake. The JRS team currently uses the SPDAT as part of our intake process with clients so we have a uniform way of measuring need and can better communicate with providers involved with HUD CoC. YWH has expressed interest in rolling out a justice-specific SPDAT tool to better understand the unique circumstances and challenges faced by individuals who are involved with the criminal justice system and who are homeless.

Collaboration with Local Community Organizations

Access Services has historically built positive relationships with community providers and county agencies in order to provide the most cohesive, beneficial, and efficient services to the people we serve. PATH-eligible clients served by JRS generally find supports through the following services:

- Outreach Teams – JRS is able to work closely with the agency's Mobile Crisis Program for immediate mobile response to crisis situations and for assistance in outreach to clients who are street homeless. JRS has also received support from the Coordinated Homeless Outreach Center's outreach team with some of our street homeless clients during code blue situations. JRS attends Norristown HUB meetings to help with the identification of individuals who pose community risk and follows up on relevant referrals.
- Physical Health Providers – Access Services has currently been advancing our agency mission of integrated health across programs where we can utilize staff RNs for basic medical assessment and medical data collection. JRS' PATH-eligible participants are often susceptible to undiagnosed, undertreated, and untreated medical issues and oftentimes lack the coverage or advocacy skills to get access to the care that they need. Our program's Blended Case Management regulations require attempts at securing a physical/screening for all program participants and coordinators facilitate the scheduling of these appointments with community providers.
- Mental Health Providers – Access Services has developed strong relationships with the county's Community Behavioral Health Centers as well as Crisis Residential Programs, and Inpatient Behavioral Health Hospitals. Coordinators are trained in Mental Health First Aid and receive continual training on assessing for appropriate level of care in order to make appropriate and helpful referrals. The mission of JRS is to reduce incarceration for people with SMI through stabilization of symptoms and connection to community mental health service providers.
- Substance Abuse Treatment Providers – JRS frequently works with program participants who have a history of substance abuse to receive services to assess, treat, and house in supported sober-living environments when appropriate.

- Peer Support – JRS is currently in the process of seeking out Forensic Peer Specialists with relevant training and lived experience to provide support, encouragement, and resources to program participants. Access Services also provides warm-line peer support through the Peer Support Talk Line which is a phone number provided to all JRS program participants.
- Employment - JRS frequently uses county employment and vocational training services for participants in need of income through employment.

Service Provision

The Justice Related Services program is a blended case management for adults with Serious Mental Illness who are involved in the criminal justice system. PATH funds are used by JRS for clients who are either street homeless or who are incarcerated and eligible for release pending housing. Many people remain incarcerated up until their maximum sentence date based solely on lack of a housing plan. For adults with SMI, length of time spent in jail is significantly longer than those without SMI. A recent study in Montgomery County found that the average length of stay in jail for people with SMI was 230 days versus general population without SMI, which averaged 72 days. Housing remains a critical area of support for these individuals who are mandated by probation to provide an address to avoid violating their probation terms and returning to jail. Currently the visibility of a person who is street homeless and suffering from an SMI makes it difficult to avoid interaction with law enforcement.

JRS' blended case managers work with the clients by utilizing the Your Way Home call center for rapid re-housing and also works with county supported housing resources when appropriate to find supervised residential settings for participants who need more structure for success in the community. In addition to physical housing, JRS case managers help facilitate benefits, employment, connection to mental health services, and community involvement to ensure stability and improvement in quality of life. For clients who have both SMI and a substance use disorder, case managers work on obtaining a PCPC for the client to determine appropriate level of care and then work to coordinate services as recommended, either through outpatient programming, recovery houses, or inpatient rehabilitation.

Currently all JRS staff are mandated to complete the University of Pittsburgh Case Management training. Staff are also encouraged to complete Mental Health First Aid training, Applied Suicide Intervention Skills Training, and SPDAT training as they are available. Two staff members are trained and have access to the HMIS system, Clarity in order to enter PATH client data. Individual coordinators maintain a spreadsheet with updates to demographics for PATH clients so that these changes can be tracked and monitored and adjusted in PATH as they occur. Case notes on PATH clients are sent to Clarity-trained staff daily to be entered into the HMIS system.

After we have secured a stable housing plan and a JRS client is no longer PATH-eligible, work with the client is billed to Magellan or from county reinvestment dollars.

Access Services complies with all state and federal regulations governing the confidentiality of substance abuse and mental health records. JRS maintains confidentiality of individuals' records via a secured electronic health record system, Evolv and back up files are stored on a protected drive only accessible through special permissions granted by the IT department and confirmed by program supervisors.

Physical charts and documents are kept in a locked area of the department and the entire office is only able to be entered with an assigned keycode. JRS has confidential releases signed by consumers for all relevant parties and is compliant with individual providers' unique release forms. As a covered program, we will meet the requirements of 42 CFR Part 2 defining the confidentiality regulations for substance abuse as it applies to client consent and disclosure of information in cases of medical information and other limited circumstances.

JRS continues to actively seek out relationships and trainings with local agencies who can assist with linking forensically involved clients to housing programs and job opportunities. JRS is actively involved on county efforts to reduce the number of people with SMI in jails. JRS currently co-chairs the county's Forensic Coalition which is committing to the national Stepping Up initiative in addition to chairing that coalitions Diversion subcommittee and sitting on the Reentry subcommittee. JRS also attends Women's Reentry Committee meetings and regularly attends county HUB meetings. JRS is actively involved in the county's Behavioral Health treatment court and completes assessments for all Behavioral Health Court applicants.

Data

JRS currently has two staff members trained in the county's HMIS system who are responsible for entering all PATH data. JRS is fully utilizing HMIS for PATH services and plans to train an additional two employees to ensure that we always have access to HMIS regardless of who is in the office. JRS maintains a separate spreadsheet to keep updates on changing demographics for PATH eligible clients.

Alignment with PATH goals

Program services provided using PATH funds will target those incarcerated in the county prison as well as street homeless individuals who have SMI and are part of an especially vulnerable adult population. Due to history of criminal charges as well as SMI that may be untreated, some of these adults are chronically homeless. JRS works to secure resources, teach skills, and provide advocacy for these individuals in order to help them succeed in permanent housing. Prison and street outreach includes working with homeless shelters, missions, and other organizations potentially serving people who are eligible for JRS through PATH funds.

Alignment with State Comprehensive Mental Health Services Plan

Currently, as part of their Comprehensive Mental Health Services Plan, Pennsylvania is transitioning to a recovery-oriented mental health system which is outlined in the state publication A Call for Change. Montgomery County was an early adapter of this and Access JRS approaches all clients in a recovery-oriented manner, providing case management services to help consumers reach the level of stability and functioning needed to avoid involvement in the criminal justice system and to maintain stable housing.

Alignment with State Plan to End Homelessness

Access Services works with Montgomery County Office of BH/DD to assure that all services provided using PATH funds are consistent with the State Plan to End Homelessness. This ensures that the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state.

Other Designated Funds

Access Services JRS receives some block grant funding to help support the administrative, overhead, and some operational costs of the PATH program.

Programmatic and Financial Oversight

Access Services JRS PATH funding is dispersed to the program through the Montgomery County Office of BH/DD. JRS submits the program budget and monthly billing to the county for review and approval.

SSI/SSDI Outreach, Access, Recovery (SOAR)

Access Services JRS goal is to have all coordinators and program supervisors complete the online SOAR training by June 30, 2017 in order to train coordinators in effective completion of benefit applications. Once coordinators are trained and using the SOAR model, outcomes will be tracked in the SOAR OAT system. To date, JRS has not had any clients receive SOAR services since program inception in January 2017.

Housing

Returning prisoners face many barriers in the private rental market. These include lack of affordability, having poor credit backgrounds, ineligibility due to criminal history, and delays in receiving benefits among other issues. JRS partners with providers to assist participants in overcoming these obstacles by locating and securing decent, affordable housing. The program has two coordinators who have recently attended a Felony Unfriendly training on barriers to housing for people re-entering the community from incarceration to increase knowledge around tenant rights and how to advocate for the population served. The program is working on building relationships with landlords to facilitate better access to open units and to identify landlords willing to rent to individuals who may have criminal justice involvement. JRS also utilizes initiatives like Fair Housing Rights to identify affordable, non-subsidized housing. Additionally, JRS works with the Office of BH/DD in accessing any and all new housing initiatives developed for the mental health population through Medicaid reinvestment funds or other county resources.

Transitional housing provides an intensive, structured living environment for adults who need on-going assistance in developing and utilizing daily living skills in preparation for moving to independent housing. Justice-involved individuals may benefit from being directed to transitional housing options in the community while their legal issues are in the process of being resolved.

As a result of family conflict sometimes there is reluctance on the part of family members to welcome an offender back into their lives. In other cases, natural supports are non-existent. In these scenarios participants need immediate housing upon release as well as access to shelters on an emergency basis if their ongoing residential arrangements are disrupted. JRS assists individuals in connecting with resources that may be available relating to emergency/short-term housing.

Homeless veterans continue to be actively sought out in staff outreach as they are disproportionately represented in both the homeless and incarcerated populations. The program attempts to make full use of the extensive resources and support that the Veterans Administration has for veterans through community partners as well as services provided directly to veterans facing homelessness. The program is committed to informing any veteran who is homeless or at imminent risk of homelessness of the VA's "Make the Call – 877-424-3838" initiative that connects callers 24/7 to VA services to overcome or prevent homelessness for veterans. JRS staff are also available to assist eligible homeless veterans to apply for HUD-VASH vouchers which target vulnerable Veterans who have experienced multiple episodes of homelessness, have been homeless four or more times in the past three years, or who have been continuously homeless for one year or longer.

Coordinated Entry

The Montgomery County Housing and Community Development Department operates Your Way Home, which is the Coordinated Entry program for homeless individuals. JRS collaborates with the Your Way Home program on a regular basis to help homeless individuals secure housing through this program.

Justice Involved

Currently Crisis Intervention Team training is not mandated in Montgomery County and currently one police department is recognized as having completed it. As an alternative, Montgomery County Emergency Services provides a three-day Crisis Intervention Specialist training to educate law enforcement around how to work with a person experiencing a mental health crisis. The curriculum focuses on:

- Introduction to Forensic Mental Health and Jail Diversion
- Overview of the Mental Health System in Pennsylvania (State and County)
- Mental Health Law and Treatment Options
- Crisis Intervention
- NAMI – In Our Own Voice: Living with Mental Illness
- Psychiatric Medication
- Mental Illness
- Substance Abuse
- Suicide Awareness

The county is also currently in the process of joining the national Stepping Up initiative to reduce the amount of people with SMI incarcerated. This will include an evaluation of training provided to law enforcement officials in assessing the role of diversion as it relates to the mission of the initiative.

Staff Information

JRS has the capacity for 15 staff (one Program Director, three Assistant Directors, and 12 Coordinators) as the program expands in its first year. Currently the program has one Program Director, two Assistant Directors, and five Coordinators of which there are 7 Caucasian females, 1 African-American female, and 1 Caucasian male. Staff are all trained in cultural competency as part of agency regulations and on-going trainings are available to ensure that the most relevant, sensitive, and appropriate services are being provided to JRS participants. Access Services abides by a person-centered, trauma-informed, and recovery-oriented model and coordinators are expected to be cognizant of, and responsive to, the needs of different populations in regards to age, gender, disability, sexual orientation, gender identity, race, religion, and any other areas of note. Reactivity to diverse populations related to demographics, criminal background, or diagnosis is assessed for in the coordinator interview process and the agency is committed to hiring individuals who are accepting and aware of differences of clients as well as knowledgeable around how to be responsive to their different needs. Coordinators are encouraged to attend relevant trainings on diversity and cultural competency as they are made available.

Client Information

Currently the broad demographic served by JRS is adults in Montgomery County who are involved in the criminal justice system and have SMI. Specifically, the demographics of all clients served since January 2017 break down as follows:

AGE –

18-24: 11
25-34: 10
35-44: 7
45-54: 12
55-64: 10
65 & Older: 1

GENDER –

Female: 10
Male: 41

RACE –

African American/Hispanic: 7
Asian: 1
Black or African American: 12

Black or African American/White: 1
Hispanic/Latino: 3
Indian/Middle Eastern: 1
White: 26

With a full staff, which will grow as the program expands, JRS will have the capacity to serve approximately 250 consumers. Currently the majority of PATH clients are incarcerated and at risk of imminent street homelessness, rather than literally homeless, and taken off PATH funding once housing is secured. Since program inception in January 2017, JRS has served 51 PATH clients, of whom 4 were literally street homeless with no shelter.

Consumer Involvement

A forensic Certified Peer Specialist (CPS) has been written into the program budget and JRS is currently looking for someone with lived experience in both the mental health and criminal justice systems to fill this role in order to offer peer support to program participants.

In addition, the county's department of BH/DD contracts with the Montgomery County Consumer Satisfaction team, which is a provider organization employing individuals in recovery to evaluate satisfaction of program participants.

Health Disparities Impact Statement

A health disparity population is one that manifests a higher incidence of disease and overall poorer health status than the general population. PATH-eligible individuals are at risk of health disparities because of more limited access to and use of available health care services than the general community because of mental illness and other factors, which may leave them vulnerable to poorer health outcomes. JRS works to connect these consumers with appropriate physical health supports in the community and also employs 2 RNs in the agency who are available as needed to consumers.

Since program inception in January 2017, out of 50 PATH-eligible consumers, Access Services JRS has served 11 Transition Age Youth (TAY) aged 18-24 through PATH funding. While there is no focused outreach specifically targeting TAY at this time, JRS is a service made available to all Montgomery County residents over the age of 18 who meet criteria and forensic need.

After a person is forensically stable, with their criminal charges having been resolved, JRS may seek to transition a TAY to the county's Transition-Age case management program, provided through Central Behavioral Health. Montgomery County also has a residential program for TAY with SMI to gain independent living skills. This program is called YALE (Young Adult Learning Environment) and JRS coordinators are available to make referrals as appropriate.

Limited English Proficiency

Access Services is able to comply with Executive Order 13166 by utilizing technology and local interpreters as needed to provide access to services for consumers with limited English proficiency. To

date, only one referral to the program has had limited English proficiency and the program was able to arrange for an interpreter while connecting the consumer to long-term community supports. The program intends to be mindful of referral trends related to people with limited English proficiency and as the need arises, will assess staffing to reflect language needs of the population served.

Budget Narrative

The funds requested in the attached budget are primarily to pay for case manager salaries and benefits. There is 1 FTE case manager coverage and, weekly, two hours for the program director, two hours for program assistant director, and two hours for the administrative assistant. Benefits included in this budget are health care insurance, workers compensation insurance, unemployment insurance and retirement benefit costs. Employer taxes are based on set percentages of wages for social security and Medicare benefits. Personnel and benefit costs account for 76% of the total budget.

Staff development, communications, legal, accounting, and advertising costs comprise 5% of the total budget. These costs are based on a percentage of total costs or estimates of direct expenses for cell phone use, printing costs for advertising and training.

Administration expenses include overhead costs for utilities, insurance, communications, and housekeeping for office space based on a percentage of total costs. This accounts for 10% of the total budget.

In the travel section of the proposal we have budgeted a portion of agency owned vehicles to be utilized as well as staff using their own vehicles. The purpose of both is to aid in searching and obtaining housing for the consumers. Costs associated with client and staff travel account for the final 9% of the total budget costs.

MONTGOMERY COUNTY
ACCESS SERVICES
Justice Related Services Department
PATH Program (FY 2017-2018 Budget)

BUDGET CATEGORY	Annual Salary	PATH-Funded FTE (hours/week)	PATH-funded Salary	TOTAL
STAFF/POSITIONS				
Director	$52,036.00	0.05	$2,602.00	$2,602.00
Assistant Director	$37,509.00	0.05	$1,875.00	$1,875.00
Caseworker	$35,700.00	1.00	$35,700.00	$35,700.00
Admin Assistant	$29,702.00	0.05	$1,485.00	$1,485.00
Sub-Total			**$41,662.00**	**$41,662.00**
FRINGE BENEFITS				
Employer Match Taxes			$3,187.00	$3,187.00
Insurance & Other Benefits			$7,916.00	$7,916.00
Retirement			$417.00	$417.00
Sub-Total			**$11,520.00**	**$11,520.00**
OTHER				
Staff Development			$1,200.00	$1,200.00
Advertising & Office Supplies			$420.00	$420.00
Communications (incl. cell phones)			$1,428.00	$1,428.00
Accounting & Legal			$360.00	$360.00
Sub-Total			**$3,408.00**	**$3,408.00**
TRAVEL				
Automobile Leased/Purchased			$810.00	$810.00
Automobile Insurance, Maint & Fuel			$720.00	$720.00
Staff/Client Travel			$5,200.00	$5,200.00
Sub-Total			**$6,730.00**	**$6,730.00**
Indirect Cost				
Administrative Costs			$7,036.00	$7,036.00
Sub-Total			**$7,036.00**	**$7,036.00**
Total PATH Buget			**$70,356.00**	**$70,356.00**

38. Philadelphia County

1101 Market Street, 7th Floor

Philadelphia, PA 19107

Contact: Marcella Mcguire

Contact Phone #: 2156854986

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-021

State Provider ID: 4221

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 438,674	$ 194,221	$ 632,895	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 438,674	$ 194,221	$ 632,895	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 438,674	$ 194,221	$ 632,895	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 438,674	$ 194,221	$ 632,895	

Source(s) of Match Dollars for State Funds:

Philadelphia County will receive a total of $1,137,107 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

Estimated Number of Persons to be Contacted who are Literally Homeless: 0

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

PHILADELPHIA COUNTY
1101 Market Street
7th Floor
Philadelphia, PA 19109

FY 2017-2018 INTENDED USE PLAN

Local Provider Description Philadelphia County will receive $289,639 State allocated PATH funds and $847,468 Federally allocated funds; totaling $1,137,107. The following are the funds broken down into each PATH funded provider:

Project	Federal Allocation	State Allocation	Total Allocation
Project Home - Outreach	$ 100,539	$ 22,967	$ 123,506
RHD - Kailo Haven	$ 0	$ 385,827	$ 385,827
RHD - La Casa	$ 338,135	$ 0	$ 338,135
RHD - Cedar Park	$ 0	$ 289,639	$ 289,639
Total	**$ 847,468**	**$ 289,639**	**$ 1,137,107**

PATH funded services are rendered via contractual agreements between the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and two provider agencies. PATH funding is only a portion of the overall funding used to support homeless services. Currently, DBHIDS funds approximately $50 million dollars annually worth of services that serve exclusively homeless persons. The two provider agencies are as follows:

Resources for Human Development (RHD) – Supportive, Supervisory and Case Mangement Services in Residential Settings, partially funded by PATH funds

Project HOME– Outreach Services, partially funded by PATH funds

Each of these agencies are contracted with the DBHIDS to provide an array of behavioral health and support services to residents of Philadelphia County. The region served by these agencies is the County of Philadelphia. The specific services provided by each agency are detailed in Section 3. Other services not listed above are available to homeless persons and to PATH participants, but are not funded by federal PATH funds.

Collaboration with the HUD Continuum of Care (CoC) Program The Department of Behavioral Health and Intellectual disAbilities (DBHIDS) allocates $50million dollars for an array of homeless services through its contracted agencies including housing (transitional and permanent), residential support, case management, and outreach and evaluation. This service total includes federally PATH funded services. PATH funded services represent a small portion of the total services available to the people that are homeless with mental health challenges in Philadelphia. It is therefore difficult to discuss PATH funded services in a discrete fashion.

The DBHIDS PATH coordinator as well as representatives from both agencies receiving PATH funds (Project Home and RHD) sits on the local Continuum of Care (CoC) Board or sub committees and contributes to the vision, development and management of the CoC. The local

CoC lead and the DBHIDS PATH coordinator have been involved with the 100 Day Challenge in Philadelphia and part of the Coordinated Entry planning and discussions. Persons who receive PATH funded services are a high priority for CoC resources.

DBHIDS works very closely and intricately with the local Philadelphia CoC. The collaboration is built upon a mutual respect and vision which is further deepened through twice monthly meetings between the CoC and DBHIDS, continual coordination regarding policies, as well as a seat held by DBHIDS' at the Philadelphia's CoC Board Meetings.

Collaboration with Local Community Organizations The designated PATH providers RHD and Project Home are well connected in the network of community providers working to end homelessness. During the winter of 2017, Project Home partnered with Health Care for the Homeless, Jefferson University Hospital Medicine, and other community partners to offer drop in center services to persons living in the downtown transportation hub. Those services included medical and psychiatric services as well as peer support and case management services. Participating agencies include Pathways to Housing PA, Horizon House and Bethesda Project. DBHIDS continually works towards the creation and coordination of policies with local organizations through the CoC Board and corresponding sub-committees.

RHD manages a significant portion of the Mental Health Residential system and has developed a newspaper targeted for and managed by homeless and formerly homeless persons, called "One Step Away". RHD operates two of the larger shelters in the city, one for single males and one for families, and operates services for persons experiencing homelessness in other counties. RHD also operates three drug and alcohol treatment programs that exclusively serve chronically homeless individuals (JOH New Start I, New Start II and Woman Space). RHD also operates a federally qualified health center, that offers low or no cost health care services for uninsured or underinsured individuals. Both agencies offer supportive employment programming that is available to PATH clients and as well as a range of Permanent Supportive Housing options. Additionally, both agencies are recipients of numerous McKinney/CoC grants.

With regards to Project Home's outreach efforts, all outreach teams are overseen by a County Coordinator of DBH Homeless Services who holds biweekly meetings to ensure lines of communication are open and coordination is smooth. In addition, all teams are responsible for adhering to shared policies and procedures.

Service Provision Philadelphia continues to use data to identify, target and prioritize the most vulnerable people on the street with the longest histories of homelessness to link to needed housing and service resources. This information is used to identify people who are eligible for Safe Havens and JOH emergency housing, and any other housing options so that these are the prioritized people targeted for housing resource. In the coming year there will be continued collaboration around creating a By Name List of people with City Departments (Office of Homeless Services) and other stakeholders, including Project Home and RHD. It should be noted that DBHIDS is not responsible for following 42 CFR Part 2 regulations, as we do not provide licensed drug and alcohol outreach programs.

- Street & Shelter Outreach

Street outreach teams are deployed city-wide in Philadelphia on a year round basis. These services have been expanded to provide 24 hour outreach. PATH funded staff are included in these efforts and are deployed throughout the city, targeting the City as well as identified "hot spots". During periods of severe winter or summer weather, outreach hours are extended in order to prevent weather-related injuries or death. Individuals who are PATH eligible and are reached via Outreach efforts, are given access to Respite and Café-style overnight placements, Safe Havens, JOH or shelter placement, on a referral basis. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic homelessness.

Service Coordination: Outreach efforts that involve mental health, and medical personnel are centrally coordinated by the Outreach Coordination Center (OCC). This resource, funded by DBHIDS, serves to both coordinate and deploy mobile outreach teams and to facilitate rapid placements into specialized residences and generic shelters. The OCC has also worked closely with the Office of Homeless Services, the Mayor's Point of contact regarding the planning, implementation, and oversight of homeless service initiatives, including the 100 Day Challenge and Coordinated Entry.

- Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with six social service agencies for the provision of 253 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. Two of these programs are specified for the Emerging Youth population, and one for couples. These housing resources provide rehabilitative services, case management and transition support. Additional long term housing subsidies are provided via Federally funded Shelter Plus Care grants to homeless persons with disabilities related to mental illness, substance abuse and/or HIV.

Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 89% during CY 2016, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process.

The transitional housing programs serving homeless adults in Philadelphia remain full. Despite capacity expansion, there remains a substantial unmet need for permanent supported housing for homeless individuals who are graduating from these transitional programs. As is the case for persons who do not currently meet the federal definition of homelessness but have no current place to go as well as persons incarcerated over 90 days, but were homeless upon prison admission and will be homeless upon prison discharge.

- Evaluation Services

Homeless persons who require emergency psychiatric assessment and stabilization services are afforded access to an eight bed crisis residence (Emergency Evaluation Center - EEC) or to five (5) Crisis Response Centers (CRCs). An assessment and treatment team,

including psychiatrist time, has been funded to work closely with the Office of Supportive Housing (OSH) Intake sites, shelters.

Service Coordination: Access to the EEC and Crisis Response Center services is centrally coordinated by the DBHIDS Acute Services Unit. The CRCs accept walk-ins. DBHIDS has a Homeless Services Unit that is responsible for the coordination of homeless services.

- Coordination & Planning

The DBHIDS participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Commissioner of the Office of Homeless Services (OHS). These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan(Code Red), outreach planning and hotspots, working with the larger community and City stakeholders, 100 Day Challenge, Coordinated Entry and Planning for people who are chronically homeless, not chronically homeless, and the emerging adult population. This also includes planning to do the VISPDAT and the TAY-VISPDAT to assess vulnerability and housing needs. Both OHS and DBHIDS work closely together and with Providers as well to ensure services are provided to those with mental and behavioral health needs.

- Gaps

There are gaps in the area of shelter capacity. Shelter capacity cannot accommodate all the persons who wish to enter emergency housing. The last Point In Time count of unsheltered individuals was January 25th, 2017 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 799 persons were sleeping on the streets of Philadelphia. It is possible that the warmer than usual weather at the time of the count in Philadelphia effected the increase in numbers from last year. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is an additional team that started during CY 16 so there is more opportunity to count more people.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

- Services for Persons with Co-occurring Substance Use Disorders

All of the services described above are available for persons with co-occurring substance use disorders and all homeless services programs are expected to develop expertise to serve persons with co-occurring disorders. In addition, the DBHIDS has developed the Journeys of Hope (JOH) programs, which offer yearlong substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

Safe Haven and Outreach staff have been trained in providing Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are

working to identify more needed resources and treatment for people. In 2017 DBHIDS provided an Opioid Task Force to work with the community around needs. We are in the planning phases of more options available for people with this need.

- Evidenced Based Practices

DBHIDS supports homeless programs, to participate in training on cognitive and cognitive behavioral therapy (CBT) training. Adapted from therapy practice, all outreach workers and safe haven staff were training on the principles of CBT. Outreach has also had significant training in motivational interviewing techniques. Outreach workers have all staff training twice a year, that focus on resource access and developing skills of evidenced based practices. At this time we are developing a training plan for outreach and safe haven staff that has Motivational Interviewing training and long term coaching as the central focus.

- Alignment with SAMHSA's Strategic Initiative #3: Military Families

All PATH funded services in Philadelphia, are available to homeless veterans. Weekly PATH funded outreach workers and VA outreach staff spend a shift on the street, engaging homeless veterans. Coordination of care with the VA occurs at the participant, program and system level to coordinate care for those who have served their country. Veterans have been placed in the safe haven system and are prioritized for access to HUDVASH voucher resources as well as VA treatment resources.

DBHIDS supports a local provider, Pathways to Housing PA, to serve veterans who are NOT eligible for VA health care, as part of the their HUD VASH initiative. Non VA Health Care eligible vets, who are Medicaid eligible receive the same services and a Housing Choice Voucher in the same manner as VA eligible vets. In this manner, no one is left behind in homelessness.

There are bi-weekly collaborative meetings with the City and the VA to collaborate and coordinate VA and homeless services and housing placement.

- Alignment with SAMHSA's Strategic Initiative #4: Recovery Support

Outreach is designed to engage the most vulnerable persons living on our streets and assist them in moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), outreach can respond to most needs they are presented with. Project Home partners with the Mental Health Association of Southeastern PA (MHASP) to offer peer engagement services to persons living in Philadelphia's transportation hub of Suburban Station. Aforementioned, the primary issue is one of capacity as we do not have enough resources to serve the population in need in its entirety.

Data Outreach Staff have been upgraded to using Tablets to do 'real time' data input into the outreach data system. With this system, weekly reports are generated for all outreach contacts and are shared with supervisors to use as a management tool. PATH Safe Haven and Outreach Providers have been trained in the new HMIS system this year and will begin to utilize HMIS for data needs as required by PATH. Project Home will submit data into HMIS when the OHS HMIS system is ready to move forward

Alignment with PATH Goals The City uses Outreach data to determine chronicity and people who are the most vulnerable and have spent the most times on the street to help inform eligibility for Housing First services, Safe Havens and any other housing options available through PHA or DBH reinvestment dollars. This data is also being used to help inform the OHS By Name List which is being built to target people with the most need and chronicity to access valuable resources for housing and to end homelessness.

Project Home also works with a variety of City Departments and stakeholders at quarterly Homeless Death Reviews to identify circumstances that may have led to someone's death on the streets and ways to collaborate to identify issues and prevention of homeless deaths. This includes the Department of Behavioral Health and Intellectual disAbilities (DBHIDS), OSH, the Medical Examiner's Office (MEO), the Prison System as well as many others. We utilize this process to ask ourselves what can we do better as a system to prevent homeless deaths.

The City, Outreach and it's various stakeholders have been working together around the 100 Day Challenge model to coordinate and collaborate around homelessness, again looking to ways to decrease homelessness on the streets of Philadelphia. With a new administration in the City and several Departments, we continue to find ways to increase all collaborative efforts. These efforts have led to the By Name List, Coordinated Entry and utilizing the VISPDAT as an assessment tool.

Alignment with State Mental Health Services Plan Our system operates within the Recovery model which includes Person First services throughout DBHIDS. The Department's Practice Guidelines for Persons in Recovery has been implemented throughout services and Providers including Project Home and RHD. Providers work closely with DBHIDS and the Office of Emergency Services for emergency planning or disaster preparedness through as well as large events that take place within the City of Philadelphia, such as the DNC in Philadelphia Summer of 2016. Coordination and collaboration mark these events as well as trainings and open lines of communication.

Alignment with State Plan to End Homelessness $43 million dollars of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have been and are in the process of receiving Narcan training and K2 training which has been increasing in Philadelphia.

Project Home and DBHIDS have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

Also, there are yearly and quarterly Point In Time (PIT) Counts to identify how many people are on the streets at the same time during the year. This helps identify other areas of the City where homeless people are so outreach services can be expanded. There is expected to be a new A sixth Outreach Team has been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City.

One RHD Path funded Safe Haven targets emerging adult males, and a second Emerging Adults Safe Haven has opened targeted females. We are seeing approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs and staff are working on training and supports for Outreach and Safe Havens to address needs of this population.

In the last year there access to Housing Choice Vouchers through PHA has virtually ended. This did slow down our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities.

Other Designated Funds DBHIDS spends $50 million dollars annually for persons experiencing homelessness, this includes funding from Medicaid, the Mental Health Block Grant and the Substance Abuse Block Grant. Different funding streams are work in collaboration to fund our efforts with the Journey of Hope Programs, Housing First Services and Safe Havens. It should be noted that these funds are not specifically designated to only serve people who are experiencing homelessness and have a serious mental illness (SMI), as some of the funds are designated for addiction services. Additionally, none of the designated funds are earmarked specifically for PATH services.

Programmatic and Financial Oversight The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Cedar Park, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical support to Cedar Park. DBHIDS provides daily support to all PATH funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR) Homeless Advocacy Project (HAP) had been providing SOAR through a grant over the last several years, but lost their funding and are not been able to provide SOAR at this time. We are working with HAP and PATH to identify grants and options for HAP to begin to provide SOAR again to people who are homeless via

Outreach and Safe Havens. HAP does continue to work with people in OHS shelter and connected to DHS for aging out youth.

Access to Housing Outreach participants have exclusive access to the DBH safe haven system that includes all three PATH funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens have very limited access to these resources, these have been severely limited.
- OHS Clearinghouse opportunities, 811 subsidies and Senior Housing

- Exclusive access to openings in the city's inventory of 605 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.

- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project. .

- Priority access to Mental Health residential services including programs operated by RHD, Horizon House and Northwestern Human Services.

- Bridge Vouchers utilizing DBHIDS reinvestment funds.

Coordinated Entry Project Home along with OHS, DBHIDS, and many other stakeholders are working together to identify a new Coordinated Entry process into the homeless services system under the CoC initiative. Although many stakeholders in Philadelphia work closely together, there is recognition that we need to coordinate admissions into homeless services and shelter in a more cohesive and collaborative way. This will utilize the VISPDAT as the assessment tool for housing placement.

Justice Involved DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. If the trend remains constant, about 30% of the PATH clients served have a criminal history.

Staff Information All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies and health disparities. Trainings occur in the Summer and Winter of each year and cover a variety of important topics with regards to training. We do not collect demographic data on staff serving PATH clients.

Client Information The projected number of people to be contacted using PATH funds is approximately 1860 persons. The majority of those will be through outreach services, while 131 will be through the residential programs. The projected number of adult clients to be enrolled using PATH funds will be 280 persons. All persons admitted to residential services (approximately 280), will be considered PATH enrolled clients and another 150 will receive outreach case management services, from Project Home. All clients served by PATH funds will be "literally" homeless (i.e., living outdoors or in an emergency shelter rather than at imminent risk of homelessness). The following are the demographics of those who received Outreach contacts:

- 73.3% had both co-occurring substance abuse and behavioral health issues
- 5.7% veterans
- 59.3% black/African-American
- 32.8% white
- 71.4% male
- 28.6% female
- 16.6% between the ages of 18-29
- 21% between the ages of 30-39
- 21.8% between the ages of 40-49
- 27.7% between the ages of 50-59
- 12.8% aged 60+

Consumer Involvement DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. Inclusivity efforts, with regard to planning and service initiatives, have increased in response to the DBHIDS' Recovery Transformation model that is implemented across the behavioral health care system. Numerous task forces have been organized to address programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia.

Safe Havens have access to Peer Specialists that come to the location and participate with residents in a variety of ways that are based on the interest and needs of the residents.
In an effort to engage families and help with a variety of needs and resources, DBHIDS also runs the Family Support Network; a place where families can stop-by to receive guidance they may

need. Safe Havens are also part of the Safe Haven Learning Collaborative and participate fully in transforming the Safe Haven system to align with DBHIDS Practice Guidelines for a recovery oriented system. They also work with outreach to create a warmer hand off in alignment with these principles.

Finally, DBHIDS' Office of Mental Health prepares an Annual Plan for Mental Health Services. This plan is distributed on an annual basis to the public, the Community Support Program (CSP) and provider agencies. A forum is then offered to the community to provide comments, feedback, and suggest programs and services for inclusion in the plan. This public forum is open to consumers, family members, as well as the provider community.

Health Disparities Impact Statement

Mental Health and physical health are strongly linked. Evidence shows that mental health disorders are associated with increased risk, occurrence, progression and outcomes of serious chronic diseases and health conditions. This appears to be caused by mental health disorders that may precede a chronic illness and that an illness can worsen a mental health disorder which can create a cycle of poor health in general. The cycle can decrease someone's ability to be a part of treatment and recovery from both. PATH funds are used to hire outreach workers, and those teams target underserved populations who are more likely to experience behavioral health disparities.

Philadelphia's street homeless population has been found to be 71.4% male and 59.3% African-American. Our staffing patterns for outreach and in the safe havens reflects similar demographics, however we do not collect data on the demographics of our staff. An increasing number of homeless persons are Spanish Speaking only and we are actively recruiting staff who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

16.6% of the street population are between the ages of 18-29, and RHD La Casa Safe Haven was transitioned to serve the TAY population to better meet the needs the needs of males within this age group and to create a bridge to Permanent Supported Housing. The total amount of PATH funds expected to be expended on services for the TAY population is $338,135A second Safe Haven has also transitioned to an emerging youth Safe Haven for women between 18-24.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

Limited English Proficiency PATH funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative The PATH Funds received are allocated for the wages and salaries of the Outreach Workers and Safe Haven Staff. This includes the cost of salaries for 35 staff in three residential programs and 5 outreach staff. All of the staff listed on the PATH 2017-2018 Budget will provide those PATH services identified in item 3b of the Intended Use Plan. Other staffing costs, including oversight and supervision, clerical support, maintenance, etc. is not paid for by the PATH Funds and, instead, will be funded by Philadelphia County.

PATH Funding will pay for the salaries of both Project HOME Outreach and RHD's Safe Havens staff. Fringe benefits will come from a different funding source.

Travel, Supplies, Indirect, and Other costs will be funded by Philadelphia County.

Total PATH Allocation……$1,137,107

Comprehensive Budget

Project Home Outreach	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Case Manager 100%	$30,388	100%	$30,388	$30,388
Case Aide	$24,165	35%	$8,458	$8,458

Response Worker	$32,588	100%	$32,588	$32,588
Response Worker	$27,080	100%	$27,080	$27,080
Response Worker	$24,992	100%	$24,992	$24,992
Subtotal	**$139,213**			**$123,506**

RHD - Kailo Haven	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Clinical Manager	$60,000	100%	$60,000	$60,000
Program Mgr	$40,000	100%	$40,000	$40,000
Supervisor	$32,000	100%	$32,000	$32,000
Supervisor	$28,497	100%	$28,497	$28,497
Peer Specialist	$11,025	100%	$11,025	$11,025
Case Mgr	$39,585	100%	$39,585	$39,585
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Subtotal	**$385,827**			**$385,827**

RHD - Cedar Park	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Program Manager	$67,000	100%	$67,000	$67,000
Case Mgr	$39,599	100%	$39,599	$39,585
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Subtotal	**$289,639**			**$289,639**

RHD - La Casa	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Program Manager	$60,000	100%	$60,000	$60,000
Case Manager	$45,000	100%	$45,000	$45,000
Residential Advisor	$26,109	99.95%	$26,095	$26,095

Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Subtotal	**$338,135**			**$338,135**

Grand Total				**$1,137,107**

39. Philadelphia County - Project HOME

1515 Fairmont Ave.

Philadelphia, PA 19130

Contact: Carol Thomas

Contact Phone #: 2152327272

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-042

State Provider ID: 4242

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Project Home will receive a total of $123,506 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 1,730

Estimated Number of Persons to be Enrolled: 150

Estimated Number of Persons to be Contacted who are Literally Homeless: 1,730

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Project HOME: Street Outreach
1515 Fairmount Avenue
Philadelphia, PA 19130
2017-2018 PATH Intended Use Plan
Philadelphia County

Local Provider Description The mission of the Project HOME (PA-042 Philadelphia: Project HOME) community is to empower persons to break the cycle of homelessness and poverty, to address structural causes of poverty, and to enable all of us to attain our fullest potential as individuals and as members of the broader society. Project Home achieves this through the provision of a continuum of care comprised of street outreach; supportive housing; and comprehensive services including health care, education, and employment. They also address the root causes of homelessness through neighborhood revitalization programs, including affordable housing development; employment training and opportunities; adult and youth education; health care; and environmental enhancement. Project HOME strives to create a stable and secure environment where we support each other in our struggles for self-esteem, recovery and the confidence to move toward self-actualization. The work of Project Home is rooted in our strong spiritual conviction of the dignity of each person.

The mission of the Project HOME community is to empower adults, children, and families to break the cycle of homelessness and poverty, to alleviate the underlying causes of poverty, and to enable all of us to attain our fullest potential as individuals and as members of the broader society. Project Home strives to create a safe and respectful environment where we support each other in our struggles for self-esteem, recovery, and the confidence to move toward self-actualization.

Project HOME achieves its mission through a continuum of services comprised of street outreach, a range of supportive housing, and comprehensive services. We address the root causes of homelessness through neighborhood-based affordable housing, economic development, and environmental enhancement programs, as well as through providing access to employment opportunities; adult and youth education; and health care. Project HOME is committed to social and political advocacy. An integral part of our work is education about the realities of homelessness and poverty and vigorous advocacy on behalf of and with homeless and low-income persons for more just and humane public policies. Project HOME is committed to nurturing a spirit of community among persons from all walks of life, all of whom have a role to play in making this a more just and compassionate society.

More detailed information regarding Project HOME can be found at their Web site, www.projecthome.org. Project Home recently received national recognition from the National Alliance to End Homelessness (NAEH) for non-profit sector achievement. Project Home, founded in 1988, has been a local and national leader in outreach to street homeless individuals through their Outreach Coordination Center (OCC). Project Home

is a non-profit social service agency that contracts with the Philadelphia County Department of Behavioral Health for residential and homeless services. Project HOME coordinates all city supported outreach

Project HOME will receive $123,506 from PATH Funding; all of which is federally allocated. These PATH funds are being used to sustain the increased capacity at the OCC. These services are intended to be aligned with the goals and recommendations of the President's New Freedom Commission, specifically related to Goal 2 Mental Health Care is Consumer and Family Driven, and Goal 4 Mental Health Screening, Assessment, and Referral. Project Home, as indicated below, actively involves consumers and families in all of its activities, including staff hiring and volunteer opportunities. Further, outreach works to engage the person where they are, offer choices, and where appropriate, refer to mental health or substance abuse treatment programs as part of the behavioral health care continuum.

Project	**Federal Allocation**	**State Allocation**	**Total Allocation**
Project Home - Outreach	$ 100,539	$ 22,967	$ 123,506
Total	**$ 100,539**	**$ 22,967**	**$ 123,506**

Collaboration with the HUD Continuum of Care (CoC) Program Project HOME is a primary recipient of local CoC funds, as well as the lead Outreach and Homeless Advocacy Organization in the city. The Project HOMEexecutive director, Sr Mary Scullion, is the Co-Chair of the city's 10 Year Plan to End Homelessness Committee. Project Home staff also sits on the McKinney Strategic Planning committee and are essential partners in any city planning efforts around ending Homelessness. Project Home was a leader in the 100 Day Challenge effort with the Office of Homeless Services (OHS) and DBHIDS to examine chronic and non-chronic homelessness, as well as youth homelessness and work to identify resources for housing. This also includes working on the Coordinated Entry system in partnership with the City and planning underway for assessing people on the street utilizing the VISPDAT.

In addition, Project HOME works very closely with Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS). DBHIDS allocates $50million dollars for an array of homeless services through its contracted agencies including housing (transitional and permanent), residential support, case management, and outreach and evaluation. The DBHIDS PATH coordinator as well as representatives Project Home sit on the local Continuum of Care CoC Board (PA-500 Philadelphia CoC) or sub committees and contributes to the vision, development and management of the CoC. The PATH Coordinator sits on the local CoC board. Philadelphia's CoC meets every 2-months Project HOME does not presently have a seat on the board, but they play active roles in board subcommittees. Persons who receive PATH funded services are a high priority for CoC resources.

Coordination with Local Community Organizations Project HOME is a recognized leader in the network of community providers working to end homelessness.

In the winter of 2017Project HOME partnered with Health Care for the Homeless, Jefferson University Hospital Medicine, and other community partners to offer drop in center services to persons living in the downtown transportation hub. Those services included medical and psychiatric services as well as peer support and case management services. Project HOME is also leading a local "Ending Chronic Street Homelessness Collaborative" that is targeting resources to the most in need. Participating agencies include Pathways to Housing PA, Horizon House and Bethesda Project. Project HOMEalso works with these Community Organizations to identify people experiencing long term chronic homelessness into their Housing First programs in collaboration with the City and other Community Providers. Project HOME has been approved to develop a federally qualified health center in that offers low or no cost health care in a neighborhood recognized as one of the poorest in Philadelphia and primary feeder or referrals to the emergency housing systems. Project Home offers supportive employment programming that is available to PATH clients and offers a significant inventory of Permanent Supportive Housing and are recipients of numerous McKinney/CoC grants.

With regards to Project HOME's outreach efforts, all outreach teams are overseen by a County Coordinator who holds biweekly meetings to ensure lines of communication are open and coordination is smooth. In addition, all teams are responsible for adhering to shared policies and procedures.

Service Provision Philadelphia continues to use data to identify, target and prioritize the most vulnerable people on the street with the longest histories of homelessness to link to needed housing and service resources. This information is used to create the City's Priority List for Housing First services and housing, as well as Safe Havens and any other housing options so that these are the prioritized people targeted for housing resources. It should be noted that DBHIDS is not responsible for following 42 CFR Part 2 regulations, as we do not provide licensed drug and alcohol outreach programs. Project HOME staff have been trained this past spring in HMIS to begin data collection in HMIS.

- Street & Shelter Outreach

Street outreach teams are deployed city wide Philadelphia on a year round basis. These services have been expanded to provide 24 hour outreach services. PATH funded staff are included in these efforts and are deployed throughout the city. During periods of severe winter or summer weather, outreach hours are extended in order to prevent weather-related injuries or death. PATH funded outreach services are afforded referral access to Boarding Home, Safe haven, cafe and shelter referral placements and facilities, during evening and weekend outreach hours. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic homelessness. Project HOME also collaborates with the Synergy Project who provides youth outreach.

Service Coordination: Outreach efforts involving mental health, Office of Homeless Services (OHS) and medical personnel are centrally coordinated by the Outreach

Coordination Center (OCC). This resource, funded by DBHIDS, serves to both coordinate and deploy mobile outreach teams, and to facilitate rapid placements into specialized residences and generic shelters. The OCC has also worked closely with the Managing Directors Office with regard to the planning, implementation, and oversight of homeless service initiatives.

- Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with sex social service agencies for the provision of 253 entry level beds designated specifically for homeless persons with mental illness or co-occurring disorders, two of the safe havens targets emerging youth and one for couples. These housing resources provide rehabilitative services, case management and transition support. Additional long term housing subsidies are provided via federally funded Shelter Plus Care grants to homeless persons with disabilities related to mental illness, substance abuse and/or HIV.

Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 89% during CY 2016, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process.

The transitional housing programs serving homeless adults in Philadelphia remain full. Despite capacity expansion, there remains a substantial unmet need for permanent supported housing for homeless individuals who are graduating from these transitional programs. As is the case for persons who do not currently meet the federal definition of homelessness but have no current place to go as well as persons incarcerated over 90 days, but were homeless upon prison admission and will be homeless upon prison discharge.

Project HOME participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Director of Office of Supportive Housing. These initiatives have included the annual winter plan (Code Blue) and summer heat emergency plan (Code Red).

- Gaps

There are gaps in the area of shelter capacity. Shelter capacity cannot accommodate all the persons who wish to enter emergency housing. The last Point In Time count of unsheltered individuals was January 25th, 2017 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 799 persons were sleeping on the streets of Philadelphia. It is possible that the warmer than usual weather at the time of the count in Philadelphia effected the increase in numbers from last year. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly.

It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is an additional team that started during CY 16 so there is more opportunity to count more people.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

- Services for Persons with Co-occurring Substance Use Disorders

All of the services described above are available for persons with co-occurring substance use disorders and all homeless services programs are expected to develop expertise to serve persons with co-occurring disorders. In addition, the DBHIDS has developed the Journeys of Hope (JOH) programs, which offer yearlong substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

Outreach staff have been trained in providing Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify more needed resources and treatment for people. In 2017 DBHIDS provided an Opioid Task Force to work with the community around needs. We are in the planning phases of more options available for people with this need.

- Evidenced Based Practices:

All Project HOME outreach workers and safe haven staff have participated in the in training on cognitive and cognitive behavioral therapy (CBT) training. Adapted from therapy practice, all outreach workers and safe haven staff were trained on the principles of CBT. Outreach has also had significant training in motivational interviewing techniques. Outreach workers have all staff training twice a year, that focus on resource access and developing skills of evidenced based practices.

- Alignment with SAMHSA's Strategic Initiative #3: Military Families

All PATH funded services in Philadelphia, are available to homeless veterans. Weekly PATH funded outreach workers and VA outreach staff spend a shift on the street, engaging homeless veterans. Coordination of care with the VA occurs at the participant, program and system level to coordinate care for those who have served their country. Veterans have been placed in the safe haven system and are prioritized for access to HUDVASH voucher resources as well as VA treatment resources. Project Home participates with the City and VA and stakeholders in bi-weekly collaborative meetings to coordinate homeless services and housing placements.

•Alignment with SAMHSA's Strategic Initiative #4: Recovery Support

Outreach is designed to engage the most vulnerable persons living on our streets and assist them in moving forward in their recovery. There are an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), outreach can respond to most needs they are presented with. This winter Project Home also partnered with the Mental Health Association of Southeastern PA (MHASP) to offer peer engagement services to persons living in Philadelphia's transportation hub of Suburban Station. Aforementioned, the primary issue is one of capacity as we do not have enough resources to serve the population in need in its entirety.

Data Outreach Staff have been upgraded to using Tablets to do 'real time' data input into the outreach data system. With this system, weekly reports are generated for all outreach contacts and are shared with supervisors to use as a management tool. PATH Safe Haven and Outreach Providers have been trained in the new HMIS system this year and will begin to utilize HMIS for data needs as required by PATH. Project Home will submit data into HMIS when the OHS HMIS system is ready to move forward

Alignment with PATH goals The City uses Outreach data to determine chronicity and people who are the most vulnerable and have spent the most times on the street to help inform eligibility for Housing First services, Safe Havens and any other housing options available through PHA or DBH reinvestment dollars. This data is also being used to help inform the OHS By Name List which is being built to target people with the most need and chronicity to access valuable resources for housing and to end homelessness.

Project HOME also works with a variety of City Departments and stakeholders at quarterly Homeless Death Reviews to identify circumstances that may have led to someone's death on the streets and ways to collaborate to identify issues and prevention of homeless deaths. This includes the Department of Behavioral Health and Intellectual disAbilities (DBHIDS), OSH, the Medical Examiner's Office (MEO), the Prison System as well as many others. We utilize this process to ask ourselves what can we do better as a system to prevent homeless deaths.

The City, Outreach and it's various stakeholders have been working together around the 100 Day Challenge model to coordinate and collaborate around homelessness, again looking to ways to decrease homelessness on the streets of Philadelphia. With a new administration in the City and several Departments, we continue to find ways to increase all collaborative efforts. These efforts have led to the By Name List, Coordinated Entry and utilizing the VISPDAT as an assessment tool.

Alignment with State Mental Health Services Plan Our system operates within the Recovery model which includes Person First services throughout DBHIDS. The Department's Practice Guidelines for Persons in Recovery has been implemented throughout services and Providers including Project HOME and RHD. Providers work

closely with DBHIDS and the Office of Emergency Services for emergency planning or disaster preparedness through as well as large events that take place within the City of Philadelphia, such as the DNC in Philadelphia Summer of 2016. Coordination and collaboration mark these events as well as trainings and open lines of communication.

Alignment with State Plan to End Homelessness $43 million dollars of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have been and are in the process of receiving Narcan training and K2 training which has been increasing in Philadelphia.

Project Home and DBHIDS have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

Also, there are yearly and quarterly Point In Time (PIT) Counts to identify how many people are on the streets at the same time during the year. This helps identify other areas of the City where homeless people are so outreach services can be expanded. There is expected to be a new A sixth Outreach Team has been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City.

One RHD Path funded Safe Haven targets emerging adult males, and a second Emerging Adults Safe Haven has opened targeted females. We are seeing approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs and staff are working on training and supports for Outreach and Safe Havens to address needs of this population.

In the last year there access to Housing Choice Vouchers through PHA has virtually ended. This did slow down our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities.

Other Designated Funds DBHIDS spends $50 million dollars annually for persons experiencing homelessness; this includes funding from Medicaid, the Mental Health Block Grant and the Substance Abuse Block Grant. Different funding streams are work in collaboration to fund our efforts with the Journey of Hope Programs, Housing First Services and Safe Havens. It should be noted that these funds are not specifically designated to only serve people who are experiencing homelessness and have a serious mental illness (SMI), as some of the funds are designated for addiction services. Additionally, none of the designated funds are earmarked specifically for PATH services.

Programmatic and Financial Oversight The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Cedar Park, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical support to Cedar Park. DBHIDS provides daily support to all PATH funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR) Homeless Advocacy Project (HAP) had been providing SOAR through a grant over the last several years, but lost their funding and are not been able to provide SOAR at this time. We are working with HAP and PATH to identify grants and options for HAP to begin to provide SOAR again to people who are homeless via Outreach and Safe Havens. HAP does continue to work with people in OHS shelter and connected to DHS for aging out youth.

Access to Housing Outreach participants have exclusive access to the DBH safe haven system that includes all three PATH funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens have very limited access to these resources, these have been severely limited.
- OHS Clearinghouse opportunities, 811 subsidies and Senior Housing

- Exclusive access to openings in the city's inventory of 605 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.

- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project. .

- Priority access to Mental Health residential services including programs operated by RHD, Horizon House and Northwestern Human Services.

- Bridge Vouchers utilizing DBHIDS reinvestment funds

Coordinated Entry Project HOME along with OHS, DBHIDS, and many other stakeholders are working together to identify a new Coordinated Entry process into the homeless services system under the CoC initiative. Although many stakeholders in Philadelphia work closely together, there is recognition that we need to coordinate admissions into homeless services and shelter in a more cohesive and collaborative way. This will utilize the VISPDAT as the assessment tool for housing placement.

Justice Involved DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. Based on these trends, we believe that 30% of PATH clients served has a criminal history.

Staff Information All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies and health disparities. We do not collect demographic information on staff serving PATH clients.

Client Information The projected number of people to be contacted by Project Home Outreach using PATH funds is approximately 1730 persons. 150 will enrolled and receive outreach case management services, from Project Home. All clients served by PATH funds will be "literally" homeless (i.e., living outdoors or in an emergency shelter rather than at imminent risk of homelessness). The following are the demographics of those who received Outreach contacts:

- 73.3% had both co-occurring substance abuse and behavioral health issues
- 5.7% veterans

- 59.3% black/African-American
- 32.8% white
- 71.4% male
- 28.6% female
- 16.6% between the ages of 18-29
- 21% between the ages of 30-39
- 21.8% between the ages of 40-49
- 27.7% between the ages of 50-59
- 12.8% aged 60+

Consumer Involvement DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. Inclusivity efforts, with regard to planning and service initiatives, have increased in response to the DBHIDS' Recovery Transformation model that is implemented across the behavioral health care system. Numerous task forces have been organized to address programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia.

CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. All DBHIDS services operated by Project HOME participate in the CST process. Safe Havens have access to Peer Specialists that come to the location and participate with residents in a variety of ways that are based on the interest and needs of the residents. Project Home has advisory boards that residents can attend and join. DBHIDS also runs the Family Support Network in an effort to engage families and help with a variety of needs and resources.
Project HOME Street outreach engages homeless individuals and families living on the streets of Philadelphia. Outreach represents building a reliable relationship that can allow individuals to consider coming inside and accepting services. The approach to services is person first, strength-based and trauma informed and Project Home recognizes that individuals with behavioral health challenges and other barriers such as deep poverty and lack of resources need assistance and care in order to increase their resources and make informed choices about their array of options.

Project HOME offers and connects people to emergency shelter placement, Safe Haven placements, and Drug and Alcohol referrals to either assessment centers at the CRCs, Journey of Hope or outpatient options. People without insurance to pay for care are referred to BHSI. The team operates within the Outreach Coordination Center (OCC) to

answer to response calls for homeless individuals and families through the City's outreach homeless hotline.

In the case of families on the street the goal is to link the family to Office of Supportive Housing (OHS) emergency services for their immediate housing needs. Outreach will transport them to the after-hour services and shelter as well as, advocate for their immediate needs and if requested by the family will assist with other services including information about permanent housing as applicable. If families refuse services and have vulnerable children we inform them that we are mandatory reporters and that we must make decisions based on the safety of the child or children.
Finally, the overall approach of Project HOME outreach is to assist persons in identifying their needs, wants and desires as they recover their lives within the framework of our mission which is listed below:

- Health Disparities Impact Statement

Mental Health and physical health are strongly linked. Evidence shows that mental health disorders are associated with increased risk, occurrence, progression and outcomes of serious chronic diseases and health conditions. This appears to be caused by mental health disorders that may precede a chronic illness and that an illness can worsen a mental health disorder which can create a cycle of poor health in general. The cycle can decrease someone's ability to be a part of treatment and recovery from both. PATH funds are used to hire outreach workers, and those teams target underserved populations who are more likely to experience behavioral health disparities.

Philadelphia's street homeless population has been found to be 71.4% male and 59.3% African-American. Our staffing patterns for outreach and in the safe havens reflects similar demographics, however we do not collect data on the demographics of our staff. An increasing number of homeless persons are Spanish Speaking only and we are actively recruiting staff who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

16.6% of the street population are between the ages of 18-29, and RHD La Casa Safe Haven was transitioned to serve the TAY population to better meet the needs the needs of males within this age group and to create a bridge to Permanent Supported Housing. The total amount of PATH funds expected to be expended on services for the TAY population is $338,135A second Safe Haven has also transitioned to an emerging youth Safe Haven for women between 18-24. Project Home collaborates with the Synergy Project, a youth outreach provider.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

Limited English Proficiency PATH funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative -The PATH funds received are allocated to cover the salaries and benefits for 5 outreach staff. All of the staff listed on the PATH 2017-2018 Budget will provide those PATH services identified in Section 4 of the Intended Use Plan. Other staffing costs, including oversight and supervision, clerical support, maintenance, etc. will be funded by Philadelphia County.

Travel, Supplies, Indirect, and Other costs will be funded by Philadelphia County.

PATH Allocation…….…….$123,506

Detailed Budget

Project Home Outreach	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Case Manager 100%	$30,388	100%	$30,388	$30,388
Case Aide	$24,165	35%	$8,458	$8,458
Response Worker	$32,588	100%	$32,588	$32,588
Response Worker	$27,080	100%	$27,080	$27,080
Response Worker	$24,992	100%	$24,992	$24,992
Total	**$139,213**			**$123,506**

Grand Total				**$123,506**

40. Philadelphia County - RHD (Cedar Park)

4926 Baltimore Ave.

Philadelphia, PA 19144

Contact: Judy Elzey

Contact Phone #: 2157246380

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID: PA-043

State Provider ID: 4243

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

RHD-Cedar Park will receive a total of $289,639 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 55

Estimated Number of Persons to be Enrolled: 55

Estimated Number of Persons to be Contacted who are Literally Homeless: 55

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Resources for Human Development: Cedar Park
4700 Wissahickon Avenue
Philadelphia, PA 19144
2017-2018 PATH Intended Use Plan
Philadelphia County

Local Provider Description Resources for Human Development (RHD) is a non-profit community behavioral health services organization center that provides a full continuum of mental health, substance abuse and physical health services. The Philadelphia County Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) contracts with RHD to provide mental health services, including PATH funded resources. Cedar Park (PA-043 Philadelphia: Resources for Human Development – Cedar Park) is a Safe Haven located 4926 Baltimore Avenue, Philadelphia, PA 19143. The PATH funds received cover part of the cost of the supportive staff at this location.

Cedar Park serves women with serious and persistent mental illness, and persons with co-occurring substance abuse issues who have recently been street homeless. This program is centrally gatekept by Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS) and is contained within the County's residential care continuum.

Cedar Park will receive $289,639 from PATH funding; all of which is allocated from the state.

Project	Federal Allocation	State Allocation	Total Allocation
RHD - Cedar Park	$ 0	$ 289,639	$ 289,639
Total	**$ 0**	**$ 289,639**	**$ 289,639**

Coordination with the HUD Continuum of Care (CoC) Program Cedar Park, represented by RHD, is a key participant in the Continuum of Care (CoC) Board and is the recipient of a variety of CoC grants to provider permanent supportive housing (PSH) to persons with serious mental illness.

In addition, RHD and Cedar Park work very closely with Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS). DBHIDS allocates $50million dollars for an array of homeless services through its contracted agencies including housing (transitional and permanent), residential support, case management, and outreach and evaluation.

The DBHIDS PATH coordinator as well as RHD sits on the local Continuum of Care (CoC) Board or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinator have been involved with the 100 Day Challenge in Philadelphia and part of the Coordinated Entry planning and discussions. Persons who receive PATH funded services are a high priority for CoC resources. RHD played a leadership role in working on the 100 Day

Challenge with all aspects of homelessness and housing for people who are chronically homeless or not chronically homeless, as in the emerging adult population who do not always meet that definition.

DBHIDS works very closely and intricately with the local Philadelphia CoC. The collaboration is built upon a mutual respect and vision which is further deepened through monthly meetings between the Office of Homeless Services (OHS), RHD, and DBHIDS, and continual coordination regarding people in Safe Havens, including Cedar Park, to identify housing, housing needs and challenges that may arise.

Collaboration with Local Community Organizations The designated PATH providers and La Casa are well connected in the network of community providers working to end homelessness. RHD operates the central intake for single men for the city. RHD manages a significant portion of the Mental Health Residential system and has a newspaper developed for and management by homeless and formerly homeless persons, called "One Step Away". RHD also operates three drug and alcohol treatment programs (JOH) that serve exclusively chronically homeless individuals, New Start I, New Start II and Womanspace. RHD also operates a federally qualified health center that offers low or no cost health care services for the uninsured or underinsured. The agency offers supportive employment programming that is available to PATH clients and has an inventory of Permanent Supportive Housing and is recipients of numerous McKinney/COC grants. RHD also works with Horizon House to identify people with the highest need for housing services through their programs (Housing First).

Service Provision Philadelphia continues to use data to identify, target and prioritize the most vulnerable people with the longest histories of living on the street to link to needed housing and service resources. This information is used to identify people who are eligible for Safe Havens and JOH emergency housing, and any other housing options so that these are the prioritized people targeted for housing resource. In the coming year there will be continued collaboration around creating a By Name List of people with City Departments (Office of Homeless Services) and other stakeholders, including Project Home and RHD. It should be noted that DBHIDS is not responsible for following 42 CFR Part 2 regulations, as we do not provide licensed drug and alcohol outreach programs. Cedar Park admits chronically homeless women to their program.

- Street & Shelter Outreach

Street outreach teams are deployed city-wide in Philadelphia on a year round basis. These services have been expanded to provide 24 hour outreach. PATH funded staff are included in these efforts and are deployed throughout the city, targeting the City as well as identified "hot spots". During periods of severe winter or summer weather, outreach hours are extended in order to prevent weather-related injuries or death. Individuals who

are PATH eligible and are reached via Outreach efforts, are given access to Respite and Café-style overnight placements, Safe Havens, JOH or shelter placement, on a referral basis. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic homelessness.

Service Coordination: Outreach efforts involving mental health, Office of Supportive Housing (OSH) and medical personnel are centrally coordinated by the Outreach Coordination Center (OCC). This resource, funded by DBHIDS, serves to both coordinate and deploy mobile outreach teams, and to facilitate rapid placements into specialized residences and generic shelters. The OCC has also worked closely with the Managing Directors Office with regard to the planning, implementation, and oversight of homeless service initiatives, including the 100 Day Challenge and Coordinated Entry Initiatives. RHD plays a strong role in this endeavor.

- Current Housing/Shelter Services and Supports

DBHIDS currently has contracts with six social service agencies for the provision of 253 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. Two of these programs are specified for the Emerging Youth population. These housing resources provide rehabilitative services, case management and transition support. Additional long term housing subsidies are provided via Federally funded Shelter Plus Care grants to homeless persons with disabilities related to mental illness, substance abuse and/or HIV.

Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 89% during CY 2016, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process.

The transitional housing programs serving homeless adults in Philadelphia remain full. Despite capacity expansion, there remains a substantial unmet need for permanent supported housing for homeless individuals who are graduating from these transitional programs. As is the case for persons who do not currently meet the federal definition of homelessness but have no current place to go as well as persons incarcerated over 90 days, but were homeless upon prison admission and will be homeless upon prison discharge.
RHD participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Director of Office of Supportive Housing. These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan (Code Red). The Office of the Managing Director has also been instrumental in working

with the DBHIDS in reference to securing federal housing and service grants targeting homeless populations.

RHD Safe Havens also work with PHA, OHS, DBHIDS and Housing First Providers to secure Permanent Supported Housing for all eligible residents. RHD continues to work with OHS and DBHIDS around the annual winter plan (Code Blue and Winter Initiative beds) and the summer heat emergency plan (Code Red), 100 Day Challenge, Coordinated Entry and Planning for people who are chronically and not chronically homeless, as well as the emerging adult population. In the future Cedar Park will be trained in the VIPSDAT to assess vulnerability and housing needs.

- Gaps

There are gaps in the area of shelter capacity. Shelter capacity cannot accommodate all the persons who wish to enter emergency housing. The last Point In Time count of unsheltered individuals was January 25th, 2017 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 799 persons were sleeping on the streets of Philadelphia. It is possible that the warmer than usual weather at the time of the count in Philadelphia effected the increase in numbers from last year. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is an additional team that started during CY 16 so there is more opportunity to count more people.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

- Services for Persons with Co-occurring Substance Use Disorders

All of the services described above are available for persons with co-occurring substance use disorders and all homeless services programs are expected to develop expertise to serve persons with co-occurring disorders. In addition, the DBHIDS has developed the Journeys of Hope (JOH) programs, which offer yearlong substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

Cedar Park staff have been trained in using Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify more needed resources and treatment for people. In 2017 DBHIDS

provided an Opioid Task Force to work with the community around needs. We are in the planning phases of more options available for people with this need.

- Evidenced Based Practices

DBHIDS supports homeless programs, to participate in training on cognitive and cognitive behavioral therapy (CBT) training. Adapted from therapy practice, all outreach workers and safe haven staff are trained on the principles of CBT. Outreach has also had significant training in motivational interviewing techniques. Safe Haven staff and Outreach workers have all staff training twice a year, that focus on resource access and developing skills of evidenced based practices.

- Alignment with SAMHSA's Strategic Initiative #3: Military Families

All PATH funded services in Philadelphia, are available to homeless veterans. Weekly PATH funded outreach workers and VA outreach staff spend a shift on the street, engaging homeless veterans. Coordination of care with the VA occurs at the participant, program and system level to coordinate care for those who have served their country. Veterans have been placed in the safe haven system and are prioritized for access to HUDVASH voucher resources as well as VA treatment resources. There are bi-weekly collaborative meetings with the City and the VA to collaborate and coordinate VA and homeless services and housing placement.

- Alignment with SAMHSA's Strategic Initiative #4: Recovery Support

Safe Haven residential services are designed to engage the most vulnerable persons living on our streets and assist them with moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), the DBHIDS Homeless Services system can respond to most needs. RHD also calls upon the experience and expertise of Certified Peer Specialists to further engage clients in the Safe Havens in their road to recovery.

Cedar Park is also working closely with the Safe Haven Learning Collaborative in an effort to provide residential transformation to align with DBHIDS Practice Guidelines and Recovery Principles, including creating a warmer hand-off with Street Outreach.

Data RHD Cedar Park has been trained in HMIS in the spring of 2017 and will begin to submit all data to HMIS while continuing to provide data to DBHIDS. Safe Havens do real time data into HMIS with their residents. Cedar Park will submit data into HMIS when the OHS HMIS system is ready to move forward.

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Alignment with PATH Goals The City uses Outreach data to determine chronicity and people who are the most vulnerable and have spent the most times on the street to help inform eligibility for Housing First services, Safe Havens and any other housing options available through PHA or DBH reinvestment dollars. This data is also being used to help inform the OHS By Name List which is being built to target people with the most need and chronicity to access valuable resources for housing and to end homelessness.

DBHIDS works with a variety of City Departments and stakeholders at quarterly Homeless Death Reviews to identify circumstances that may have led to someone's death on the streets or in emergency housing, and ways to collaborate to identify issues and prevention of homeless deaths. This includes the Department of Behavioral Health and Intellectual disAbilities (DBHIDS), OSH, the Medical Examiner's Office (MEO), the Prison System as well as many others. We utilize this process to ask ourselves what can we do better as a system to prevent homeless deaths.

The City, Outreach and it's various stakeholders have been working together around the 100 Day Challenge model to coordinate and collaborate around homelessness, again looking to ways to decrease homelessness on the streets of Philadelphia. With a new administration in the City and several Departments, we continue to find ways to increase all collaborative efforts. These efforts have led to the By Name List, Coordinated Entry and utilizing the VISPDAT as an assessment tool.

Alignment with State Mental Health Services Plan Our system operates within the Recovery model which includes Person First services throughout DBHIDS. The Department's Practice Guidelines for Persons in Recovery has been implemented throughout services and Providers including Project Home and RHD. Providers work closely with DBHIDS and the Office of Emergency Services for emergency planning or disaster preparedness through as well as large events that take place within the City of Philadelphia, such as the DNC in Philadelphia Summer of 2016. Coordination and collaboration mark these events as well as trainings and open lines of communication.

Alignment with State Plan to End Homelessness $43 million dollars of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe

Haven staff have received Narcan training and K2 training which has been increasing in Philadelphia.

DBHIDS and RHD have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

Also, there are yearly and quarterly Point In Time (PIT) Counts to identify how many people are on the streets at the same time during the year. This helps identify other areas of the City where homeless people are so outreach services can be expanded. There is expected to be a new A sixth Outreach Team has been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City.

In the last year, access to Housing Choice Vouchers through PHA has become very limited. This has decreased our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities.

Other Designated Funds DBHIDS spends $50 million dollars annually for persons experiencing homelessness, this includes funding from Medicaid, the Mental Health Block Grant and the Substance Abuse Block Grant. Different funding streams are work in collaboration to fund our efforts with the Journey of Hope Programs, Housing First Services and Safe Havens. It should be noted that these funds are not specifically designated to only serve people who are experiencing homelessness and have a serious mental illness (SMI), as some of the funds are designated for addiction services. Additionally, none of the designated funds are earmarked specifically for PATH services.

Programmatic and Financial Oversight The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Cedar Park, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical support to Cedar Park. DBHIDS provides daily support to all PATH funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR) Homeless Advocacy Project (HAP) had been providing SOAR through a grant over the last several years, but lost their funding and are not been able to provide SOAR at this time. We are working with HAP and PATH to identify grants and options for HAP to begin to provide SOAR again

to people who are homeless via Outreach and Safe Havens. HAP does continue to work with people in OHS shelter and connected to DHS for aging out youth.

Access to Housing Outreach participants have exclusive access to the DBH safe haven system that includes all three PATH funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens no longer have access as a priority to these resources, these have been severely limited.
- OHS Clearinghouse opportunities, 811 subsidies and Senior Housing

- Exclusive access to openings in the city's inventory of 605 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.

- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project. .

- Priority access to Mental Health residential services including programs operated by RHD, Horizon House and Northwestern Human Services.

- Bridge Vouchers utilizing DBHIDS reinvestment funds.

Coordinated Entry RHD along with OSH, DBHIDS, and many other stakeholders are working together to identify a new Coordinated Entry process into the homeless services system under the CoC initiative. Although many stakeholders in Philadelphia work closely together, there is recognition that we need to coordinate admissions into homeless services and shelter in a more cohesive and collaborative way.

Justice Involved DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually

working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. Based on these trends, we believe that 30% of PATH clients served have a criminal history.

Staff Information All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies and health disparities. We do not collect demographic information on staff serving PATH clients.

Client Information The projected number of people to be contacted using PATH funds is approximately 1860 persons. The majority of those will be through outreach services, while 131 will be through the residential programs. The projected number of adult clients to be enrolled using PATH funds will be 280 persons. All persons admitted to residential services (approximately 280), will be considered PATH enrolled clients and another 150 will receive outreach case management services, from Project Home. Cedar Park specifically expects to contact approximately 55 people and enroll that same number as all referrals to Cedar Park are pre-approved by DBHIDS as meeting eligibility requirements prior to admission. So all residents are contacted and enrolled on the same day. All clients served by PATH funds will be "literally" homeless (i.e., living outdoors or in an emergency shelter rather than at imminent risk of homelessness). The following are the demographics of those who received Outreach contacts:

- 73.3% had both co-occurring substance abuse and behavioral health issues
- 5.7% veterans
- 59.3% black/African-American
- 32.8% white
- 71.4% male
- 28.6% female
- 16.6% between the ages of 18-29
- 21% between the ages of 30-39
- 21.8% between the ages of 40-49
- 27.7% between the ages of 50-59
- 12.8% aged 60+

Consumer Involvement DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. Inclusivity efforts, with regard to planning and service initiatives, have increased in response to the DBHIDS' Recovery Transformation model that is implemented across the behavioral health care system. Numerous task forces have been organized to address

programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia.

Safe Havens have access to Peer Specialists that come to the location and participate with residents in a variety of ways that are based on the interest and needs of the residents. In an effort to engage families and help with a variety of needs and resources, DBHIDS also runs the Family Support Network; a place where families can stop-by to receive guidance they may need. Safe Havens are also part of the Safe Haven Learning Collaborative and participate fully in transforming the Safe Haven system to align with DBHIDS Practice Guidelines for a recovery oriented system. They also work with outreach to create a warmer hand off in alignment with these principles. Cedar Park requests that every resident list a family member or someone they consider to be family to program events and DBHIDS concurrent reviews.

Finally, DBHIDS' Office of Mental Health prepares an Annual Plan for Mental Health Services. This plan is distributed on an annual basis to the public, the Community Support Program (CSP) and provider agencies. A forum is then offered to the community to provide comments, feedback, and suggest programs and services for inclusion in the plan. This public forum is open to consumers, family members, as well as the provider community.

Health Disparities Impact Statement Mental Health and physical health are strongly linked. Evidence shows that mental health disorders are associated with increased risk, occurrence, progression and outcomes of serious chronic diseases and health conditions. This appears to be caused by mental health disorders that may precede a chronic illness and that an illness can worsen a mental health disorder which can create a cycle of poor health in general. The cycle can decrease someone's ability to be a part of treatment and recovery from both. PATH funds are used to hire outreach workers, and those teams target underserved populations who are more likely to experience behavioral health disparities.

Philadelphia's street homeless population has been found to be 71.4% male and 59.3% African-American. Our staffing patterns for outreach and in the safe havens reflects similar demographics, however we do not collect data on the demographics of our staff. An increasing number of homeless persons are Spanish Speaking only and we are actively recruiting staff who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are

looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

16.6% of the street population are between the ages of 18-29, and RHD La Casa Safe Haven was transitioned to serve the TAY population to better meet the needs the needs of males within this age group and to create a bridge to Permanent Supported Housing. The total amount of PATH funds expected to be expended on services for the TAY population is $338,135A second Safe Haven has also transitioned to an emerging youth Safe Haven for women between18-24.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

Limited English Proficiency PATH funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative The PATH Funds received are allocated for the salaries and benefits for 10 direct care staff at Cedar Park specifically. All of the staff listed on the PATH 2017-2018 Budget will provide those PATH services identified in section 4 of the Intended Use Plan.

Other staffing costs, including oversight and supervision, clerical support, maintenance, etc. will be funded by Philadelphia County.

Travel, Supplies, Indirect, and Other costs will be funded by Philadelphia County.

PATH Allocation…… Total: $289,639

Comprehensive Budget

RHD - Cedar Park	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Program Manager	$67,000	100%	$67,000	$67,000
Case Mgr	$27,040	100%	$27,040	$27,040
Ld Resident Advisor	$26,000	100%	$26,000	$26,000
Resident Advisor	$24,900	100%	$24,900	$22,880
Resident Advisor	$24,900	100%	$24,900	$22,880
Resident Advisor	$24,900	100%	$24,900	$22,880
Resident Advisor	$24,900	100%	$24,900	$22,880
Resident Advisor	$24,900	80%	$19,968	$19,968
Resident Advisor	$24,900	80%	$19,968	$19,968
Resident Advisor	$24,900	80%	$19,968	$19,968
Subtotal	**$294,340**			**$289,639**

41. Philadelphia County - RHD (Kailo Haven)

2107 Tioga St

Philadelphia, PA 19140

Contact: Jim McPhail

Contact Phone #: 2152258645

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID: PA-061

State Provider ID: 4261

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

RHD-Kailo Haven will receive a total of $385,827 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 60

Estimated Number of Persons to be Enrolled: 60

Estimated Number of Persons to be Contacted who are Literally Homeless: 60

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Resources for Human Development: Kailo Haven
4700 Wissahickon Avenue
Philadelphia, PA 19144
2016-2017 PATH Intended Use Plan
Philadelphia County

Local Provider Description Resources for Human Development (RHD) is a non-profit community behavioral health services organization center that provides a full continuum of mental health, substance abuse and physical health services. The Philadelphia County Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) contracts with RHD to provide mental health services, including PATH funded resources. Kailo Haven (PA-061 Philadelphia: Resourced for Human Development – Kailo Haven) is a Safe Haven located at 2107 Tioga Street, Philadelphia, PA 19134. The PATH funds received cover part of the cost of the supportive staff at this location.

Kailo Haven serves persons with serious and persistent mental illness, and persons with co-occurring substance abuse issues who have recently been street homeless. This program is centrally gatekept by Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS) and is contained within the County's residential care continuum.

Kailo Haven will receive $385,827 from PATH funding; all of which is federal allocated.

Project	Federal Allocation	State Allocation	Total Allocation
RHD - Kailo Haven	$ 0	$385,827	$ 385,827
Total	**$ 0**	**$385,827**	**$ 385,827**

Coordination with the HUD Continuum of Care (COC) Program Kailo Haven, represented by RHD, is a key participant in the Continuum of Care (CoC) Board and is the recipient of a variety of CoC grants to provider permanent supportive housing (PSH) to persons with serious mental illness.

In addition, RHD and Kailo Haven work very closely with Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS). DBHIDS allocates $50million dollars for an array of homeless services through its contracted agencies including housing (transitional and permanent), residential support, case management, and outreach and evaluation.

The DBHIDS PATH coordinator as well as RHD sits on the local Continuum of Care (CoC) Board or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinator have been involved with the 100 Day Challenge in Philadelphia and part of the Coordinated Entry planning and discussions. Persons who receive PATH funded services are a high priority for CoC resources. RHD played a leadership role in working on the 100 Day Challenge with all aspects of homelessness and housing for people who are chronically

homeless or not chronically homeless, as in the emerging adult population who do not always meet that definition.

DBHIDS works very closely and intricately with the local Philadelphia CoC. The collaboration is built upon a mutual respect and vision which is further deepened through monthly meetings between the Office of Homeless Services (OHS), RHD, and DBHIDS, and continual coordination regarding people in Safe Havens, including Cedar Park, to identify housing, housing needs and challenges that may arise.

Collaboration with the Local Community Organizations The designated PATH providers and Kailo Haven are well connected in the network of community providers working to end homelessness. RHD operates the central intake for single men for the city. RHD manages a significant portion of the Mental Health Residential system and has a newspaper developed for and management by homeless and formerly homeless persons, called "One Step Away". RHD also operates three drug and alcohol treatment programs (JOH) that serve exclusively chronically homeless individuals, New Start I, New Start II and Womanspace. RHD also operates a federally qualified health center that offers low or no cost health care services for the uninsured or underinsured. The agency offers supportive employment programming that is available to PATH clients and has an inventory of Permanent Supportive Housing and is recipients of numerous McKinney/COC grants. RHD also works with Horizon House to identify people with the highest need for housing services through their programs (Housing First).

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The transitional housing programs serving homeless adults in Philadelphia remain full. Despite capacity expansion, there remains a substantial unmet need for permanent supported housing for homeless individuals who are graduating from these transitional programs. As is the case for persons who do not currently meet the federal definition of homelessness but have no current place to go as well as persons incarcerated over 90 days, but were homeless upon prison admission and will be homeless upon prison discharge.

RHD participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Director of Office of Supportive Housing. These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan (Code Red). The Office of the Managing Director has also been instrumental in working with the DBHIDS in reference to securing federal housing and service grants targeting homeless populations.

RHD Safe Havens also work with PHA, OHS, DBHIDS and Housing First Providers to secure Permanent Supported Housing for all eligible residents. RHD continues to work with OHS and DBHIDS around the annual winter plan (Code Blue and Winter Initiative

beds) and the summer heat emergency plan (Code Red), 100 Day Challenge, Coordinated Entry and Planning for people who are chronically and not chronically homeless, as well as the emerging adult population. Kailo Haven increases it's census by 10 beds during the winter outreach months as well. In the future Kailo Haven will be trained in the VIPSDAT to assess vulnerability and housing needs.

- Gaps

There are gaps in the area of shelter capacity. Shelter capacity cannot accommodate all the persons who wish to enter emergency housing. The last Point In Time count of unsheltered individuals was January 25th, 2017 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 799 persons were sleeping on the streets of Philadelphia. It is possible that the warmer than usual weather at the time of the count in Philadelphia effected the increase in numbers from last year. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is an additional team that started during CY 16 so there is more opportunity to count more people.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

- Services for Persons with Co-occurring Substance Use Disorders

All of the services described above are available for persons with co-occurring substance use disorders and all homeless services programs are expected to develop expertise to serve persons with co-occurring disorders. In addition, the DBHIDS has developed the Journeys of Hope (JOH) programs, which offer yearlong substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

Kailo Haven staff have been trained in using Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify more needed resources and treatment for people. In 2017 DBHIDS provided an Opioid Task Force to work with the community around needs. We are in the planning phases of more options available for people with this need.

- Evidenced Based Practices

DBHIDS supports homeless programs, to participate in training on cognitive and cognitive behavioral therapy (CBT) training. Adapted from therapy practice, all outreach workers and safe haven staff are trained on the principles of CBT. Outreach has also had significant training in motivational interviewing techniques. Safe Haven staff and Outreach workers have all staff training twice a year, that focus on resource access and developing skills of evidenced based practices.

- Alignment with SAMHSA's Strategic Initiative #3: Military Families

All PATH funded services in Philadelphia, are available to homeless veterans. Weekly PATH funded outreach workers and VA outreach staff spend a shift on the street, engaging homeless veterans. Coordination of care with the VA occurs at the participant, program and system level to coordinate care for those who have served their country. Veterans have been placed in the safe haven system and are prioritized for access to HUDVASH voucher resources as well as VA treatment resources. There are bi-weekly collaborative meetings with the City and the VA to collaborate and coordinate VA and homeless services and housing placement.

- Alignment with SAMHSA's Strategic Initiative #4: Recovery Support

Safe Haven residential services are designed to engage the most vulnerable persons living on our streets and assist them with moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), the DBHIDS Homeless Services system can respond to most needs. RHD also calls upon the experience and expertise of Certified Peer Specialists to further engage clients in the Safe Havens in their road to recovery.

Kailo Haven is also working closely with the Safe Haven Learning Collaborative in an effort to provide residential transformation to align with DBHIDS Practice Guidelines and Recovery Principles, including creating a warmer hand-off with Street Outreach.

Data RHD Kailo Haven has been trained in HMIS in the spring of 2017 and will begin to submit all data to HMIS while continuing to provide data to DBHIDS. Safe Havens do real time data into HMIS with their residents. Kailo Haven will submit data into HMIS when the OHS HMIS system is ready to move forward

Alignment with PATH Goals The City uses Outreach data to determine chronicity and people who are the most vulnerable and have spent the most times on the street to help inform eligibility for Housing First services, Safe Havens and any other housing options available through PHA or DBH reinvestment dollars. This data is also being used to help inform the OHS By Name List which is being built to target people with the most need and chronicity to access valuable resources for housing and to end homelessness.

DBHIDS works with a variety of City Departments and stakeholders at quarterly Homeless Death Reviews to identify circumstances that may have led to someone's death

on the streets or in emergency housing and ways to collaborate to identify issues and prevention of homeless deaths. This includes the Department of Behavioral Health and Intellectual disAbilities (DBHIDS), OSH, the Medical Examiner's Office (MEO), the Prison System as well as many others. We utilize this process to ask ourselves what can we do better as a system to prevent homeless deaths.

The City, Outreach and it's various stakeholders have been working together around the 100 Day Challenge model to coordinate and collaborate around homelessness, again looking to ways to decrease homelessness on the streets of Philadelphia. With a new administration in the City and several Departments, we continue to find ways to increase all collaborative efforts. These efforts have led to the By Name List, Coordinated Entry and utilizing the VISPDAT as an assessment tool.

Alignment with State Mental Health Services Plan Our system operates within the Recovery model which includes Person First services throughout DBHIDS. The Department's Practice Guidelines for Persons in Recovery has been implemented throughout services and Providers including Project Home and RHD. Providers work closely with DBHIDS and the Office of Emergency Services for emergency planning or disaster preparedness through as well as large events that take place within the City of Philadelphia, such as the DNC in Philadelphia Summer of 2016. Coordination and collaboration mark these events as well as trainings and open lines of communication.

Alignment with State Plan to End Homelessness $43 million dollars of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have received Narcan training and K2 training which has been increasing in Philadelphia.

DBHIDS and RHD have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

Also, there are yearly and quarterly Point In Time (PIT) Counts to identify how many people are on the streets at the same time during the year. This helps identify other areas

of the City where homeless people are so outreach services can be expanded. There is expected to be a new A sixth Outreach Team has been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City.

In the last year, access to Housing Choice Vouchers through PHA has become very limited. This has decreased our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities.

Other Designated Funds DBHIDS spends $50 million dollars annually for persons experiencing homelessness, this includes funding from Medicaid, the Mental Health Block Grant and the Substance Abuse Block Grant. Different funding streams are work in collaboration to fund our efforts with the Journey of Hope Programs, Housing First Services and Safe Havens. It should be noted that these funds are not specifically designated to only serve people who are experiencing homelessness and have a serious mental illness (SMI), as some of the funds are designated for addiction services. Additionally, none of the designated funds are earmarked specifically for PATH services.

Programmatic and Financial Oversight The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Cedar Park, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical support to Cedar Park. DBHIDS provides daily support to all PATH funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR) Homeless Advocacy Project (HAP) had been providing SOAR through a grant over the last several years, but lost their funding and are not been able to provide SOAR at this time. We are working with HAP and PATH to identify grants and options for HAP to begin to provide SOAR again to people who are homeless via Outreach and Safe Havens. HAP does continue to work with people in OHS shelter and connected to DHS for aging out youth.

Access to Housing Outreach participants have exclusive access to the DBH safe haven system that includes all three PATH funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens no longer have access as a priority to these resources, these have been severely limited.
- OHS Clearinghouse opportunities, 811 subsidies and Senior Housing

- Exclusive access to openings in the city's inventory of 605 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.

- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project. .

- Priority access to Mental Health residential services including programs operated by RHD, Horizon House and Northwestern Human Services.

- Bridge Vouchers utilizing DBHIDS reinvestment funds.

Coordinated Entry RHD along with OSH, DBHIDS, and many other stakeholders are working together to identify a new Coordinated Entry process into the homeless services system under the CoC initiative. Although many stakeholders in Philadelphia work closely together, there is recognition that we need to coordinate admissions into homeless services and shelter in a more cohesive and collaborative way.

Justice Involved DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and are given access to Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. Based on these trends, we believe that 30% of PATH clients served have a criminal history.

Staff Information All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies

and health disparities. We do not collect demographic information on staff serving PATH clients.

Client Information The projected number of people to be contacted using PATH funds is approximately 1860 persons. The majority of those will be through outreach services, while 131 will be through the residential programs. The projected number of adult clients to be enrolled using PATH funds will be 280 persons. All persons admitted to residential services (approximately 280), will be considered PATH enrolled clients and another 150 will receive outreach case management services, from Project Home. Kailo Haven specifically expects to contact approximately 60 people and enroll that same number as all referrals to Kailo Haven are pre-approved by DBHIDS as meeting eligibility requirements prior to admission. So all residents are contacted and enrolled on the same day. All clients served by PATH funds will be "literally" homeless (i.e., living outdoors or in an emergency shelter rather than at imminent risk of homelessness). The following are the demographics of those who received Outreach contacts:

- 73.3% had both co-occurring substance abuse and behavioral health issues
- 5.7% veterans
- 59.3% black/African-American
- 32.8% white
- 71.4% male
- 28.6% female
- 16.6% between the ages of 18-29
- 21% between the ages of 30-39
- 21.8% between the ages of 40-49
- 27.7% between the ages of 50-59
- 12.8% aged 60+

Consumer Involvement DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. Inclusivity efforts, with regard to planning and service initiatives, have increased in response to the DBHIDS' Recovery Transformation model that is implemented across the behavioral health care system. Numerous task forces have been organized to address programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia. At Kailo Haven cards and stamps are provided to residents who want to contact family members and this helps in repairing possibly damaged relationships. Family of choosing

are invited to events or to visit, or join for meals. Kailo Haven also holds cook outs and holiday meals for residents and their family or friend and supports.

Safe Havens have access to Peer Specialists that come to the location and participate with residents in a variety of ways that are based on the interest and needs of the residents. In an effort to engage families and help with a variety of needs and resources, DBHIDS also runs the Family Support Network; a place where families can stop-by to receive guidance they may need. Safe Havens are also part of the Safe Haven Learning Collaborative and participate fully in transforming the Safe Haven system to align with DBHIDS Practice Guidelines for a recovery oriented system. They also work with outreach to create a warmer hand off in alignment with these principles.

Kailo Haven has an advisory committee run by the residents and the leadership go to all staff meetings. They give and receive input concerning any issues or policies and are part of all decision making procedures. Residents also form their own recovery and goal plans.

Finally, DBHIDS' Office of Mental Health prepares an Annual Plan for Mental Health Services. This plan is distributed on an annual basis to the public, the Community Support Program (CSP) and provider agencies. A forum is then offered to the community to provide comments, feedback, and suggest programs and services for inclusion in the plan. This public forum is open to consumers, family members, as well as the provider community.

Health Disparities Impact Statement

Mental Health and physical health are strongly linked. Evidence shows that mental health disorders are associated with increased risk, occurrence, progression and outcomes of serious chronic diseases and health conditions. This appears to be caused by mental health disorders that may precede a chronic illness and that an illness can worsen a mental health disorder which can create a cycle of poor health in general. The cycle can decrease someone's ability to be a part of treatment and recovery from both. PATH funds are used to hire outreach workers, and those teams target underserved populations who are more likely to experience behavioral health disparities.

Philadelphia's street homeless population has been found to be 71.4% male and 59.3% African-American. Our staffing patterns for outreach and in the safe havens reflects similar demographics, however we do not collect data on the demographics of our staff. An increasing number of homeless persons are Spanish Speaking only and we are actively recruiting staff who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender

variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

16.6% of the street population are between the ages of 18-29, and RHD La Casa Safe Haven was transitioned to serve the TAY population to better meet the needs the needs of males within this age group and to create a bridge to Permanent Supported Housing. The total amount of PATH funds expected to be expended on services for the TAY population is $338,135A second Safe Haven has also transitioned to an emerging youth Safe Haven for women between18-24.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

Limited English Proficiency PATH funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative The PATH Funds received are allocated for the salaries and benefits for 19 direct care staff at Kailo Haven specifically. All of the staff listed on the PATH 2017-2018 Budget will provide those PATH services identified in section 4 of the Intended Use Plan.

Other staffing costs, including oversight and supervision, clerical support, maintenance, etc. will be funded by Philadelphia County.

Travel, Supplies, Indirect, and Other costs will be funded by Philadelphia County.

PATH Allocation…… Total: $385,827

Clinical Manager	$0	100%	$0	$0
Program Dir	$40,000	100%	$40,000	$62,000
Supervisor	$32,000	100%	$32,000	$32,000
Supervisor	$32,000	100%	$28,497	$32,000
Peer Specialist	$0	100%	$0	$0
Case Mgr	$39,585	100%	$39,585	$39,585
Resident Advisor	$27,040	100%	$27,040	$27,040
Resident Advisor	$27,040	100%	$27,040	$27,040
Resident Advisor	$27,040	100%	$27,040	$27,040
Resident Advisor	$24,980	100%	$24,980	$24,980
Resident Advisor	$24,980	100%	$24,980	$24,980
Resident Advisor	$24,980	50%	$24,980	$12,490
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
D.S. Personnel	$27,040	62%	$27,040	$16,768
Subtotal	**$385,827**			**$385,827**

$0

42. Philadelphia County - RHD (La Casa)

504 Washington Ave

Philadelphia, PA 19147

Contact: Howard McNeill

Contact Phone #: 2154625041

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID: PA-059

State Provider ID: 4259

Geographical Area Served: Southeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				
g. Housing	$ 0	$ 0	$ 0	
No Data Available				
h. Construction (non-allowable)				
i. Other	$ 0	$ 0	$ 0	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

RHD-La Casa will receive $338,135 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 25

Estimated Number of Persons to be Enrolled: 25

Estimated Number of Persons to be Contacted who are Literally Homeless: 25

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Resources for Human Development: La Casa
4700 Wissahickon Avenue
Philadelphia, PA 19144
2017-2018 PATH Intended Use Plan
Philadelphia County

Local Provider Description Resources for Human Development (RHD) is a non-profit community behavioral health services organization center that provides a full continuum of mental health, substance abuse and physical health services. The Philadelphia County Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) contracts with RHD to provide mental health services, including PATH funded resources. La Casa (PA – 059 Philadelphia: Resources for Human Development – La Casa) is a Safe Haven located at 504 Washington Avenue, Philadelphia, PA 19147. The PATH funds received cover part of the cost of the supportive staff at this location.

La Casa serves homeless transition aged males (18-24). This program is centrally gatekept by Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS) and is contained within the County's residential care continuum.

La Casa will receive $338,135 from PATH funding; all of which is federal allocated.

Project	Federal Allocation	State Allocation	Total Allocation
RHD - La Casa	$ 338,135	$ 0	$ 338,135
Total	**$ 338,135**	**$ 0**	**$ 338,135**

Coordination with the HUD Continuum of Care (CoC) Program La Casa, represented by RHD, is a key participant in the Continuum of Care (CoC) Board and is the recipient of a variety of CoC grants to provider permanent supportive housing (PSH) to persons with serious mental illness.

In addition, RHD and La Casa work very closely with Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS). DBHIDS allocates $50million dollars for an array of homeless services through its contracted agencies including housing (transitional and permanent), residential support, case management, and outreach and evaluation.

The DBHIDS PATH coordinator as well as RHD sits on the local Continuum of Care (CoC) Board or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinator have been involved with the 100 Day Challenge in Philadelphia and part of the Coordinated Entry planning and discussions. Persons who receive PATH funded services are a high priority for CoC resources. RHD played a leadership role in working on the 100 Day Challenge with all aspects of homelessness and housing for people who are chronically homeless or not chronically homeless, as in the emerging adult population who do not always meet that definition.

DBHIDS works very closely and intricately with the local Philadelphia CoC. The collaboration is built upon a mutual respect and vision which is further deepened through monthly meetings between the Office of Homeless Services (OHS), RHD, and DBHIDS, and continual coordination regarding people in Safe Havens, including Lacasa, to identify housing, housing needs and challenges that may arise.

Collaboration with Local Community Organizations The designated PATH providers and La Casa are well connected in the network of community providers working to end homelessness. RHD operates the central intake for single men for the city. RHD manages a significant portion of the Mental Health Residential system and has a newspaper developed for and management by homeless and formerly homeless persons, called "One Step Away". RHD also operates three drug and alcohol treatment programs that serve exclusively chronically homeless individuals, New Start I, New Start II and Womanspace. RHD also operates a federally qualified health center that offers low or no cost health care services for the uninsured or underinsured. The agency offers supportive employment programming that is available to PATH clients and has an inventory of Permanent Supportive Housing and is recipients of numerous McKinney/COC grants. RHD also works with Horizon House to identify people with the highest need for housing services through their programs (Housing First).

Service Provision - Philadelphia continues to use data to identify, target and prioritize the most vulnerable people on the street link to needed housing and service resources. This information is used to identify people who are eligible for Safe Havens and JOH emergency housing, and any other housing options so that these are the prioritized people targeted for housing resource. In the coming year there will be continued collaboration around creating a By Name List of people with City Departments (Office of Homeless Services) and other stakeholders, including Project Home and RHD. It should be noted that DBHIDS is not responsible for following 42 CFR Part 2 regulations, as we do not provide licensed drug and alcohol outreach programs.

La Casa provides shelter for transition aged youth and also provides some outreach to this population. They work with various youth homeless groups in the City to reach out for referrals from the Synergy Project (youth outreach), Covenant House shelter, Youth Valley House and the Attic, all youth providers.

- Street & Shelter Outreach

Street outreach teams are deployed city-wide in Philadelphia on a year round basis. These services have been expanded to provide 24 hour outreach. PATH funded staff are included in these efforts and are deployed throughout the city, targeting the City as well as identified "hot spots". During periods of severe winter or summer weather, outreach hours are extended in order to prevent weather-related injuries or death. Individuals who

are PATH eligible and are reached via Outreach efforts, are given access to Respite and Café-style overnight placements, Safe Havens, JOH or shelter placement, on a referral basis. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic homelessness. La Casa also works with the Synergy Program who provide youth outreach and they will reach out to this population to seek referrals. They have built strong relationships with youth providers in the City.

Service Coordination: Outreach efforts that involve mental health, and medical personnel are centrally coordinated by the Outreach Coordination Center (OCC). This resource, funded by DBHIDS, serves to both coordinate and deploy mobile outreach teams and to facilitate rapid placements into specialized residences and generic shelters. The OCC has also worked closely with the Office of Homeless Services, the Mayor's Point of contact regarding the planning, implementation, and oversight of homeless service initiatives, including the 100 Day Challenge and Coordinated Entry.

Service Coordination: Outreach efforts involving mental health, Office of Supportive Housing (OSH) and medical personnel are centrally coordinated by the Outreach Coordination Center (OCC). This resource, funded by DBHIDS, serves to both coordinate and deploy mobile outreach teams, and to facilitate rapid placements into specialized residences and generic shelters. The OCC has also worked closely with the Managing Directors Office with regard to the planning, implementation, and oversight of homeless service initiatives, including the 100 Day Challenge and Coordinated Entry Initiatives. RHD plays a strong role in this endeavor.

- Current Housing/Shelter Services and Supports

DBHIDS currently has contracts with six social service agencies for the provision of 253 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. Two of these programs are specified for the Emerging Youth population. These housing resources provide rehabilitative services, case management and transition support. Additional long term housing subsidies are provided via Federally funded Shelter Plus Care grants to homeless persons with disabilities related to mental illness, substance abuse and/or HIV.

Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 89% during CY 2016, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process.

The transitional housing programs serving homeless adults in Philadelphia remain full. Despite capacity expansion, there remains a substantial unmet need for permanent supported housing for homeless individuals who are graduating from these transitional programs. As is the case for persons who do not currently meet the federal definition of homelessness but have no current place to go as well as persons incarcerated over 90 days, but were homeless upon prison admission and will be homeless upon prison discharge.
RHD participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Director of Office of Supportive Housing. These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan (Code Red). The Office of the Managing Director has also been instrumental in working with the DBHIDS in reference to securing federal housing and service grants targeting homeless populations.

RHD Safe Havens also work with PHA, OHS, DBHIDS and Housing First Providers to secure Permanent Supported Housing for all eligible residents. RHD continues to work with OHS and DBHIDS around the annual winter plan (Code Blue and Winter Initiative beds) and the summer heat emergency plan (Code Red), 100 Day Challenge, Coordinated Entry and Planning for people who are chronically and not chronically homeless, as well as the emerging adult population. In the future La Casa will be trained in the VIPSDAT and the TAY-VISPDAT if that is appropriate to assess vulnerability and housing needs.

- Gaps

There are gaps in the area of shelter capacity. Shelter capacity cannot accommodate all the persons who wish to enter emergency housing. The last Point In Time count of unsheltered individuals was January 25th, 2017 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 799 persons were sleeping on the streets of Philadelphia. It is possible that the warmer than usual weather at the time of the count in Philadelphia effected the increase in numbers from last year. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is an additional team that started during CY 16 so there is more opportunity to count more people.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

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will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

La Casa staff have been trained in using Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify more needed resources and treatment for people. In 2017 DBHIDS provided an Opioid Task Force to work with the community around needs. We are in the planning phases of more options available for people with this need.

- Evidenced Based Practices

DBHIDS supports homeless programs, to participate in training on cognitive and cognitive behavioral therapy (CBT) training. Adapted from therapy practice, all outreach workers and safe haven staff are trained on the principles of CBT. Outreach has also had significant training in motivational interviewing techniques. Safe Haven staff and Outreach workers have all staff training twice a year, that focus on resource access and developing skills of evidenced based practices.

- Alignment with SAMHSA's Strategic Initiative #3: Military Families

All PATH funded services in Philadelphia, are available to homeless veterans. Weekly PATH funded outreach workers and VA outreach staff spend a shift on the street, engaging homeless veterans. Coordination of care with the VA occurs at the participant, program and system level to coordinate care for those who have served their country. Veterans have been placed in the safe haven system and are prioritized for access to HUDVASH voucher resources as well as VA treatment resources. There are bi-weekly collaborative meetings with the City and the VA to collaborate and coordinate VA and homeless services and housing placement.

- Alignment with SAMHSA's Strategic Initiative #4: Recovery Support

Safe Haven residential services are designed to engage the most vulnerable persons living on our streets and assist them with moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), the DBHIDS Homeless Services system can respond to most needs. RHD also calls upon the experience and expertise of Certified Peer Specialists to further engage clients in the Safe Havens in their road to recovery.

La Casa is also working closely with the Safe Haven Learning Collaborative in an effort to provide residential transformation to align with DBHIDS Practice Guidelines and Recovery Principles, including creating a warmer hand-off with Street Outreach.

Data RHD La Casa has been trained in HMIS in the spring of 2017 and will begin to submit all data to HMIS while continuing to provide data to DBHIDS. Safe Havens do real time data into HMIS with their residents. La Casa will submit data into HMIS when the OHS HMIS system is ready to move forward

Alignment with PATH Goals The City uses Outreach data to determine chronicity and people who are the most vulnerable and have spent the most times on the street to help inform eligibility for Housing First services, Safe Havens and any other housing options available through PHA or DBH reinvestment dollars. This data is also being used to help inform the OHS By Name List which is being built to target people with the most need and chronicity to access valuable resources for housing and to end homelessness.

DBHIDS works with a variety of City Departments and stakeholders at quarterly Homeless Death Reviews to identify circumstances that may have led to someone's death on the streets or in emergency housing, and ways to collaborate to identify issues and prevention of homeless deaths. This includes the Department of Behavioral Health and Intellectual disAbilities (DBHIDS), OSH, the Medical Examiner's Office (MEO), the Prison System as well as many others. We utilize this process to ask ourselves what can we do better as a system to prevent homeless deaths.

The City, Outreach and it's various stakeholders have been working together around the 100 Day Challenge model to coordinate and collaborate around homelessness, again looking to ways to decrease homelessness on the streets of Philadelphia. With a new administration in the City and several Departments, we continue to find ways to increase all collaborative efforts. These efforts have led to the By Name List, Coordinated Entry and utilizing the VISPDAT as an assessment tool.

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Alignment with State Mental Health Services Plan Our system operates within the Recovery model which includes Person First services throughout DBHIDS. The Department's Practice Guidelines for Persons in Recovery has been implemented throughout services and Providers including Project Home and RHD. Providers work closely with DBHIDS and the Office of Emergency Services for emergency planning or disaster preparedness through as well as large events that take place within the City of Philadelphia, such as the DNC in Philadelphia Summer of 2016. Coordination and collaboration mark these events as well as trainings and open lines of communication.

Alignment with State Plan to End Homelessness $43 million dollars of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate

closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have received Narcan training and K2 training which has been increasing in Philadelphia.

RHD and DBHIDS have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

Also, there are yearly and quarterly Point In Time (PIT) Counts to identify how many people are on the streets at the same time during the year. This helps identify other areas of the City where homeless people are so outreach services can be expanded. There is expected to be a new A sixth Outreach Team has been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City.

LaCasa Safe Haven targets emerging adult males, and a second Emerging Adults Safe H aven has opened targeted females. We are seeing approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs and staff are working on training and supports for Outreach and Safe Havens to address needs of this population.

In the last year there access to Housing Choice Vouchers through PHA has become very limited. This has decreased our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities.

Other Designated Funds DBHIDS spends $50 million dollars annually for persons experiencing homelessness, this includes funding from Medicaid, the Mental Health Block Grant and the Substance Abuse Block Grant. Different funding streams are work in collaboration to fund our efforts with the Journey of Hope Programs, Housing First Services and Safe Havens. It should be noted that these funds are not specifically designated to only serve people who are experiencing homelessness and have a serious mental illness (SMI), as some of the funds are designated for addiction services. Additionally, none of the designated funds are earmarked specifically for PATH services.

Programmatic and Financial Oversight The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Lacasa, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical support to La Casa. DBHIDS provides daily support to all PATH funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR) Homeless Advocacy Project (HAP) had been providing SOAR through a grant over the last several years, but lost their funding and are not been able to provide SOAR at this time. We are working with HAP and PATH to identify grants and options for HAP to begin to provide SOAR again to people who are homeless via Outreach and Safe Havens. HAP does continue to work with people in OHS shelter and connected to DHS for aging out youth.

Access to Housing Outreach participants have exclusive access to the DBH safe haven system that includes all three PATH funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens no longer have access as a priority to these resources, these have been severely limited.
- OHS Clearinghouse opportunities, 811 subsidies and Senior Housing
- Exclusive access to openings in the city's inventory of 605 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.
- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project. .
- Priority access to Mental Health residential services including programs operated by RHD, Horizon House and Northwestern Human Services.
- Bridge Vouchers utilizing DBHIDS reinvestment funds.

Coordinated Entry – RHD along with OSH, DBHIDS, and many other stakeholders are working together to identify a new Coordinated Entry process into the homeless services system under the CoC initiative. Although many stakeholders in Philadelphia work closely together, there is recognition that we need to coordinate admissions into homeless services and shelter in a more cohesive and collaborative way.

Justice Involved DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. Based on these trends, we believe that 30% of PATH clients served have a criminal history.

Staff Information All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies and health disparities. We do not collect demographic information on staff serving PATH clients.

Client Information The projected number of people to be contacted using PATH funds is approximately 1860 persons. The majority of those will be through outreach services, while 131 will be through the residential programs. The projected number of adult clients to be enrolled using PATH funds will be 280 persons. All persons admitted to residential services (approximately 280), will be considered PATH enrolled clients and another 150 will receive outreach case management services, from Project Home. LaCasa specifically expects to contact approximately 25 people and enroll that same number as all referrals to La Casa are pre-approved by DBHIDS as meeting eligibility requirements prior to admission. So all residents are contacted and enrolled on the same day. All clients served by PATH funds will be "literally" homeless (i.e., living outdoors or in an emergency shelter rather than at imminent risk of homelessness). The following are the demographics of those who received Outreach contacts:

- 73.3% had both co-occurring substance abuse and behavioral health issues
- 5.7% veterans
- 59.3% black/African-American
- 32.8% white
- 71.4% male
- 28.6% female

- 16.6% between the ages of 18-29
- 21% between the ages of 30-39
- 21.8% between the ages of 40-49
- 27.7% between the ages of 50-59
- 12.8% aged 60+

Consumer Involvement DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. Inclusivity efforts, with regard to planning and service initiatives, have increased in response to the DBHIDS' Recovery Transformation model that is implemented across the behavioral health care system. Numerous task forces have been organized to address programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia.

La Casa employs a Peer Specialists at their location who participates and works with residents in a variety of ways that are based on the interest and needs of the residents. In an effort to engage families and help with a variety of needs and resources, DBHIDS also runs the Family Support Network; a place where families can stop-by to receive guidance they may need. Safe Havens are also part of the Safe Haven Learning Collaborative and participate fully in transforming the Safe Haven system to align with DBHIDS Practice Guidelines for a recovery oriented system. They also work with outreach to create a warmer hand off in alignment with these principles.

La Casa utilizes a person-centered approach to support individuals to increase quality of life and overall wellness. This is also to help obtain and sustain housing in the community of their choosing. Staff at La Casa provides trauma-informed care. Residents are encouraged to have family members and significant others of their choosing be associated as they prefer on their recovery journey. There are visiting hours and internet access for communications, as well as several measures implemented that foster family involvement.

Finally, DBHIDS' Office of Mental Health prepares an Annual Plan for Mental Health Services. This plan is distributed on an annual basis to the public, the Community Support Program (CSP) and provider agencies. A forum is then offered to the community to provide comments, feedback, and suggest programs and services for inclusion in the plan. This public forum is open to consumers, family members, as well as the provider community.

Health Disparities Impact Statement Mental Health and physical health are strongly linked. Evidence shows that mental health disorders are associated with increased risk, occurrence, progression and outcomes of serious chronic diseases and health conditions. This appears to be caused by mental health disorders that may precede a chronic illness and that an illness can worsen a mental health disorder which can create a cycle of poor health in general. The cycle can decrease someone's ability to be a part of treatment and recovery from both. PATH funds are used to hire outreach workers, and those teams target underserved populations who are more likely to experience behavioral health disparities.

Philadelphia's street homeless population has been found to be 71.4% male and 59.3% African-American. Our staffing patterns for outreach and in the safe havens reflects similar demographics, however we do not collect data on the demographics of our staff. An increasing number of homeless persons are Spanish Speaking only and we are actively recruiting staff who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system. LaCasa has been trained around various LGBTQ needs to serve this population of emerging youth.

16.6% of the street population are between the ages of 18-29, and RHD La Casa Safe Haven was transitioned to serve the TAY population to better meet the needs the needs of males within this age group and to create a bridge to Permanent Supported Housing. The total amount of PATH funds expected to be expended on services for the TAY population is $338,135A second Safe Haven has also transitioned to an emerging youth Safe Haven for women between18-24.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

Limited English Proficiency PATH funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative - The PATH Funds received are allocated for the salaries and benefits for 13 direct care staff at La Casa. All of the staff listed on the PATH 2017-2018 Budget will provide those PATH services identified in section 4 of the Intended Use Plan.

Other staffing costs, including oversight and supervision, clerical support, maintenance, etc. will be funded by Philadelphia County.

Travel, Supplies, Indirect, and Other costs will be funded by Philadelphia County.

PATH Allocation…… Total: $338,135

Comprehensive Budget

RHD - La Casa	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Director	$61,325	100%	$61,325	$61,325
case manager	$45,000	100%	$45,000	$45,000
dir serv prof	$27,040	100%	$27,040	$27,040
dir serv prof	$26,000	100%	$26,000	$26,000
dir serv prof	$26,000	100%	$26,000	$26,000
dir serv prof	$26,000	100%	$26,000	$26,000
dir serv prof	$26,000	100%	$26,000	$26,000
dir serv prof	$26,000	60%	$15,600	$15,600
dir serv prof	$26,000	60%	$15,600	$15,600
dir serv prof	$26,000	60%	$15,600	$15,600
dir serv prof	$26,000	60%	$15,600	$15,600
cps	$29,120	100%	$29,120	$29,120
ops manager	$37,000	25%	$9,250	$9,250
Subtotal	**$399,485**			**$338,135**

43. Schuylkill County - Service Access and Management, Inc.

590 Terry Reiley Way

Pottsville, PA 17901

Contact: Gerald Achenbach

Contact Phone #: 5706212700

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-064

State Provider ID: 4264

Geographical Area Served: Northeast Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)

i. Other	$ 34,816	$ 11,605	$ 46,421	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 34,816	$ 11,605	$ 46,421	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 34,816	$ 11,605	$ 46,421	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 34,816	$ 11,605	$ 46,421	

Source(s) of Match Dollars for State Funds:

Schuylkill County will receive a total of $46,421 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 300

Estimated Number of Persons to be Enrolled: 90

Estimated Number of Persons to be Contacted who are Literally Homeless: 180

Number staff trained in SOAR in grant year ending in 2017: 0

Number of PATH-funded consumers assisted through SOAR: 0

Agency Providing Services:

Service Access and Management, Inc.
590 Terry Reiley Way
Pottsville, PA 17901

PDX: PA-064 Schuylkill: Service Access and Management, Inc.

Schuylkill County, Pennsylvania

PATH Intended Use Plan FY 2017-2018

1. **Local Provider Description –**
Provide a brief description of the provider organization receiving PATH funds, including name, type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization), region served, and the amount of PATH funds the organization will receive. Please include full name and mailing address of provider organization in the IUP. Also, separately, please list the provider name as it appears in PDX.

   The sole provider for PATH (Projects for Assistance in Transition from Homelessness) services in Schuylkill County for the 2017-2018 fiscal year will be:

   Service Access and Management, Inc.
   590 Terry Reiley Way
   Pottsville, PA 17901

   PDX: PA-064 Schuylkill: Service Access and Management, Inc.

   Service Access and Management, Inc. is a community mental health provider.

   The Schuylkill County Mental Health/Developmental Services (MH/DS) Program is responsible for seeing that individuals with mental health illnesses receive a full continuum of services in Schuylkill County, including housing services. Rather than providing housing services directly, the Schuylkill County Mental Health/Developmental Services Program contracts with Service Access and Management, Inc. for the provision of housing services for individuals with mental health illnesses in Schuylkill County

   This Intended Use Plan will serve consumers in Schuylkill County. Even though Service Access and Management, Inc. operates in forty-eight (48) Pennsylvania counties and six (6) counties in New Jersey, this particular Intended Use Plan is only for Schuylkill County, Pennsylvania.

The mission of Service Access & Management, Inc. is to help people throughout our service area enhance the quality of their lives by effectively and efficiently managing and/or providing needed, accessible and individually satisfying human services.

In part, our Vision Statement reads: Since our consumers are our most important focus, we treat each individual with dignity and integrity. Relentlessly committed to results, we actively use outcomes to measure and evaluate our performance and impact future growth.

Service Access and Management, Inc. is an organization with tight community ties, we respect and build upon the culture of each geographic area and service program. Additionally, we build bridges to others within our communities, resulting in meaningful working partnerships. With a strong operational backbone and an impeccable reputation, payors seek us out to manage their human service delivery systems and provide needed services.

Service Access and Management, Inc. programs, including Case Management/Service Coordination, are accredited by CARF (Commission on Accreditation of Rehabilitation Facilities).

Either directly, or through local partner providers, Service Access and Management, Inc. consumers with housing needs are eligible to receive the following services:

Certified Peer Support Services

Clubhouse/Psychiatric Rehabilitation

Crisis Intervention

Crisis Residential

In-Patient Behavioral Health

Mental Health Case Management

Mobile Psychiatric Rehabilitation

Out-Patient Psychiatry and Therapy

Representative Payeeship

Supported Living Program (on-site housing assistance)

Transitional Living Program (on-site housing assistance)

Vocational Services

Schuylkill County is scheduled to receive a total of $46,421 in PATH funding for the 2017 – 2018 fiscal year. Of this amount, $11,605 is the State (Block Grant) Match and $34,816 is the Federal Allocation. The local contribution is $37,205, plus additional funds in the amount of $25,600 for rental subsidies, security deposits, furniture, household items, motel vouchers, transportation vouchers and emergency food needs.

2. **Collaboration with HUD Continuum of Care (CoC) Program –**
Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry and coordinated assessment activities. If you are not currently working with the Continuum(s) of Care briefly explain the approaches to be taken by the agency to collaborate with the CoC(s) in the areas where PATH operates.

Schuylkill County's current membership in the HUD Continuum of Care Program is with the Central Valley Regional Homeless Advisory Board (RHAB). On July 1, 2014, Schuylkill County was transferred into the Central Valley Region, due to realignment. The Service Access and Management, Inc. Housing Coordinator is an active participant in the Central Valley Regional Homeless Advisory Board. The Housing Coordinator has taken a lead role in the Central Valley Regional Homeless Advisory Board by serving as the Co-Chair, and is a member of the larger Pennsylvania Eastern Continuum of Care Board. Participation in the Continuum of Care began in October 2009 and will continue. The Central Valley Regional Homeless Advisory Board meets monthly. Service Access and Management, Inc. is represented at each meeting.

Two organizations within our county are HUD Continuum of Care (CoC) recipients. Those recipients are Schuylkill Women in Crisis and Resources for Human Development. The Service Access and Management, Inc. PATH program collaborates regularly with Schuylkill Women in Crisis and Resources for Human Development.

Whenever the Service Access and Management, Inc. PATH program enrolls a female who has experienced any form of domestic violence or possible domestic violence, we ask that consumer to immediately sign release of information forms and we, then, contact Schuylkill Women in Crisis for their assistance.

Resources for Human Development has developed and opened twelve apartments with the assistance of HUD Continuum of Care (CoC) funds. Our PATH Master Case Manager works closely with the Resources for Human Development case manager. Together, they have placed a number of PATH consumers into Resources for Human Development apartments.

Other local planning activities and program coordination initiatives involving housing matters regarding persons who have a mental illness are overseen by the Local Housing Options Team (LHOT). Service Access and Management, Inc. has three (3) staff members that actively serve on the Schuylkill County Local Housing Options Team (LHOT). The LHOT is chaired by the Service Access and Management, Inc. Housing Director. The LHOT meets on a monthly basis; however, LHOT may meet more often

when the need arises. The LHOT met often during November 2016, December 2016 and January 2017 to plan for the January 2017 Point-in-Time Count.

Other local planning activities, along with coordination of programs, has provided persons with mental health illnesses the opportunity to reside in one of five permanent supportive housing apartment buildings that have been developed through program coordination with Block Grant funds. Admission into these five apartment buildings is initiated by submitting an application to Service Access and Management, Inc. Permanent supportive housing opportunities that currently exist to assist PATH consumers who are homeless and have a mental health illness include:

a. Barefield Plaza is the home to three apartments that have been set aside for individuals with serious mental health illnesses, including PATH consumers. Each of these apartments is a two bedroom apartment.

b. The NHS Human Services Mt. Hope apartment building includes ten (10) beds. Six (6) of those beds have been set aside for individuals with serious mental health illnesses, including PATH consumers. Some apartments are one bedroom apartments and some are two bedroom apartments.

c. Two additional apartments at 719 North Second Street, Pottsville, Pennsylvania, were later added to the permanent supportive housing inventory. Three beds are available at 719 North Second Street for consumers affected by a mental health illness, including PATH consumers.

d. In April of 2016, another two permanent supportive housing units were completed at 610 West Market Street in Pottsville, Pennsylvania. There are three bedrooms available at this location for consumers affected by a mental health illness, including PATH consumers.

e. In December of 2016, three additional permanent supportive housing units were completed at 21 South Centre Street in Pottsville, Pennsylvania. There are three bedrooms available at this location for consumers affected by a mental health illness, including PATH consumers.

f. Soon, construction will begin on a seven unit apartment building located at 200 South Centre Street in Pottsville, Pennsylvania. PATH consumers will be targeted for tenancy in that building which will be a site-based Section 8 building.

g. A full-time Housing Coordinator assists in many housing matters. The duties of the Housing Coordinator complement PATH services. The Housing Coordinator supervises the PATH Master Case Manager.

3. **Collaboration with Local Community Organizations –**
Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance abuse, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

Schuylkill County has a wide array of key services available to PATH consumers. These services include, but are not limited to:

a. Blended Case Management. These services link and coordinate individuals with serious and persistent mental illnesses to needed community resources. Regulations require face-to-face visits. Service Access and Management, Inc. is the sole provider of blended case management services in the county.

b. Administrative Case Management. These services provide support to individuals with serious and persistent mental illnesses who need assistance in accessing community resources. Contacts may be completed by telephone or face-to-face. In addition, all intakes at Service Access and Management, Inc. occur through Administrative Case Management. Here is where we often learn of individuals who are homeless or at imminent risk of homelessness. This is a strong addition to PATH outreach activities.

c. Supportive Living. In-home services are provided to help individuals develop and maintain the skills necessary to live independently in their own communities. Two companies, Allied and NHS Human Services, provide these services through a contractual arrangement with Service Access and Management, Inc. This allows for consumer choice.

d. Transportation. Services are available at no cost or very low cost for personal, medical or job related transportation. In Schuylkill County, county government operates public transportation. For PATH consumers who are also served by Servants to All, transportation is offered at no cost.

e. Outpatient Services. Five providers within the county provide specialized services including, but not limited to, medication management, psychotherapy and intensive outpatient services.

f. Crisis Intervention and Crisis Residential. These services are available to assist consumers with immediate telephone, face-to-face or mobile response in times of crisis.

g. Community Employment. Provides for work experiences, job training and job coaching in preparation for gainful employment.

h. Vocational Rehabilitation. Provides services in preparation for the return to gainful employment.

i. Peer Support Services. Certified Peer Specialists provide mentoring and support to individuals with serious mental illnesses to increase coping skills and resilience.

j. Psychiatric Rehabilitation. This is a site based psychiatric rehabilitation program.

k. Clubhouse Program. The Clubhouse Program is structured around a work-day model.

l. Intellectual Developmental Disability Case Management. These services link and coordinate individuals with Intellectual Developmental Disabilities and a Mental Health Diagnosis to needed community resources. Regulations require face-to-face visits. Service Access and Management, Inc. is the sole provider of intellectual developmental disability case management services in the county.

m. Mobile Psychiatric Rehabilitation. Mobile Psychiatric Rehabilitation is available to individuals who are not able to access traditional services due to transportation issues.

3.a. Provide specific information about how coordination with other outreach teams is achieved.

Coordination of outreach activities is achieved in a number of ways. Because we have a very active Local Housing Options Team (LHOT) that includes representatives from all major providers who assist with housing matters, we communicate regularly. In addition to this regular, on-going networking, we also have more intensive coordination with certain outreach teams between our Local Housing Options Team meetings.

The most active partner is Servants to All. Servants to All is a relatively new non-profit that was founded specifically for the purpose of assisting the homeless. Servants to All opened its day program on November 4, 2015. Almost every day, there is communication between Servants to All and Service Access and Management, Inc. regarding our common clients.

The PATH Master Case Manager visits with consumers for a few hours each Friday at the Servants to All day center.

Many other entities connect and coordinate with Service Access and Management, Inc. because of our active role in housing matters. Some of our most active partners are Children and Youth Services, Allied Services, Northwest

Human Services, Resources for Human Development, United Presbyterian Church, Bethesda E.C. Church, Adult Probation, the Transition Age Youth Committee, CareerLink, Salvation Army, the County Courthouse, Schuylkill Community Action, the County Mental Health Office, SafeHaven Crisis Residential, Schuylkill Medical Center, the City of Pottsville Housing Authority and the Schuylkill County Housing Authority.

4. Service Provision – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:

4.a. Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services, and maximize serving the most vulnerable adults who are literally and chronically homeless.

Since beginning its administration of PATH in July 2010, Service Access and Management, Inc. has employed one full-time case manager dedicated solely to the PATH Program. We will continue to employ one full-time, dedicated case manager in the PATH Program. By using this model, Service Access and Management, Inc. is able to align the PATH Master Case Manager's job description to the PATH goals. Our focus will be case management. Street outreach in Schuylkill County has been discussed on numerous occasions with a variety of professionals. Although there are certain instances where active street outreach outside of the office is beneficial, we have found that we are able to provide more effective and efficient assistance to the PATH population by focusing on case management and serving the many individuals who walk into our office. A strong network of local human service professionals recommends Service Access and Management, Inc. to those in need of housing assistance. So, outreach also occurs as those who are literally homeless seek out Service Access and Management, Inc. instead of Service Access and Management, Inc. searching for the homeless.

Our PATH Master Case Manager actively seeks out individuals who may be in need in two ways. The PATH Master Case Manager conducts routine visits to Safe Haven. Individuals with a mental health diagnosis who are in a controlled state of crisis are eligible to reside at the Safe Haven program for a limited amount of time. In addition to Safe Have visits, the PATH Master Case Manager visits the Servants to All day program one or more times each week.

Aggressive outreach is not a necessity in Schuylkill County because, oftentimes, a person who is homeless, or a family member of a person who is homeless, will seek out our PATH Master Case Manager by name. Monica Kissinger's (PATH Master Case Manager) name is becoming synonymous with homelessness throughout Schuylkill County, based on her successful reputation for assisting those who are homeless. We have learned that through our PATH Master Case Manager's networking and reputation, persons who are literally homeless have

found us. During this current fiscal year, from July 1, 2016, through June 30, 2017, we anticipate that approximately three hundred (300) potential PATH consumers will either walk into the Service Access and Management, Inc. office or call the PATH Master Case Manager to seek assistance.

One full-time PATH Master Case Manager will continue to work hand-in-hand with PATH consumers in assisting them with locating housing and securing other services. The case manager will do this, directly, through written goals with the PATH consumers.

The PATH Master Case Manager will also engage in various forms of outreach. The outreach may include: (a) observing and engaging an individual who appears to be homeless, (b) locating a person who has been observed and is reported to be homeless, (c) addressing the availability of PATH services with community agencies and other entities so that they may direct potential PATH enrollees to Service Access and Management, Inc. and (d) visiting programs that traditionally attract individuals who may be homeless such as soup kitchens, food banks and drop-in centers.

4.b. Provide specific examples of how the agency maximizes use of PATH funds by leveraging use of other available funds for PATH client services.

The leveraging of other available funds for PATH client services is a real strength of the PATH program.

One constant source of leverage is though our County Mental Health Office. The County Mental Health Office, in collaboration with the Block Grant Board, sees that permanent supported housing apartments are available, furniture is provided for the permanent supported housing apartments, matching funds are available for the PATH grant, funds are available for emergency motel and rooming house vouchers and rental subsidy monies (above and beyond resources already in place) are also offered to PATH consumers.

PATH consumers also benefit from the Transition Age Youth Program that provides rental subsidies, furniture, household supplies and monies for identification document application fees for individuals ages 18 through 25.

The Schuylkill Community Action office is routinely involved in programs to assist the homeless. Currently, PATH consumers benefit from emergency motel vouchers and the Rapid Rehousing program that are offered through Schuylkill Community Action.

Servants to All, a local non-profit that assists the homeless, works closely with PATH consumers. Servants to All sometimes offers long term emergency housing in single room occupancy placements and operates an overnight shelter for men and makes these supports available for PATH consumers.

4.c. Describe any gaps that exist in the current service systems.

Our greatest gap has been the absence of an emergency shelter. There was a temporary homeless shelter in Schuylkill County that opened in February 2014, and closed during April 2014. There is no current emergency 24/7 emergency shelter operating in Schuylkill County for the general population. Our only 24/7 shelter in the county is a shelter that specializing in addressing issues of women who are victims of domestic violence. However, some progress has been made. Servants to All is collaborating with the United Presbyterian Church and has developed an overnight men's shelter. There are two limitations. One, the shelter is for men only, and, two, the shelter is only open during overnight hours.

Schuylkill County has lacked a residential housing program to assist transition age youth since 2012. In an attempt to partially rectify that matter, on August 1, 2015, a Transition Age Youth program was implemented in Schuylkill County. The program seeks to house sixteen (16) transition age youth, who have been diagnosed with mental health needs, over a two year period. The project assists this population with subsidized rent, security deposits, furniture and household supplies. Professionals will assist transition age youth with accessing housing and becoming successful tenants. So, even though a residential program does not exist, there is a well-funded and well-supported program to assist transition age youth.

The availability of Housing Choice (Section 8) Vouchers has been improving; however, there is still a gap in the current service systems. There are two housing authorities in Schuylkill County – the City of Pottsville Housing Authority and the Schuylkill County Housing Authority. There is a waiting list for public housing in both housing authorities. Both the City of Pottsville Housing Authority and Schuylkill County Housing Authority have placed strict limitations on the remaining number of Housing Choice (Section 8) Vouchers that are available.

Other challenges that are found in Schuylkill County include:

(1) Limited housing options for persons who are homeless.

(2) Limitations for successful prisoner re-entry.

(3) Some limitations to public transportation.

(4) Difficulty in locating apartments that can pass Housing Choice (Section 8) Voucher inspections.

4.d. Provide a brief description of the current services available to clients who have both a serious mental illness and a substance use disorder.

Both mental health and drug and alcohol outpatient providers take into consideration the presence of a co-occurring diagnosis. There are both drug and

alcohol non-hospital detoxification and rehabilitation services available within the county and non-hospital and hospital based treatment services available outside of the county that include detoxification, rehabilitation and half-way houses.

Many outpatient mental health providers treat the mental health diagnosis as primary and consider the drug and alcohol issues in their treatment; although, there is no outpatient treatment specific to co-occurring mental health and substance abuse issues in Schuylkill County. Outpatient providers in Schuylkill County for substance abuse and alcohol abuse are Clinical Outcomes Group, Inc., Gaudenzia, and Schuylkill Health Counseling.

Consumers are also encouraged to utilize Alcoholics Anonymous and other professional support groups.

Currently, our County Drug and Alcohol Program is funded to provide a significant amount of rental subsidies to individuals with drug and alcohol issues. Oftentimes, these individuals are also identified with a serious mental health illness.

4.e. Describe how the local provider agency pays for providers or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support collection of PATH data in HMIS.

Our staff members complete their Company-Wide trainings on our Learning Management System (LMS) Network of Care. The information within those trainings is not only approved by several "approval bodies" but also use material and information that is evidenced-based. Service Access and Management, Inc. makes sure all materials and educational information used in training our Service Access and Management, Inc. staff is accurate and up-to-date with the most recent data/topics/trends. LMS is a training resource that is a contracted service. Service Access and Management, Inc. staff not only complete Company-Wide mandated trainings but also have full access to more than three hundred (300) optional courses.

In addition to on-going training through our Learning Management System (LMS) Network of Care, the PATH Master Case Manager attends other trainings and events that are related to housing matters and services that are beneficial to consumers who are homeless. The Housing Coordinator will often have the PATH Master Case Manager join him in meetings where the PATH Master Case Manager may acquire new information. For example, the Housing Coordinator has provided presentations to the County Forensics Task Force and the Schuylkill County Recovery Team. The PATH Master Case Manager attended the meetings and contributed to the presentations.

These training options will continue in 2017 – 2018.

In regards to trainings and activities that are available to support the migration of PATH data into HMIS, Service Access and Management, Inc. is already a registered user of HMIS and well-versed in the use of HMIS. As a registered user, Service Access and Management, Inc. is continuously notified by the Department of Community and Economic Development Pennsylvania Homeless Management Information System (Pennsylvania HMIS) of trainings that are available through webcasts. We have found these webcasts to be very beneficial and have often participated. In addition to participating in the webcasts, our Housing Coordinator has worked with the Pennsylvania HMIS Information Technology Consultant in customizing data collection to meet our specific needs.

Currently, we enter our data into a local, Service Access and Management, Inc. based, complex, highly sophisticated data base entitled CPR-Web. So, entering data into a technically advanced electronic data base is not new to us.

We have taken on the migration of PATH data into HMIS. All PATH clients have been entered into the system with success.

4.f. Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations. If you do, please explain your system to ensure those regulations are followed.

Service Access and Management, Inc. is not a drug and alcohol facility but there are processes in place to protect all consumer information. During intake into Service Access and Management's PATH program, and all other programs at Service Access and Management, Inc., the consumer is provided documents to notify them of their rights for privacy and how their information may be used by supplying them with the HIPAA Notification of Privacy Practices in both English and Spanish (other languages are available upon request). Consumers are given a copy of Service Access and Management, Inc. Grievance Procedures to access if they feel that any of their rights have been violated during their time with Service Access and Management, Inc.

Service Access and Management, Inc. also cooperates with requests from drug and alcohol facilities when those facilities have separate, more specific forms. For example, Pyramid Health Care and Roxbury will request that their forms are also included when partnering on cases.

To ensure that all PATH consumers' information is protected, our PATH Master Case Manager uses HMIS and CPR-Web, which are both secure databases. Service Access and Management, Inc. also has a "release" process for any consumer information that is shared with another agency. The consumer must consent to this release of information by signing a release. The consumer may withdraw the release at any time if they choose.

4.g. Specific examples of how the agency plans to better link clients with criminal justice histories to health services, housing programs, job opportunities and other supports (e.g., jail diversion, active involvement in re-entry), OR specific efforts to minimize the challenges and foster support for PATH clients with a criminal history (e.g. jail diversion, active involvement in reentry)

Service Access and Management, Inc.'s PATH program serves many consumers with a criminal history in all types of situations. Service Access and Management, Inc.'s PATH Master Case Manager works with consumers at all points in the criminal justice system process. Often, our PATH Master Case Manager will attend hearings with consumers who have been charged with crimes or who are facing eviction. The PATH Case Manager can work with individuals in prison as well as those who are about to be discharged. The PATH Master Case Manager can help consumers access resources and act as a point-of-contact for probation and parole officials.

Consumers who are in need of health services and enrolled in Service Access and Management's PATH program can work with the PATH Master Case Manager to seek out health services for which they are eligible. Often, health needs are identified during enrollment, and the PATH Master Case Manager can refer or empower the consumer to refer themselves for health services.

While in the community, consumers with a criminal history often have trouble accessing public housing and other affordable housing due to their previous criminal charges. Service Access and Management, Inc.'s PATH Master Case Manager has established a close relationship with our two public housing authorities and is very well versed on what information is needed to assist consumers with "exceptions" and to address previous charges. This would include a letter of rehabilitation from treatment facilities, letters of completion from probation and parole officials, confirmations of diagnosis and other information that makes their applications more likely to be approved. If the application is denied, the PATH Master Case Manager can help the consumer file an appeal and, again, help the consumer secure documents needed to improve their chances of prevailing at their appeal hearing.

Service Access and Management, Inc.'s Housing Coordinator also sits on the "Screening Committee" of the local Bridge House. On this committee, the Housing Coordinator reviews applicants that may be in the PATH program. The consumers who are reviewed by this committee have previous criminal charges, housing issues and, often, drug and alcohol issues.

Service Access and Management, Inc. is an active member of the County Forensics' Task Force that strives to solve criminal justice issues by involving all companies, agencies and governmental services in problem solving. Service

Access and Management, Inc. also has the opportunity to provide input and raise issues with the Criminal Justice Advisory Board.

A large percentage of PATH consumers have criminal backgrounds. Oftentimes, the active caseload includes at least seventy-five percent (75%) of consumers with criminal backgrounds.

5. **Data - Describe the provider's status on the transition to collect PATH data in HMIS. If providers are not fully utilizing HMIS for PATH services, please describe plans to complete HMIS implementation. For *providers who are fully utilizing HMIS, describe plans for continued training and how providers will support new staff*.**

Service Access and Management, Inc. is a registered user of HMIS and the PATH staff is well-versed in the use of HMIS. During 2010-2011, we had our first experience with HMIS when we entered data into HMIS to support HPRP (Homeless Prevention and Rapid Re-Housing Program). In addition, the PATH Master Case Manager relies upon Service Access and Management, Inc.'s in-house CPR-Web database to enter data multiple times each day. So, database usage is a normal and an expected part of our procedures.

Timeline

(2013-2014) Service Access and Management, Inc. Housing staff participated in trainings provided by the Department of Community and Economic Development, both Intake/Caseworker Training and Agency Manager Training.

On August 8-9, 2013, the statewide PATH conference provided county based PATH staff with the training and tools necessary to begin entering date immediately into HMIS. On August 15-16, 2013, DCED provided more webinar training for data entry/system management for HMIS users.

Service Access and Management's PATH Master Case Manager and Housing Coordinator continue to participate in new PATH trainings and other valuable PATH Webinars and Conference calls. The PATH staff participated in PATH Quarterly Conference Call on August 7, 2014, December 10, 2014, March 3, 2015, and June 10, 2015. Additionally, the PATH staff has participated in the following: PATH Basic Training on September 15, 2014, PATH Data Exchange Webinar on October 15, 2014, PATH Technical Assistance Conference Call on October 21, 2014, PATH Annual Reporting Webinar for PATH providers on October 2, 2014, and PA-HMIS Client Track Trainings on November 3, 2014, November 4, 2014, and November 6, 2014.

(2015-2016) Monica Kissinger, the PATH Master Case Manager participated in the PATH Technical Assistance (TA) Conference which was held over two days in State College on April 20, 2016, and April 21, 2016.

Additionally, the PATH Master Case Manager and Housing Coordinator intend to participate in future PATH trainings, webinars and conference calls that will benefit Service Access and Management's, Inc's. PATH program.

(2016-2017) Service Access and Management, Inc.'s PATH consumer information was placed on forms and those forms were placed in individual consumer PATH binders. Those binders were replaced with more detailed data input into HMIS. HMIS began to be utilized to collect all contact information including telephone inquiries and walk-ins even though sometimes those individuals who are making telephone inquiries and walking in are not eligible or choose to not be enrolled.

Service Access and Management's PATH Master Case Manager and Housing Coordinator continued to participate in new PATH trainings and other valuable PATH Webinars and conference calls when they became available.

PA DCED served as the Administrator/HMIS Lead Agency for Service Access and Management's PATH program. PA DCED utilized Eccovia Solutions, Inc. (ClientTrack, Inc.) as the software vendor who provided the hosting services of the web-based case management system that Service Access and Management's PATH program used. The specific HMIS PATH director is Dave Weathington of PA DCED.

(2017-2018) Service Access and Management, Inc. Housing staff will fully utilize Client Track (HMIS) for all PATH consumer data entry. Due to this, the former PATH binder process will be replaced. Detailed information for every PATH consumer, referral and contact is placed into Client Track on a daily basis by the PATH Master Case Manager. This enables reports to be 'pulled' from HMIS for yearly reporting and individual TAY reports.

Service Access and Management, Inc.'s PATH Master Case Manager and Housing Coordinator will continue to participate in new PATH trainings and other valuable PATH Webinars and Conference calls when they become available. All SAM Housing staff are on the HMIS mailing list and receive all notifications of new HMIS required trainings and optional training opportunities.

In the event that Service Access and Management, Inc. would need to train new staff to use HMIS, there is a library of trainings available within the HMIS (Client Track). Trainings are available by PDF documents and are also in recorded webinar form located at http://www.pennsylvaniacoc.org/pahmis/. New staff would be required to complete all trainings relating to PATH and HMIS. Support from HMIS is also offered to help with the training of new staff.

6. **Alignment with PATH goals – Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.**

The Service Access and Management, Inc.'s PATH program has always and will continue to focus on outreach and case management.

Regarding case management, even though our PATH funding is limited, we do employ a fulltime, dedicated PATH Master Case Manager. The County contributes monies to support this position. The PATH Master Case Manager benefits not only from state level PATH technical assistance, but the PATH Master Case Manager also benefits from all of the technical assistance and training that supports all of Service Access and Management, Inc.'s case managers. Because we have employed a PATH Case Manager since July 2010, we fully understand the role the PATH Master Case Manager.

During fiscal year 2015-2016, our PATH Master Case Manager attended the PATH two day technical assistance conference in State College on April 20, 2016, and April 21, 2016. Our PATH Master Case Manager will also attend the next statewide PATH conference from June 13 – 15, 2017.

In addition to the history of the position, along with the everyday Service Access and Management, Inc. support of the positon, our current PATH Master Case Manager completed the Service Access and Management, Inc. Master Case Manager program.

PATH consumers are well supported with strong case management in Schuylkill County.

Our outreach is somewhat unique in Schuylkill County. The City of Pottsville is the hub for most persons who are homeless because all primary and critical county human services are located in Pottsville. The Service Access and Management, Inc. office is located within walking distance of all center city services and resources. We have found that the vast majority of those who qualify for PATH services visit the Service Access and Management, Inc. office in large numbers. From July 1, 2016, through June 30, 2017, we project that 290 potential PATH consumers will either walked into the Service Access and Management, Inc. office or call the PATH Master Case Manager to seek assistance.

The PATH Master Case Manager will also seek out reports of individuals who are homeless and attempt to locate those individuals.

Since the opening of the Servants to All day program facility in Schuylkill County (called My Father's House) on November 4, 2015, all individuals who are homeless, or at imminent risk of homelessness, oftentimes first visit My Father's House and are then referred to the Service Access and Management, Inc. office. Because there is a close relationship between the PATH program and My Father's House, individuals who arrive at My Father's House, and who declare a mental health illness or demonstrate symptoms, are referred to the PATH Master Case Manager.

7. Alignment with State Comprehensive Mental Health Services Plan – Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

The State Comprehensive Mental Health Services Plan states:

> "OMHSAS has implemented an OMHSAS Permanent Supportive Housing Initiative utilizing local, state and federal resources to expand affordable, supportive housing and residential programs for adults."

Schuylkill County has taken a very aggressive approach in the development of permanent supportive housing. Our first units were opened in 2011. We now have twenty-one (21) permanent supportive housing beds. The development of seven (7) additional beds is in progress. PATH consumers are often selected for tenancy in permanent supportive housing.

The State Comprehensive Mental Health Services Plan also states:

> "Our progress with the development of housing options continues to recognize that many individuals, who have a disability, including individuals who have a serious and persistent mental illness, can live successfully in the community if they have appropriate supports and services."

Schuylkill County's PATH Master Case Manager has dual expertise – in mental health and in housing. With these skills, along a supportive community, PATH consumers have multiple housing options in the community including permanent supportive housing, public housing and apartments supported through Housing Choice Vouchers.

8. Alignment with State Plan to End Homelessness – Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness.

The newly released ***Homelessness in Pennsylvania: Causes, Impacts, and Solutions, A Task Force and Advisory Committee Report*** indicates that some of the primary purposes

of PATH programs are to focus on "assisting individuals in identifying and securing housing." (page 53, footnote number 107) The Service Access and Management, Inc. PATH Master Case Manager writes goals with each consumer that we serve. In almost all cases, those goals focus on securing housing. The Service Access and Management, Inc. PATH is clearly consistent with the ***Homelessness in Pennsylvania: Causes, Impacts, and Solutions, A Task Force and Advisory Committee Report.***

8.a. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state.

The Service Access and Management, Inc. PATH program focuses on case management. Upon identifying individuals who are qualified to receive PATH services, our PATH Master Case Manager does a very detailed and thorough intake. During that intake process, a significant amount of information is gathered regarding the individual's housing status and many related matters.

Through the intake process, we determine the specific type of housing that best matches the needs of the PATH consumer. We identify demographics such as location, number of bedrooms, first floor needs and other related details.

We study history to determine if there are legal barriers, criminal history, drug and alcohol issues and, possibly, outstanding arrears from previous rental history.

Housing options are then reviewed such a permanent supported housing, public housing, Housing Choice Voucher options and fair market apartments.

Because we have a professional network in place, we also explore supports such as Reinvestment Contingency Funds, Transition Age Youth Reinvestment funds (if applicable), Rapid Rehousing funds and Block Grant funds.

8.b. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning, and the process for updating and testing their emergency response plans.

In the event of a disaster that would impact the ability of PATH consumers to access services, or endanger PATH consumers, disaster preparedness is managed through the Company-Wide Emergency Response and Business Recovery Plan. This plan addresses various types and levels of disasters that may be managed within the building and those disasters that would require the Service Access and Management, Inc. office to move to a pre-determined alternate site within the local community.

The purpose of this plan is to formalize and document Service Access and Management, Inc.'s response to emergencies and, more importantly, to increase protection to persons served, their families and our stakeholders, as well as our employees, and to ensure continuation of the organization and services provided.

The Service Access and Management, Inc. Schuylkill County Executive Team reviews the plan annually and makes any necessary changes. We also routinely conduct two fire drills a year and one bomb threat drill. We have also conducted a variety of table top drills to address a number of possible scenarios that could arise unexpectedly with consumers and staff members. This past year, we had the Service Access and Management, Inc. Personal Safety Coordinator do a simulation of an active shooter drill. A more detailed simulation will occur across all sites in the near future and Schuylkill County has agreed to be a test site.

In respect to the specific housing needs of those consumers served through PATH, we are experienced and skilled in meeting emergency housing needs. Should a disaster occur that would require a PATH consumer to be housed in a setting other than that individual's primary residence, the PATH Master Case Manager would seamlessly move that individual into a local single room occupancy setting or one of the local motels that we use regularly. There are always vacancies in our local motels. In addition, Service Access and Management, Inc. has a strong partnership with Servants to All. With that partnership in place, in an emergency, we would look to Servants to All to house males in its overnight shelter and to house females in rooming houses.

We have also established a means to immediately purchase food and household supplies. Of course, above and beyond the direct efforts of our company, we would also reach out to community services such as the Red Cross, Schuylkill Community Action, the Salvation Army and others.

9. Other Designated Funds – Indicate whether the Mental Health Block Grant, Substance Abuse Block Grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illness in your organization. Please indicate if any of these funds are earmarked for PATH services specifically.

The PATH program is well supported by additional funds.

The primary source of additional funds that serve PATH consumers is County Block Grant funds. Block Grant funds are used to assist PATH consumers in a variety of ways, including:

a. monthly rents
b. security deposits
c. furniture
d. basic household supplies
e. apartment renovations
f. emergency motel vouchers
g. rent in arrears

PATH consumers are also eligible to access Reinvestment Contingency Funds. These funds support PATH consumers in a variety of ways, including:

a. monthly rents
b. security deposits
c. basic household supplies
d. fees for obtaining state issued identification, birth certificate, social security card or other documents required for state and federal housing
e. criminal background and application fees to obtain permanent supportive housing
f. money owed to a Public Housing Authority in order to become eligible for a Section 8 Housing Choice Voucher or other Project Based Subsidy Housing

PATH consumers are also often represented in the Transition Age Youth program. PATH consumers, who qualify, are assisted in a variety of ways, including:

a. monthly rents
b. security deposits
c. furniture
d. basic household supplies
e. rents in arrears
f. personal identification document costs

When appropriate, we also partner with other companies and agencies and engage PATH consumers in those services such as the Rapid Re-Housing program that is managed by Schuylkill Community Action.

10. Programmatic and Financial Oversight –
In cases where the state provides funds through intermediary organizations (i.e., county agencies, regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

The County's Office of Mental Health's fiscal staff maintains an ongoing dialogue with Service Access and Management, Inc.'s fiscal staff. In addition, the County's Office of Mental Health fiscal staff and administration conduct monthly meetings with Service Access and Management, Inc.'s fiscal staff and administration to review financial history, activity and forecasted expenditures.

11. SSI/SSDI outreach, Access, Recovery (SOAR) –
Describe your (provider's) plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and then track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. For the grant year 2016-2017, include all of the following data:

11.a. The number of staff trained in SOAR.

Two Service Access and Management, Inc.'s staff were trained in SOAR during grant year 2015 – 2016. (Service Access and Management, Inc.'s Housing Coordinator actually served as the county organizer and coordinator with the Commonwealth to ensure that fifteen human service agency staff enrolled in SOAR training.)

11.b. The number of staff who provided assistance with SI/SSDI applications using the SOAR model.

No staff were able to provide assistance with SI/SSDI applications using the SOAR model.

11.c. The number of consumers assisted through SOAR.

No consumers were assisted directly through SOAR. Even though no PATH funded consumers were assisted with a complete SOAR application, trained Service Access and Management, Inc. staff now have a much better understanding of the Social Security application process and are able to apply that knowledge when assisting PATH funded consumers.

11.d. Application eligibility results (i.e., approval rate on initial application, average time to approve the application)

There is no available data.

11.e. The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application).

There are currently no staff members dedicated to implementing SOAR, part or full-time. There is only PATH position funded with our $46,421 grant and that PATH Master Case Manager is focused on assisting the homeless with finding housing. The SAM Housing staff and SAM's Blended Case Managers (BCMs) do assist with the completion of SSI/SSDI applications. This is done by guiding the consumer through the application process, helping the consumer gather the necessary information and informing the consumer as to how the process works.

11.f. Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]

Even though there is not a formal alternative system in place, the PATH Master Case Manager and Housing Coordinator are on the SOAR email list and receive

regular updates about the program and participate in SOAR webinars when possible.

12. Housing –

Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

There are a number of strategies in place. Through the work of the Local Housing Options Team and the Service Access and Management, Inc. Housing staff, current strategies will become better defined and new strategies will be pursued. These include:

(a) City of Pottsville Housing Authority and the Schuylkill County Housing Authority. The county's two housing authorities have become true advocates in addressing the housing needs of persons with mental health illnesses who are homeless or at risk of imminent homelessness. Service Access and Management, Inc. has established linkages with the housing authorities that expedite, to the extent possible, placements in public housing and securing Section 8 vouchers.

The Housing Coordinator at Service Access and Management, Inc. has become a single point of contact with the housing authorities in matters regarding persons with mental health illnesses who are homeless or at imminent risk of homelessness. This single point of contact concept, and Service Access and Management, Inc.'s relationships with the housing authorities, has enhanced the services provided by the PATH Master Case Manager.

(b) Bridge Housing. The Bridge House Program is a transitional housing program operated by Schuylkill Community Action for residents of Schuylkill County who are homeless or at imminent risk of homelessness. The program serves men, women and children with residency limited to three to twelve months. Residents must follow rules, attend programs and participate with case management and goal plans. The PATH Master Case Manager has Bridge Housing as an option that may be pursued when working with PATH consumers. The Housing Coordinator also serves on the Screening Committee for the Bridge Housing program.

(c) Housing Contingency Rental Subsidies. Service Access and Management, Inc. receives funding to assist consumers transition into apartments who are homeless or who are at risk of imminent homelessness. Monies are available to subsidize the security deposit, first month's rent (and even a few subsequent months of rent, as necessary) and rents in arrears. This is often all that is necessary to bridge the gap between homelessness and permanent housing.

(d) Housing Contingency Single Room Occupancy (SRO) Payments. Service Access and Management, Inc. receives funding to assist consumers who are homeless or who are at imminent risk of homelessness transition into a single room occupancy unit. While in the SRO, Service Access and Management, Inc. staff will work with the consumer in determining how long the SRO stay appears appropriate and when/where a transition should take place.

(e) Base Funded Motel Vouchers. Service Access and Management, Inc. receives funding to assist consumers who are homeless or who are at imminent risk of homelessness by moving them from the street into a motel as a stop gap measure. There are situations where public housing or permanent supportive housing can be secured as a step after the motel stay.

(f) Community Rehabilitative Residence (CRR). In Schuylkill County, there are two Community Rehabilitative Residence sites (CRRs). Service Access and Management, Inc. staff is integral in the placement and monitoring of consumers as they enter and exit the CRRs. The PATH Master Case Manager has regular updates as to the availability of openings in the CRRs should that be an appropriate strategy for a PATH client. The PATH Master Case Manager also assists consumers move from the CRRs into more traditional housing.

(g) Permanent Supportive Housing (PSH). Through the use of HealthChoices Reinvestment funds, local Base funds and Block grant funds, multiple permanent supportive housing apartments have been developed. During phase one of the development of permanent supportive housing, twelve beds became available. Another bed was added during phase two. Two more beds were added in phase three. Phase four is complete and has provided three more beds.

Permanent supportive housing beds first became available in June 2011. Currently, twenty-one (21) permanent supportive housing beds are available in the City of Pottsville. Another two (2) beds will be available in 2017-2018.

(h) Personal Care Homes. This is a somewhat restrictive housing environment; however, in some cases, this type of housing is necessary to ensure health and safety until the consumer is better prepared for a more independent living arrangement.

(i) Servants To All / My Father's House. As of November 2015, My Father's House has served as a homeless daytime resource center for Schuylkill County. The PATH Master Case Manager coordinates with My Father's House to screen for PATH eligibility. My Father's House assists with temporary housing, housing searches, food, job searches, clothing, spiritual needs and referrals to other services.

(j) Servants to All Overnight Shelter. During November 2016, an overnight shelter for men opened at the United Presbyterian Church in Pottsville. PATH consumers are eligible as overnight guests.

(k) Rooming Houses. Servants to All provides overnight shelter to females in contracted rooming houses. PATH consumers are eligible to stay in the Servants to All rooming houses.

(l) Transition Age Youth Program. Beginning August 1, 2015, Service Access and Management, Inc. implemented program dedicated to assisting 16 transition age youth. The program was scheduled to end June 30, 2017, but may be extended. Eligible transition age youth will receive assistance with rental costs, security deposits, furniture purchases, personal identification fees, household supplies and will have access to professionals who will assist them with accessing housing and being successful tenants. The Transition Age Youth Program will continue into 2017 – 2018.

13. Coordinated Entry –

Indicate if/how your organization is engaged with the local coordinated-entry processes of your CoC. Please also describe the roles of key partners in the CoC.

Service Access and Management, Inc.'s Housing Coordinator is a board member of the Eastern Pennsylvania Continuum of Care that has established a Coordinated Entry Subcommittee which is working to bring the process to the Eastern Pennsylvania Continuum of Care. Coordinated Entry is set to begin in December 2017 in the area that the Service Access and Management, Inc's. PATH case manager serves. Once developed and implemented, the Eastern Pennsylvania Continuum of Care's Coordinated Entry process will include the area serviced by Service Access and Management, Inc.'s PATH program. When Coordinated Entry is established in the area, Service Access and Management's PATH program plans to fully participate. The Coordinated Entry program will be governed/monitored by the Eastern Pennsylvania Continuum of Care.

Service Access and Management's PATH program is participating in all preparations and trainings for Coordinated Entry. This includes the "snapshot" tracking of phone calls received in a two week time frame and also the June 2017 Central Valley Regional Homeless Advisory Board meeting that Jason Alexander from Capacity for Change will be discussing the implementation of Coordinated Entry.

HUD has listed seventeen components as coordinated entry priority areas. Service Access and Management, Inc. has an understanding of these priorities and has many in place. Once the Eastern Pennsylvania Continuum of Care develops and implements coordinated entry, Service Access and Management, Inc. will be an active participant in the implementation process.

14. Justice Involved –

Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate % of law enforcement that has been CIT trained and any feedback on effectiveness.

Currently, Schuylkill County does not have any Crisis Intervention Teams. Training has been offered by the Family Training and Advocacy Center; however, no police departments have been able to commit to the training. Training opportunities will continue to be offered.

15. Staff Information

15.a. Describe the demographics of staff serving the clients.

The Service Access and Management, Inc. Schuylkill County staff, including all management, professional and administrative support staff, totals seventy-one (71). Of this total, sixty (60) are females and eleven (11) are males. The age range is twenty-three (23) years of age to sixty-seven (67) years of age. The staff consists of sixty-seven (67) Caucasians, two (2) African American, one (1) Asian and one (1) Hispanic/Latino.

15.b. Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients.

All Service Access and Management, Inc. staff members are trained to be sensitive to age, gender, disabilities and racial/ethnic differences of clients. In addition, there are periodic trainings available that address the area of lesbian, gay, bisexual and transgender. Upon employment with our organization, all new staff members complete an intensive New Staff Orientation (NSO). Trainings beginning with a Company Overview and presentation of SAM, Inc.'s Policy and Procedures followed by a De-Escalation/Safety Training (DST) course.

<u>Our staff is required to complete the following trainings:</u>

- Violence in the Workplace – How to Prevent and Defuse for Employees
- Diversity for All Employees
- Suicide Assessment and Intervention
- Defensive Driving For Noncommercial Motorists
- Ethics – What Employees Need to Know
- OSHA / Blood borne Pathogens
- SAM, Inc. - Person Served & Family-Centered Services including People First Language
- SAM, Inc. - Mandated Reporting
- Emergency Action and Fire Prevention

- Sexual Harassment – What Employees Need to Know
- SAM, Inc. - Intro to CARF Standards
- SAM, Inc. - Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health (HITECH)
- SAM, Inc. -Acceptable Use for Computer Devices- Acknowledgement
- SAM, Inc. - Fraud, Waste & Abuse Training
- SAM, Inc. New Staff Orientation (NSO) - Training Reference Guide: A Comprehensive Guide to Company-Wide Policy (Acknowledgment)

Service Access and Management, Inc. also has an E-Learning site (LMS online trainings) which provides our staff with well over three hundred (300) training opportunities. The E-Learning site has a search feature which allows staff to focus independent/individualized trainings on areas such as "diversity" and "age." Staff members may also request to attend trainings offered outside of the organization.

15.c. Discuss the extent to which staff are receptive to differences of clients.

In addition to the new staff orientation and mandated trainings regarding respect for others' differences, Service Access and Management, Inc. is accredited by the Commission on Accreditation of Rehabilitation Facilities. Through that intensive accreditation process, Service Access and Management, Inc. must pass a rigorous process to affirm its receptiveness to differences in our clients.

In addition to the formalized trainings and assessments, Service Access and Management, Inc. operates in forty-eight (48) Pennsylvania counties and six (6) New Jersey and, therefore, faces differences on a day-to-day basis within our own company.

15.d. Identify the extent to which staff receive periodic training in cultural competence and health disparities.

Service Access and Management, Inc.'s beliefs about cultural competence are described in our organization's annual Cultural Competence and Diversity Plan. That Plan states:

> "Cultural competence and diversity is a critical component in meeting our mission and vision as an organization. This means being aware of and sensitive to the increasingly diverse population that comprises the communities that we serve. It also means developing a working partnership with individuals from a variety of diverse and unique values, beliefs, and practices and providing services and resources which foster and accommodate cultural diversity.

According to the U.S. Department of Health and Human Services, Department of Minority Health, cultural and linguistic competency is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (Adapted from Cross, 1989)."

Cultural competency is important because it is, "One of the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes."

Each staff member receives annual training in:

a. Diversity for All Employees
b. Assessing Individual Cultural Competence

In addition, each staff member has on-going electronic access to all company policies. One particular policy that is addressed in training and is available at all times to each staff member is the Language Assistance Policy and Procedure.

16. Client Information

16.a. Describe the demographics of the client population.

The demographics of the client population during the most recent annual report follow:

AGE

0	17 and Under
13	18 – 23 years
22	24 – 30 years
50	31 – 50 years
19	51 – 61 years
0	62 and over
0	Don't know
0	Refused

GENDER

59	male
45	female
0	Don't Know
0	Refused

RACE/ETHNICITY

1	American Indian or Alaskan Native
0	Asian
7	Black or African American
0	Native Hawaiian or other Pacific Islander
92	White
0	Two or More Races
4	Don't Know
0	Refused

HOUSING STATUS (AT FIRST CONTACT)

11	Outdoors (e.g. street, abandoned or public building, automobile)
44	Short term shelter
0	Long term shelter
38	Own or someone else's apartment, room or house Hotel, SRO, boarding house
0	Halfway house, residential treatment program Institution (psychiatric or other hospital, nursing home, etc.)
1	Jail or correctional facility
10	Other
0	Unknown

LENGTH OF TIME LIVING OUTDOORS OR IN SHORT TERM SHELTER AT FIRST CONTACT

26	Less than 2 days
39	2 to 30 days
14	31 to 90 days
11	91days to one year
14	Over one year
0	Unknown

16.b. Project the number of adult clients to be contacted.

The projected number of adult clients to be contacted during the 2017 – 2018 year using PATH funds by the PATH Master Case Manager will be approximately three hundred (300). Because Service Access and Management, Inc. either provides or oversees all mental health case management services contracted through Schuylkill County's MH/DS Program, our PATH Master Case Manager will have a sound network of sources to identify persons who have a mental health illness and who are homeless or at imminent risk of homelessness.

16.c. Identify expected number of adult clients to be enrolled

The projected number of adult clients who have a mental health illness and who are homeless or at imminent risk of homelessness and who will be be enrolled by the PATH Master Case Manager will be approximately ninety (90).

16.d. Give estimated percentage of adult clients served using PATH funds to be literally homeless.

The percentage of adult clients to be served with PATH funds and who are projected to be "literally" homeless will be approximately sixty percent (60%) of clients served with PATH funds.

17. Consumer Involvement –

Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be *meaningfully* involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix I "Guidelines for Consumer and Family Participation".

All Service Access and Management, Inc. staff complete a Person-Served and Family Centered Services training upon employment and, again, annually. Service Access and Management, Inc. staff members receive training on how to complete an Individual Service Plan (ISP) and an Individual Family Service Plan (IFSP). Service Access and Management, Inc. staff members are also trained in the appropriate use of People First Language.

Persons who are homeless and have serious mental illnesses and any family members will be involved at the organizational level in the planning, implementation and evaluation of PATH-funded services in the following ways:

a. Service Access and Management, Inc. is legally managed by the Service Access and Management, Inc. Board of Directors. According to the Board's by-laws, one board member must be a person with a serious and persistent mental illness. Monthly PATH statistics are shared with the Board of Directors each time the Board meets.

b. The day-to-day operations of Schuylkill County's MH/DS Program are managed through a contractual relationship with Service Access and Management, Inc. The Board of Directors of Schuylkill County's MH/DS Program includes consumer membership.

c. Service Access and Management, Inc. is involved with the local chapter of the National Alliance on Mental Illness (NAMI) on an on-going basis. Consumers participate in NAMI.

d. Service Access and Management, Inc. is a member of the Schuylkill County Recovery Team. The purpose of the Recovery Team is to support the mission of recovery. The partnership includes consumers, family members, providers and interested stakeholders.

e. Service Access and Management, Inc. is a member of the Schuylkill Employment Transformation Committee. This committee is composed of professionals from a variety of arenas and also includes consumers and family members. The committee's purpose is to study and develop initiatives that place value in hiring persons who are disabled.

f. Service Access and Management, Inc. is a member of the Community Support Program (CSP). The CSP membership includes consumers, family members, professionals and community representatives. The CSP, through collaboration of the members, strives to assess the effectiveness of the behavioral health system, decrease stigmas and increase awareness.

g. Service Access and Management, Inc. is a member of the Schuylkill County Forensics Task Force. Membership often includes a peer specialist along with appropriate professionals. The committee focuses on improving service delivery between systems.

h. A mental health consumer is a member of the Service Access and Management, Inc. Program Committee.

i. During the development of the most recent capital project, consumer input was sought regarding the location and amenities of an apartment building that would be selected to the renovated for mental health consumers.

18. Health Disparities Impact Statement –
Please identify efforts to support the Transition Age Youth (TAY) disparity population by providing the following:

18.a. The unduplicated number of TAY individuals who are expected to be served using PATH funds.

Service Access and Management (SAM) expects to serve forty (40) Transitional Age Youth (TAY) during the 2017 – 2018 PATH fiscal year.

18.b. The total amount of PATH funds expected to be expended on services for the TAY population.

SAM, Inc. expects to expend $28,808 on services for the TAY population in the PATH program.

18.c. The types of services funded by PATH that are available for TAY individuals.

The primary service that is available to TAY individuals that is funded by PATH is case management. In addition, all TAY consumers are eligible to participate in:

i. Blended Case Management. These services link and coordinate individuals with serious and persistent mental illnesses to needed community resources. Regulations require face-to-face visits. Service Access and Management, Inc. is the sole provider of blended case management services in the county.

ii. Administrative Case Management. These services provide support to individuals with serious and persistent mental illnesses who need assistance in accessing community resources. Contacts may be completed by telephone or face-to-face. In addition, all intakes at Service Access and Management, Inc. occur through Administrative Case Management. Here is where we often learn of individuals who are homeless or at imminent risk of homelessness. This is a strong addition to PATH outreach activities.

iii. Supportive Living. In-home services are provided to help individuals develop and maintain the skills necessary to live independently in their own communities. Two companies, Allied and NHS Human Services, provide these services through a contractual arrangement with Service Access and Management, Inc. This allows for consumer choice.

iv. Transportation. Services are available at no cost or very low cost for personal, medical or job related transportation. In Schuylkill County, county government operates public transportation.

v. Outpatient Services. Five providers within the county provide specialized services including, but not limited to, medication management, psychotherapy and intensive outpatient services.

vi. Crisis Intervention and Crisis Residential. These services are available to assist consumers with immediate telephone, face-to-face or mobile response in times of crisis.

vii. Community Employment. Provides for work experiences, job training and job coaching in preparation for gainful employment.

viii. Vocational Rehabilitation. Provides services in preparation for the return to gainful employment.

ix. Peer Support Services. Certified Peer Specialists provide mentoring and support to individuals with serious mental illnesses to increase coping skills and resilience.

x. Psychiatric Rehabilitation. This is a site based psychiatric rehabilitation program.

xi. Clubhouse Program. The Clubhouse Program is structured around a work-day model.

xii. Intellectual Developmental Disability Case Management. These services link and coordinate individuals with Intellectual Developmental Disabilities and a Mental Health Diagnosis to needed community resources. Regulations require face-to-face visits. Service Access and Management, Inc. is the sole provider of intellectual developmental disability case management services in the county.

xiii. Mobile Psychiatric Rehabilitation. Mobile Psychiatric Rehabilitation is available to individuals who are not able to access traditional services due to transportation issues.

18.d. A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population.

Service Access and Management, Inc. received a Transition Age Youth grant effective August 1, 2015. Our goal was to serve a minimum of sixteen (16) transition age youth prior to July 1, 2017. To qualify, the transition age youth must have a serious mental health illness.

To date (May 2017) we have assessed forty-five (45) transition age youth and have financially assisted eighteen (18) transition age youth.

The Transition Age Youth grant funds are used to assist PATH consumers in a variety of ways, including:

a. monthly rents
b. security deposits
c. furniture
d. basic household supplies
e. rents in arrears
f. personal identification document costs

The Transition Age Youth (TAY) Housing Contingency Fund Committee meets regularly to assess the needs of each transition age youth who is either enrolled in the program or is being considered for enrollment. Detailed qualitative and quantitative records are maintained to document the commitment to transition age youth. in almost all cases, the transition age youth consumers are receiving benefits that exceed consumers in the general population.

19. Limited English Proficiency –

Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the HHS *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-title-VI/index.html?language=es.

The most recent census data reports:

> "The most common language spoken in Schuylkill County, Pennsylvania, other than English is Spanish. 4.6% of Schuylkill County citizens are speakers of a non-English language. That is lower than the national average of 21%."

Even though, statistically, more than ninety-five percent (95%) of PATH consumers speak English, Service Access and Management, Inc. is well-prepared to address the needs of limited English proficient (LEP) persons. With Spanish being the language spoken by the majority of limited English proficient (LEP) persons, Service Access and Management, Inc. is well-equipped to address the needs of that population. Service Access and Management, Inc. employs many individuals who speak Spanish and have developed many forms and other material in Spanish.

Ultimately, no matter what language is spoken by our PATH consumers, Service Access and Management, Inc. has a contract with Interpretalk which provides immediate access to interpreters in all languages. Never has the needs of a limited English proficient (LEP) person hampered the delivery of PATH services.

20. Budget Narrative –

Provide a *descriptive* budget narrative that includes the local-area provider's use of PATH funds. Include separated federal allocation, state match and other PATH funds. For example: $10,000 federal allocation, $3,333 state match, $1000 PATH specific base fund match.

The budget narrative follows:

Schuylkill County will receive a federal allocation of $34,816.

Schuylkill County will receive a state match allocation of $11,605.

Schuylkill County will contribute $37,205 toward the PATH costs listed below through the use of County Block Grant and Base funds.

An additional amount of $25,600 in County Block Grant funds and Base funds has been set aside to assist with rental subsidies, security deposits, furniture, household items, motel vouchers, transportation vouchers and emergency food needs.

PATH costs that are certain are:

a. Case management services costs include health, dental, vision, life insurance, FICA, Worker's Compensation. ($60,129) The PATH Master Case Manager will develop case plans for delivering community services to PATH eligible recipients. The case plans will be developed in partnership with the recipients and will focus on the coordination of evaluations, treatment, housing and/or care of individuals, tailored to individual needs and preferences. The PATH Master Case Manager will assist individuals in accessing needed services, coordinate the delivery of services in accordance with the case plan and follow-up and monitor progress. Activities may include financial planning, access to entitlement assistance and representative payee services and others.

The PATH Master Case Manager will also provide outreach by seeking out and assisting individuals who do not access traditional services. This will include (a) limited face-to-face interactions with literally homeless who live in nontraditional settings such as living on the street, (b) distribution of flyers and other methods of public announcements and (c) "inreach" as a form of outreach where the PATH Master Case Manager will visit food banks, soup kitchens, the Salvation Army and other areas that are frequented by persons who are homeless.

Our PATH Master Case Manager will provide persons who are homeless with linkages to local agency services. To support persons who are homeless as they move into housing, Service Access and Management, Inc.'s PATH Master Case Manager will assist in referring these individuals to supported living programs offered by two local providers.

The PATH Master Case Manager will also measure, track and respond to behavioral health disparities from any subpopulation that may have disparate access to, use of, or outcomes from PATH services

b. Travel costs. ($4,811) The PATH Master Case Manager will incur travel expenses while working directly with PATH clients and while conducting outreach activities.

c. Supplies and cell phone costs. ($533) We want the PATH Master Case Manager to be mobile, yet responsive to the immediate needs of clients, potential clients, local agencies and outreach sites. A cell phone will make this possible.

d. Indirect costs. ($6,547) This is the allowable block grant rate and includes costs for services such as accounting, insurance and human resources.

Service Access and Management, Inc.
590 Terry Reiley Way
Pottsville, PA 17901

PDX: PA-064 Schuylkill: Service Access and Management, Inc.

Schuylkill County, Pennsylvania

PATH Intended Use Plan for FY 2017-2018

PATH Budget for FY 2017-2018

- Federal Funds: $34,816
- State (Block Grant) Funds: $11,605
- Local Contribution: $37,205
- Additional Local Funds: $25,600

Line Item	Annual	PATH Funded Full Time Equivalency Position	Federal PATH Funds	State, Local and Additional Block Grant PATH Funds	Total
Position (Case Manager – 1.0 FTE)	36,002	1.0 FTE	17,404	18,598	36,002
Fringe benefits and costs (health, dental, vision, life insurance, FICA, workers' compensation)	24,127	1.0 FTE	11,663	12,464	24,127
Travel	4,811		2,326	2,485	4,811
Supplies and cell phone costs	533		258	275	533
Total direct	65,474		31,651	33,823	65,474
Indirect (as allowed by Block Grant guidelines)	6,547		3,165	3,382	6,547
TOTAL	72,021		34,816	37,205	72,021
Minimum Block Grant required (PATH State)	11,605				
Additional Block Grant Funds	25,600				

44. York County - Bell Socialization Services

160 South George Street

York, PA 17401

Contact: Crystal Ouedraogo

Contact Phone #: 7178485767

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-002

State Provider ID: 4202

Geographical Area Served: Central Region

Planning Period From **7/1/2017** to **6/30/2018**

The state can either enter all the IUPs and associated budgets as in prior years, or they may allow IUP users to enter their own information into WebBGAS. For more information on allowing IUP users to enter their own details, please see the tutorial under the Training Tab in WebBGAS that instructs states and IUP providers on this new process.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	$ 0	$ 0	$ 0	

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	

No Data Available

d. Equipment	$ 0	$ 0	$ 0	

No Data Available

e. Supplies	$ 0	$ 0	$ 0	

No Data Available

f. Contractual	$ 0	$ 0	$ 0	

No Data Available

g. Housing	$ 0	$ 0	$ 0	

No Data Available

h. Construction (non-allowable)				
i. Other	$ 115,612	$ 22,113	$ 137,725	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 115,612	$ 22,113	$ 137,725	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 115,612	$ 22,113	$ 137,725	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0	$ 0	$ 0	
l. Grand Total (Sum of j and k)	$ 115,612	$ 22,113	$ 137,725	

Source(s) of Match Dollars for State Funds:

York County will receive a total of $68,312 in federal and state PATH funds to use in York County.
York County will also receive an additional $69,413 ($64,378 federal and $5035 state match) specifically for training and HMIS development/monitoring. Federal PATH funds will total $115,612, which combined with $22,113 in state match funds gives a grand total of $.137,725.

Estimated Number of Persons to be Contacted: 150

Estimated Number of Persons to be Enrolled: 24

Estimated Number of Persons to be Contacted who are Literally Homeless: 113

Number staff trained in SOAR in grant year ending in 2017: 4

Number of PATH-funded consumers assisted through SOAR: 0

Bell Socialization Services – PATH Intended Use Plan
2017-2018
York/Adams Counties

Local Provider Description

Type of organization: Bell Socialization Services, Inc., Private, Non - Profit

Bell Socialization Services, Inc. is a non-profit provider agency serving persons with mental illness, mental retardation, and those who are homeless. The Supported Housing Program within the Mental Health Department provides services to the mentally ill who are either homeless or are in need of assistance from community resources offered in York County including outreach services as defined by PATH, case-management, referrals for other services; e.g. health care, job training, social rehabilitation and additional housing supports . Clients served range between the ages of 18-72. The only age requirement is that they be over the age of 18. The services are provided predominately to York City. However, services are not limited to the city, but include York County. Bell also subcontracts with York County MH/IDD as a provider for PATH services.

Provider Information:

Bell Socialization Services
160 S. George St.
York, Pa 17401

York County MH/IDD
100 W. Market St.
York, Pa 17401

***Provider name as it appears in PDX: Bell Socialization Services**

Indicate the amount of PATH funds the organization will receive.

$51,234 is the federal PATH allocation
$17,078 is the state PATH allocation
$68,312 is the total allocation

See attached budget for expenditure breakdown

Collaboration with HUD Continuum of Care

The Program Coordinator and Assistant Director of the Mental Health Department are currently working with York County Continuum of Care through the York County Planning Commission and a variety of human service agencies in York County to coordinate services rendered for the homeless and mentally ill. Meetings are held once a month and referrals are made and received to assist consumers in housing.

Collaboration with Local Community Organizations

Mental Health: Additionally, linkages among local programs within the community include: Intensive Case Management and Case Management offered through the York/Adams MH/IDD Program and SAM. Consumers are referred from all case management units. The PATH Supported Housing Program (SHP) staff work along with Case Management staff by providing the housing component. There is a joint working relationship between PATH Supported Housing Program and case management to ensure continuity of care.

The SHP works with agencies providing psychiatric and therapeutic services. These agencies include Bell Socialization Services, Inc. Assertive Community Treatment Team, York Guidance Center, Susquehanna Counseling Services, and Wellspan Behavioral Health Services at Edgar Square (part of Wellspan Behavioral Health). The SHP receives referrals from and refers consumers to these agencies. The SHP works with these agencies in assisting consumers with obtaining medication and other psychiatric services. SHP staff will transport consumers to appointments and work closely with psychiatrists and therapists and other program staff in ensuring consumer stabilization.

Emergency Housing: York County has a number of emergency shelters that are utilized by and coordinate services with the SHP. These include: The Bell Family Shelter, Rescue Mission for Men, Rescue Mission for Women and Children, and the domestic violence Access Shelter. Not only can these shelters make referrals to the SHP for mentally ill people, but often times the SHP staff guide mentally ill people to these shelters as appropriate, in order to get immediate assistance to prevent them from being on the street or in a potentially harmful situation. The shelter services staff and the SHP staff have a working relationship to coordinate the best services for the consumers. The SHP will then work solely with the consumers, once they leave the shelters, to assure that stabilization continues.

Community Supports: There are additional community services that provide support to the community and are commonly utilized by the SHP. In addition, these agencies can refer consumers to the SHP. They include The Housing Council which provides renter skills training and financial assistance to homeless persons; Community Progress Council which provides generic case management and in some cases emergency funding for an overnights stay at a motel, should the shelters be filled to capacity. Local food banks, soup kitchens and churches are also utilized by the SHP.

Primary Health: Local hospitals also work with the SHP by referring individuals (and their families where applicable), for services. The SHP staff makes every attempt to meet the referred person(s) while they are in the hospital to help start the housing process prior to their discharge date. Wernersville State Hospital has also worked with the SHP by making referrals for services for those who wish to live or return to York County.

Social/Financial: The SHP also works with the Mental Health America assisting with referrals for the Compeer Program, or working jointly with consumers who have a Representative Payee on financial matters. The SHP also works with the Department of Public Assistance in helping consumers in obtaining medical, cash/or food stamp benefits. The SHP will work with the Social Security Office in helping consumers with applying for and attempting to obtain benefits.

Employment: The SHP has also developed a working relationship with Vocational Rehabilitation and Oasis House through Bell Socialization Services, Inc. and the Office of Vocational Rehabilitation.

The SHP further works closely with Bell Socialization Services, Inc. Community Residential Apartment Services (CRAS) program. The SHP receives referrals from and refers consumers to the group home. The SHP staff work with consumers in the residential program when they have met their goals and are ready to move into their own apartment in the community. CRAS also provides respite care services for consumers in the community who have presenting symptoms and require support and supervision in hopes of avoiding hospitalizations. The SHP refers consumers to this service when needed and work closely with the residential staff to ensure stabilization.

Permanent Housing: The SHP works closely with many management agencies (who offer subsidized apartments for the elderly/handicapped/disabled), realtors, and private landlords in the community. Assistance is given with completing applications for subsidized housing; gathering necessary paperwork, setting up appointments, and assisting individuals with transportation. The program has also established ongoing communications with landlords and realtors.

Service Provisions

In the Supported Housing Program we operate on a case by case status when referring individuals to certain programs. Once a need is establish through meetings with the consumer and any supports referrals are made to apply for SSI/SSDI, VA services and dual diagnosis programs. Supported Housing staff makes the initial contact to these providers and attends first appointment and meetings at the consumers request. Supported Housing staff has and continue to work with dual diagnosis facilities such as True North, White Deer Run and Wellspan Behavioral Health. Caseworkers with Supported Housing general work with Wellspan Behavioral Health due to the establish relationship with psychiatrist, therapist, and nurses. Consumers attend group meetings with their peers to address the stressor, concerns and progress when dealing with both mental illness and drug addiction. Consumer can also see a nurse and therapist if needed to address dual diagnosis concerns, issues medication management and progress.

Outreach: Street outreach is conducted on a quarterly basis at various homeless camps and hangouts throughout the city of York. The Program Coordinator and the caseworkers outreach at local shelters, soup kitchens and other organization that service the homeless population. Outreach also includes any face-to-face contact with consumers that link them to services. All outreach is conducted by a PATH funded caseworker.

Staff Training: trainings are offered throughout the year based on practicality and usefulness to the staff's job requirements.

Case Management, these services include providing assistance in obtaining and coordinating social maintenance services for the eligible homeless and general housing needs of the consumers. Referrals are made to representative payee services if needed, as well as applying for Social Security benefits, food stamps, and housing and energy assistance. Case Management services are performed by a PATH funded caseworker.

Housing services: Planning for housing, Technical assistance, Coordination of services

Gaps in the current service system.

One gap being addressed is being short staffed for the ever growing caseloads of mentally ill consumers in need of support services as well as an already addressed gap of extra support services needed for some of the SHP consumers in order to keep them out of the state and local hospitals. Another gap that needs to be further addressed would be financially assisting PATH consumers with rents and security deposits or rents at a percentage for PATH consumers.

Another gap previously addressed in prior PATH applications is that of affordable housing available in the community. Bell Socialization Services, Inc. has taken steps to address this issue with development of three apartment buildings in the city of York. The first being Penn Apartments, consisting of 7 apartments (6 one bedroom and 1 two bedroom unit) each apartment is rented at 30% of the consumers income. Philadelphia Street apartments consisting of four apartments, these apartments work with Section 8 vouchers. York Apartments provides eight apartments available to homeless mentally ill people. In 2006, Bell started the Transitional Age Apartment Program, which provides four individuals from the ages of 18 to 29 years of age. These apartments are subsidized at 30% of the consumer’s income. All of the above mentioned apartments also include outreach services provided by the SHP.

Another gap currently affecting the disbursement of effective housing services revolves around the sex offender population; these individuals are essentially

prohibited from securing housing because they are unable to reside near minors. Clearly, the majority of available rental units fall under this designation, making it virtually impossible to house these individuals. As a result, these individuals are more prone to itinerant living and/or homelessness; often, this type of living situation leads to recidivism.

Services available for clients who have both serious mental illness and substance use disorder.

Services available for consumers who have both serious mental illness and substance use disorder are given information about available community resources. These resources include York/Adams Drug and Alcohol Program, Stepping Stone Counseling, York Hospital Counseling and Education Services, Alcoholics and Narcotics Anonymous and a local Dual Diagnosis group that meets weekly. In addition the SHP staff has a working relationship with York County's Drug and Alcohol Case Management.

Describe how the local provider agency, pays for or otherwise supports evidenced-based practices, trainings for local PATH-funded staff, and trainings and activities to support migration of PATH data into HMIS.

The SHP currently utilizes the HMIS system to enter and track housing data, in order to "collect the most accurate and representative information on individuals and families who experience homelessness." The HMIS System is funded by the York County Planning Commission as part of the Continuum of Care initiative to end homelessness. The SHP Program Coordinator currently serves on the York County HMIS planning committee. Training and supports are provided by the York County Planning Commission.

Data

The SHP along with the York County Planning Commission continues to document data in HMIS and works closely with the HMIS provider to implement the new PATH/HMIS system requirements. The SHP Program Coordinator currently serves on the York County HMIS planning committee. Training and supports are provided by the York County Planning Commission.

HMIS Administrator: Kelly Blechertas
Program Reporting Specialist-York Planning Commission
28 E. Market St. York, Pa 17403

Alignment with PATH Goals

SHP has developed program goals to outreach to homeless individual at local shelters, libraries and soup kitchen's. We also provide outreach services at Bell Socialization's drop in center, where individuals frequently drop in to socialize,

make phone calls, receive support from staff as well as seek refuge form the weather elements. In an effort to further service the chronic homeless population the SHP developed a goal to take a day of action where we walk the city streets and known areas where homeless individual gather and provide them information with hopes of the individual participating in PATH services in the future.

Alignment with State Mental Health Services Plan

Currently SHP Program Coordinator has developed and implemented an emergency response fact sheet to give to consumers in our program. Caseworker will review emergency response knowledge with the consumer on a quarterly basis to ensure that consumers are aware of emergency exit plans, emergency numbers and nearest shelter facilities in case of weather or nuclear disaster. The Program Coordinator for SHP is also working with the caseworkers to developing an emergency planning kit for consumers in our program. PATH Supported Housing Program (SHP) staff work along with Case Management staff by providing the housing component and assisting with teaching consumer the necessary procedures in an emergency situation. There is a joint working relationship between PATH Supported Housing Program and case management to ensure continuity of care.

Alignment with State Plan to End Homelessness

The Supported Housing Program (SHP) staff continues efforts in out reaching to local shelters by visiting shelters on a monthly or quarterly basis to homeless individuals. SHP staff also outreach to local soup kitchens and libraries in search of individuals needing services. Our goal for SHP is to continue to provide support to homeless individuals and help them obtain and maintain safe and affordable housing within their community. In an effort to continue to educate staff, the Program Coordinator participates in several committees to address the housing need for homeless individuals the York County area. Future goal of SHP would be the chance to embark on the Housing First model in effort to house the homeless at a faster rate then what we currently provide. Services available for consumers who have serious mental illness, literally homeless and chronically homeless are given information about available community resources; such as local soup kitchens, shelters, rental assistance programs and mental health outpatient services. In addition the SHP staff has a working relationship with York County COC, MH/IDD, York Housing Authority, Community Progress Council, York Rescue Mission, Women and Family Shelter and many other services providers that assist the homeless population.

Other Designated Funds

Currently Bell Socialization Supported Housing PATH Program does not receive funds from Mental Health Block Grant nor Substance Abuse Block Grant.

Programmatic and Financial Oversight

PATH funds are dispersed to York County MH/IDD, which are then dispersed to Bell Socialization Services. On an annual basis the budget is reviewed and reports are developed and submitted to York County MH/IDD.

SSI/SSDI Outreach, Access, Recovery (SOAR)

The SHP Program is in the process of having four staff completing online SOAR training. This training is offered to PATH staff and staff will be certified within the next year. PATH staff is currently completing online SOAR classes and most staff are at least 50% complete of the class. To date, there are no SHP staff that have completed the SOAR training. For grant year 2017-2018, it is anticipated that all staff will be SOAR trained. Subsequently, no PATH funded consumers have been assisted through SOAR at this time.

Housing

The Housing Specialist has an established working relationship with local landlords and property management companies and receives updated information on current rental properties. The SHP Program Coordinator also participates in monthly Continuum of Care meetings to end homelessness in York County.

SHP staff has linkages and makes referrals to other community service providers as needed (i.e. social and vocational rehabilitation services, therapy services, adult basic education, etc.). The SHP also helps consumers to access community housing-related services.

Providers frequently used by PATH program:

Dutch Kitchen (provides 59 single occupancy rooms)

Penn Apartments (provides 7 subsidized apartments and support staff)

York Apartments (provides 8 apartments that are subsidized for homeless mentally ill consumers along with support staff)

E. Philadelphia St. Apartments (provides 4 low income apartments for the mentally ill)

Delphia Management Corporation (provides subsidized housing)

York Housing Authority (provides subsidized housing)

Transitional Age Apartments (provides transitional housing for 4 individuals between the ages of 18 – 29 years of age)

York and Adams County Rescue Missions and the York County YMCA. These two community partners offer emergency shelter and subsidized rents for Individuals.

Coordinated Entry

Currently there is no Coordinated Entry for York County. Several conversation at the Continuum of Care (COC) meeting have occurred about coordinated entry, but currently we do not have a working Coordinated Entry system.

Justice Involved

Bell Socialization is aware of the challenges when assisting individuals who are homeless and have either drug and alcohol history and/or criminal history. Currently Bell Socializations works with specific programs that work assist individuals who have a criminal history. Once an individual is approved for PATH and may have a criminal history; the caseworker will coordinate services with York County Probation or State Parole to ensure that the individuals recidivism rate remains as low as possible. Currently it is estimated that we service about 10% of consumer who have some type of criminal history.

Staff Information

The Supported Housing staff is representative of the culturally diverse population of the service area. Currently there are 3 African American, 2 Caucasian, and 1 Latino staff. Staffs that directly work with PATH consumers consist of 3 African Americans and 1 Caucasian individual. One SHP staff member is bi-lingual (English/Spanish). The SHP works with Sendero, the Latino social rehabilitation program of Bell Socialization Services, Inc. and is sensitive to the varying needs of a culturally diverse population. Trainings are offered on a monthly basis to remain aware of cultural diversities of the community we serve. Trainings are presented by members of the community and address topics such as; Veterans Affairs, Jewish Cultural, Hispanic/Latino Cultural, African American and Native American Cultural. Referrals are also made from The Spanish American Center to SHP. Mailers are sent out annually to get feedback from family members concerning ideas they may have to better the program and services. A bi-annual survey is conducted for SHP consumers to both solicit feedback on quality of the services received and ideas for improvement. By implementing cultural diversity trainings on a monthly basis and ensuring our staff represents a culturally diverse population, the SHP is able to avoid pitfalls which contribute to our programs success.

Client Information

In recent past we serviced 39 individuals in our PATH Program. Of the individuals served in the PATH program 71% resided in emergency shelter, 5% resided in transitional housing for homeless individuals, 11% stayed with family, 8% stayed with friends and 2% lived in conditions uninhabitable for humans. 22% of individuals served were experience homelessness less than two days, 45% 2-30 days, 5% 31-90 days, 11% 91 days to 1 year, 11% over 1 year and 2% unknown amount of time. 28% of our clientele have co-occurring substance use disorders and 71% have no co-occurring substance use disorder. 2% of clients were Veterans and 97% were non-Veterans. 2% of the population served is American Indian or Alaskan Native, 40% are African American, 57% are Caucasian. 28% are between the ages of 18-23, 42% are ages 24-30, 14% 31-50 and 14% 51-61. 57% of the population served is females and 42% are males. 71% of our individuals were in imminent of losing their housing and 42% are unstably housed and at risk of losing their housing. Of the population that are in the PATH Program 37% have major mental health diagnosis such as Schizophrenia, Major Depression, Psychotic Disorder and Bi-Polar. With daily contact with individuals who are experiencing homelessness or at risk of homelessness, we anticipate to increase our PATH recipients by enrolling two individuals per month to total 24; which in turn we will be servicing a total of 59 individuals receiving PATH services and anticipate that we will have to outreach 5% of those individuals. It is anticipated that we will contact roughly 150 consumers. To date we currently services 39 individuals with two pending PATH intakes and continue to strive to reach our goals to service more individuals who meet PATH requirements. Our goal continues to grow the program and service 40-45 individuals on a regular basis during 2017-2018.

Consumer Involvement

There are currently consumers sitting in on the Continuum of Care meetings to try to focus services towards the target populations. Family members are encouraged to participate in the planning and implantation of consumer services and program goals. The SHP works with Consumer Satisfaction Program as well as The National Alliance for the Mentally Ill to provide consumers with information and empowerment to maintain independence and housing opportunities. Mailers are sent out annually to get feedback from family members concerning ideas they may have to better the program and services. A bi-annual survey is conducted for SHP consumers to both solicit feedback on quality of the services received and ideas for improvement. Consumers currently assist with new-hire trainings and goal planning within the agency. Consumers are encouraged to participate in both competitive employment and volunteer opportunities within the agency.

Health Disparities Impact Statement

In most recent history our PATH program serviced 71% of consumers who are between the ages of 18-30. Currently we service 39 PATH individuals, 13 of which are between the ages of 18-30. Currently PATH funds are geared towards case management. In trying to further expand our services to the Transitional Age Youth (TAY), Supported Housing would like to explore the option to merge with a current Supported Housing program that services consumers between the ages of 18-29 in which we call our Young Adult Program. By merging these programs individuals who meet the criteria could identify more housing options by utilizing PATH funds. In Supporting Housing we feel case management would be beneficial to TAY consumers to help further their independence by teaching them budgeting skills, cooking(as needed), daily living, medication management and linkage with vocational opportunities. At this time our Supported Housing program receives no extra funds to support TAY consumers, but we are willing to further the conversation about merging programs that are already both operated under the Support Housing Program. Currently consumers in our Young Adult Program are supported by an Occupancy Coordinator who serves as a landlord for the program. Consumers would also receive support from a support case worker who works with consumers on their daily living skills, medication management and various other tasks to keep our individuals independent. Currently the supports case worker can also be contacted outside of normal business hours to provide support to the Young Adult consumers in emergent situations.

Limited English Proficiency

PATH caseworkers attempt to identify disparities and advocate for the best healthcare available for the consumer. PATH staff has developed relationships with community partners and referrals are made by PATH staff to ensure appropriate continuity of care. Trainings are presented by members of the community and address topics such as; Veterans Affairs, Jewish Cultural, Hispanic/Latino Cultural, African American and Native American Cultural. Referrals are also made from The Spanish American Center to SHP. The Supported Housing staff is responsive and sensitive to the culturally diverse population of the service area. Language barriers are addressed at the initial assessment and enrollment into the PATH program. If a need is identified; referrals or translation needs are handled accordingly to ensure appropriate in-language primary care services.

Budget Narrative

All Path funds are used for Case Manager Salaries.
Personnel:

Funding of $63,615 is being requested to provide for the full-time salary. These positions will be located in the Bell Socialization Services Mental Health Department, whose work concentration is to increase and create housing resources in the county for homeless or at imminent risk of homelessness persons with serious mental illness. Total request for salaries is $63,615.

Fringe Benefits:

Funding of $7079 is being requested to provide for the full-time fringe benefits of a MH Housing Case Manager. Fringe benefits include the following costs: FICA at $4867, health insurance at $2012, retirement at $200, Total request for fringe benefits is $7079.00

BUDGET TABLE
Bell Socialization
Supported Housing-PATH Program
FY 2017-2018 Budget

*Please add additional rows as necessary

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
Case Manager	25,286.00	2.5	63,615	63,615
sub-total				**63,615.00**
Fringe Benefits				
FICA Tax	4,867.00			4,867.00
Health Insurance	2,012.00			2,012.00
Retirement	200.00			200.00
Life Insurance				
sub-total				**7,079.00**
Travel				
Local Travel for Outreach				

Travel to training and workshops				
sub-total				**0.00**
Equipment				
(list individually)				
sub-total				
Supplies				
Office Supplies				
Consumer-related items				
sub-total				
Other				
Staff training				
One-time rental assistance				
Security deposits				
Postage				
sub-total				**0.00**
Total PATH Budget				**70,694.00**

III. State Level Information

A. Operational Definitions

Term	Definition
Homeless Individual:	Pennsylvania's operational definition as it relates to the PATH program is as restrictive as the PHS legislative definition. The definition used to define a homeless individual is as follows: Homeless Individual – "an individual who lacks housing (without regard to membership in a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing."
Imminent Risk of Becoming Homeless:	Pennsylvania's definition for "imminent risk of becoming homeless" has changed slightly since last year and is defined as follows: Imminent Risk of Becoming Homeless – includes those individuals who are likely to meet the Federal definition of "homeless individual," as listed above, unless additional supports are provided. This commonly includes any of the following criteria: doubled-up living arrangement where the individual's name is not on the lease, living in a condemned building without a place to move, arrears in rent/utility payments, having received an eviction notice without a place to move, living in over-crowded conditions, living in substandard housing as also recognized by the Housing Assistance Program (HAP) and Housing and Urban Development (HUD) programs, living in temporary or transitional housing that carries time limits, as well as individuals being discharged from a health care or criminal justice institution without a place to live.
Serious Mental Illness:	Pennsylvania's definition of "serious mental illness" is as follows: Serious Mental Illness (SMI) – Pennsylvania adopted the SAMHSA definition of "serious mental illness" as follows: "persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the [DSM-IV], resulting in functional impairment which substan¬tially interferes with or limits one or more major life activi¬ties" (CSAT, 1998, p. 265). Such major life activities can include: • Basic daily living skills (e.g., eating, maintaining personal hygiene) • Instrumental living skills (e.g., managing money, negotiating transportation, taking medication as prescribed) • Functioning in social, family, and vocational or educational contexts Pennsylvania, within the definition of serious mental illness, has also established an Adult Priority Group. The full text of this definition can be referenced in PA Office of Mental Health Bulletin 94-04. In order to be included in the Adult Priority Group, a person's condition must: "meet the Federal definition of serious mental illness; be age 18+ (or 22+ if in Special Education); have diagnosed schizophrenia, major affective disorder, psychotic disorder NOS or borderline personality as per the disorder DSM-V or its successor documents, as designated by the American Psychiatric Association diagnostic codes 295.xx, 296.xx, 298.9x or 301.83; and meet at least one of the following criteria: • (Treatment History), B. (Functioning Level) or C. (Coexisting Condition or Circumstance). A. Treatment History o Current residence in or discharge from a state mental hospital within the past two years; or o Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years; or – o Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years; or o One or more years of continuous attendance in a community mental health or prison psychiatric service (at least one unit of service per quarter) within the past two years; or o History of sporadic course of treatment as evidenced by at least three missed appointments within the past six months, inability or unwillingness to maintain medication regimen or involuntary commitment to outpatient services; or o One or more years of treatment for mental illness provided by a primary care physician or other non-mental health agency clinician, (e.g., Area Agency on Aging) within the past two years. • Functioning Level Global Assessment of Functioning Scale (DSM-III-R, pages 12 and 20) rating of 50 or below. • Coexisting Condition or Circumstance: o Coexisting diagnosis: ? Psychoactive Substance Use Disorder; or ? Mental Retardation; or ? HIV/AIDS; or ? Sensory, Developmental and/or Physical Disability; or o Homelessness *; or o Release from criminal detention. ** In addition to the above definition of the Adult Priority Group, any adult who met the

	standards for involuntary treatment (as defined in Chapter 5100 Regulations – Mental Health Procedures) within the 12 months preceding the assessment is automatically assigned to this high priority consumer group.
Co-occurring Serious Mental Illness and Substance Abuse Disorders:	Pennsylvania's definition of co-occurring serious mental illness and substance use disorder has not changed since last year and is defined as: "Individuals who have at least one serious mental disorder and a substance use disorder, where the mental disorder and substance use disorder can be diagnosed independently of each other." Individuals who meet the above definition for SMI and are diagnosed with a substance abuse disorder as defined in the DSM-IV-R or revisions thereafter are considered to have a co-occurring diagnosis.

Footnotes:

III. State Level Information

B. Veterans

Narrative Question:

Describe how the state gives consideration in awarding PATH funds to entities with demonstrated effectiveness in serving veterans experiencing homelessness.

Footnotes:

OMHSAS has always supported PATH programs that have developed collateral contacts with local veterans' organizations to identify and enroll eligible homeless veterans. During site visits and in review of intended use plans, the State PATH coordinator strongly encourages all PATH providers to continue to make special efforts to reach veterans who are among unsheltered homeless.

Counties have also been establishing partnerships with their local VA and other agencies that serve homeless veterans and their families in order to better serve this population within their respective communities. At the 2017 Statewide PATH Conference held in June 2017, a representative from The Veterans Multi-Service Center attended the 3-day conference as an additional resource for PATH providers.

In response to inquiries about choosing a target demographic for our PATH disparity statement, PA PATH entities indicated several services and programs in place for veterans across PA. Many areas are prioritizing persons who are NOT HUD VASH eligible for other resources. Several are participating in collaborations for Supportive Services for Veteran Families Program (SSVF) to provide temporary assistance to veterans during a housing crisis. Programs are aimed at preventing homelessness and improving veteran stability. These services include, but are not limited to outreach, case management, transportation assistance, housing counseling, financial planning, legal services, employment search assistance, life skills training, housing vouchers, temporary financial assistance and assistance with obtaining VA and other public benefits. Aid with accessing MH counseling as well as D&A counseling for individuals is also arranged as needed.

OMHSAS will continue to provide support and leadership through a collaborative and comprehensive approach to increase access to appropriate services, prevent suicide, promote emotional health and reduce homelessness among the veteran population. OMHSAS will continue to encourage the use of PATH funding to facilitate PATH-eligible, innovative community-based solutions that foster access to evidence-based prevention, treatment, and recovery support services for military service members, veterans and their families.

III. State Level Information

C. Recovery Support

Narrative Question:

Describe how the services to be provided using PATH funds will reduce barriers to accessing effective services that sustain recovery for individuals with mental and substance use disorders who experience homelessness.

Footnotes:

2017 PA Recovery Support

PA's efforts to reduce barriers to accessing effective services that sustain recovery for individuals with mental and substance use disorders who experience homelessness revolve around strategies outlined in State plans. In May 2016, Pennsylvania released its revised Olmstead Plan for Pennsylvania's State Mental Health System (Plan). The Plan was first issued in 2011 and revised in 2013, and reflects the commonwealth's continued progress toward ending the unnecessary institutionalization of adults who have a serious and persistent mental illness. The revised Plan contains specific steps for the commonwealth to take in order to achieve that goal and calls for implementation to be reviewed at regular intervals to assess progress and determine the need for revision and updates.

The revised Plan retains the core elements and principles of the original Plan and includes a revision explaining new funding sources for integrated housing through a demonstration project. Additionally, this revised Plan includes updates and new steps to help accomplish the goal of ending unnecessary institutionalization of adults with serious and persistent mental illness and children with serious emotional disturbance, including those dually diagnosed with a substance use disorder, medical complication, or intellectual disability. The Plan emphasizes community integration including employment opportunities, while utilizing natural supports to assist individuals on their recovery journey.

Another document released in May 2016 is the Department of Human Services', DHS, 5-Year Affordable Housing Strategy. This piece, composed by the leaders of the Department of Human Services (DHS), the Pennsylvania Housing Finance Agency (PHFA), and the Department of Community and Economic Development (DCED), is a comprehensive plan to connect Pennsylvanians to affordable, integrated and supportive housing. DHS will leverage internal and external resources and collaborate with all levels of government and private agencies to make housing resources and services more accessible and available to a wide range of individuals served by DHS, which include:

- Individuals who live in institutions but could live in the community with housing services and supports
- Individuals and families who experience homelessness or are at-risk of homelessness
- Individuals who have extremely low incomes and are rent-burdened

Some of the initial steps announced in the 5-Year Plan include the following:

- Using a portion of the "Money Follows the Person" federal grant funds to expand the number of regional housing coordinators across the state from 11 to at least 14. These coordinators work with local housing authorities and stakeholders to help transition individuals to the community.
- Enhancing and expanding use of the housing network database operated by PHFA that can be used to match those who need housing with affordable housing throughout Pennsylvania
- Continuing the "Rapid Rehousing" pilot program that is ongoing in Philadelphia to help those who have had recently become homeless and those with have experienced housing instability find permanent housing

- Expanding the use of Medicaid dollars to help move people to stable housing and maintain housing through housing-related supports

Since 2016, the number of regional housing coordinators has expanded to 14, providing 1 regional housing coordinator per region. Below is an overview of how the RHC role has expanded across PA DHS mental health and intellectual disabilities systems as provided by Mary Penny, Statewide Housing Coordinator for the Self-Determination Housing Project of Pennsylvania:

- RHCs provide technical assistance to social service and other professional staff statewide with the goals of ensuring adequate housing is available to meet the needs of people with disabilities and older adults
- The RHCs attend local housing meetings with service providers and other agencies in their service area to identify the needs of the service area
- RHCs facilitate the Prepared Renter Education Program (PREP) Train the Trainer Program and have been doing so for 10 years. This program provides information on everything a prospective tenant needs to know such as how to apply for housing, how to be a successful tenant, addiction protection tools, how to apply for benefits including SSI and SSDI to name a few.
- The RHCs can assist in helping social service professionals' work with property owners and property managers/landlords to understand the needs of consumers with disabilities
- The RHCs provide technical assistance on providing reasonable accommodation, Fair Housing issues with landlords, and solving difficult housing issues
- The RHCs are on various boards, Local Housing Option Teams and are always at the table with latest information from HUD, PHFA etc
- The RHCs work directly with the Local Lead Agencies who are rolling out the 811 program

These materials build on the November 2006 *A Plan for Promoting Housing and Recovery-Oriented Services*, which was drafted with support from consumers, providers, county MH/ID programs and other stakeholders. This document provides guidance to county MH/ID programs for their planning, resource allocation, development of effective supportive housing models and modernization of housing approaches. The Plan spells out specific actions for OMHSAS, its state partners and county MH/ID programs for housing policy and development. With this, many counties began partnering with various supportive housing programs within their boundaries to provide PATH-related services to its PATH consumers.

OMHSAS recognizes that in order to recover, people need several things. First, people need a safe and stable place to live. Therefore, many PATH programs provide rental assistance and security deposit payments to aid recipients in securing stable housing and receiving the range of supports they need to manage mental illnesses and/or other disabilities. OMHSAS allocates funds to programs that provide linkage and referral services to PATH consumers.

Second, OMHSAS recognizes that individuals need to be full, participating members of their communities to achieve full recovery. Individuals with behavioral health conditions do not

recover in isolation, they recover with families and in the community. Pennsylvania's PATH programs have formed successful collaborations with other community agencies in an effort to promote rehabilitation and support, as well as to increase and accelerate the likelihood of recovery for those with behavioral health illnesses. Some PATH counties have partnered with local drop-in centers and club houses to provide community-based services to its PATH consumers. In addition, several PATH-funded programs employ a peer support specialist to assist PATH consumers in their recovery journey. All of these collaborative efforts help provide much needed social activity, adequate income, personal relationships, recognition and respect from others in the communities.

The attached IUPs will address the specific services that counties intend to provide using PATH funds to reduce barriers to accessing effective services that sustain recovery for individuals with mental and substance use disorders who are homeless. They also outline their efforts in establishing appropriate supports to make a consumer's recovery goals possible. The goal is for people with behavioral health conditions to thrive, not merely function in their community.

III. State Level Information

D. Alignment with PATH Goals

Narrative Question:

Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

Footnotes:

2017 PA Alignment with PATH goals

Street outreach and case management are standard expectations for all PA PATH programs. Providers meet with people on the streets, at free meals, shelters, MH drop-in centers and other locations in which literally homeless adults are found. These interactions maintain PATH presence, continue relationship building and encourage the hardest to reach participants to access services with more consistency.

The prioritization of street outreach and case management is reiterated and enforced in many ways. For example, the State PATH Contact, SPC, holds mandatory quarterly calls on which PATH principles and expectations are systematically reviewed and discussed. One-third of the call is reserved specifically for providers to ask each other for tips and methodology in these areas. Guest speakers also provide additional training on various related topics.

Site visits are also used to review specific tactics employed to reach the PATH target population. The SPC will discuss potential modifications and note them in the site visit report if needed.

Another forum in which street outreach and case management are reinforced as priorities is at conferences. The PA PATH program was fortunate to have the 2017 Statewide PATH Conference in June 2017. Conference programming included, but was not limited to, System of Care partners presenting on overcoming barriers through natural and community supports, a youth and young adult panel discussion, Crisis Intervention Team use and benefits, and the importance of using HMIS data to review and revise programming based on statistical results. Attendees were also encouraged to network and share strong outreach methods related to locale type and target markets.

As providers participate in HUD Continuums of Care, CoC, prioritization of those experiencing literal homelessness is again highlighted in related coordinated entry efforts. Several PATH providers serve in leadership roles in PA's CoCs.

Also, the Request for Proposals that was developed to select new PATH programs in November 2009 and January 2011 was designed to promote programs that serve the literally homeless population. Pennsylvania selects its new PATH programs through a very competitive request for proposals (RFP) process. The guidelines that were used in 2010/2011 to evaluate the PATH proposals gave significant weight to counties/programs that would provide outreach services to literally homeless individuals. PA will continue to use this approach in any PATH RFPs issued in the future.

The SPC will continue to provide any training and technical assistance that the providers may need. This is important since many of our providers are located in rural areas where the traditional urban methods of outreach may not yield the desired outcomes.

III. State Level Information

E. Alignment with State Comprehensive MH Services Plan

Narrative Question:

Describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

Footnotes:

2017 PA Alignment with State MH Services Plan

State Comprehensive Mental Health Services Plan

The PATH services offered collectively throughout Pennsylvania are consistent with the general mental health services offered through Pennsylvania's comprehensive mental health service plan. This is supported by the inclusion of PATH services in Pennsylvania's Community Mental Health Services Block Grant, which also serves as the Comprehensive Mental Health Services Plan for Pennsylvania. This plan is reviewed by the State Mental Health Planning Council and approved at the federal level.

PATH providers offer services that supplement existing mainstream mental health efforts in Pennsylvania. Collaboration and coordination between mainstream mental health services and PATH services exists in all counties that currently receive PATH funding. The State PATH Contact, SPC, is able to assure this through regular monitoring activities. The SPC has strongly accentuated the importance of increased collaboration beyond the mental health arena and into other relevant systems such as housing, health, and vocation. This is a message that strongly echoes the content and spirit of the New Freedom Commission Report.

Pennsylvania's Comprehensive Mental Health Services Plan recognizes the homeless or those who are at risk of homelessness as a special population. This group requires specialized attention beyond general mental health services that exist in all of Pennsylvania's (67) counties. The State PATH Contact has direct input into Pennsylvania's Mental Health Block Grant and block grant interviews with monitors at the federal level. Through site visits with the county PATH coordinators, the SPC is able to ensure consistency, coordination and collaboration with existing mental health services.

PATH activities are also coordinated with Pennsylvania's 2014-2018 Consolidated Plan. The Consolidated Plan for the Commonwealth of Pennsylvania (or Consolidated Plan) describes the efforts of the Commonwealth in addressing the housing, community, homeless and economic development needs of its constituents. The Consolidated Plan is intended to outline the goals, strategies and resources to be utilized in addressing those needs as well as related information on performance in realizing these goals. Each year the Commonwealth is required to submit an Annual Action Plan based on the goals of the Consolidated Plan as part of its application process to the U.S. Department of Housing and Urban Development (HUD).

Consolidated Plan

The Pennsylvania Consolidated Plan (Plan) also recognizes the special needs of the PATH population. The Plan covers the needs of the residents that are not directly funded with HUD funding and is submitted to HUD on a five-year cycle. Although Pennsylvania's Department of Community and Economic Development (DCED) is responsible for the Consolidated Plan, OMHSAS is also involved in its development.

The Plan's major goal is to reduce homelessness for all populations throughout the Commonwealth. To achieve this goal, DCED relies on the actions of 16 Continuums of Care (CoC) to address the economic, social, and health problems of the homeless populations in their respective regions. The CoC drives the direction of activities to address the homelessness needs. These needs were previously brought forth in the CoC Homelessness Steering Committee.

The CoC Homeless Steering Committee has been restructured with the implementation of local level CoC meetings as the new governing method. Included are the 14 county-based CoCs and 2 regional CoC's, which are collectively known as "Balance of State." The Balance of State covers 53 of Pennsylvania's 67 counties. This includes 33 counties that are part of the Eastern PA CoC, and 20 counties in the Western PA CoC. This process began in the summer of 2014 and as of February 2015, they CoCs officially became Eastern PA CoC- PA 509 and Western PA CoC – PA 601. Each CoC Board has quarterly meetings that are open to "everyone interested in working to prevent and end homelessness. This includes affordable housing providers, landlords, service providers, employers, law enforcement, health care, clergy, philanthropists, and concerned citizens."

The CoC Homeless Steering Committee is slated to meet monthly and include representation from numerous Commonwealth Departments that have a vested interest in homelessness. DHS/OMHSAS is an active member of this steering committee. Through OMHSAS' ongoing representation and communication with the CoCs and funding sources, the PATH population and their needs are continually represented in broader planning initiatives.

Urban counties and local PATH providers are encouraged to participate in the development of their local Consolidated Plan, a piece completed by the direct entitlements of HUD. This participation allows for the identification of needs and goals across all systems. One outcome of coordination of providers and OMHAS on the former PA CoC Steering Committee was the establishment of housing specialists in some of the (48) County MH/ID programs. Many of the county PATH contacts also serve as housing specialists or work closely with the housing specialists.

Homelessness Program Coordination Committee/Interagency Council

The Homelessness Program Coordination Committee, HPC, is a statewide committee comprised of the public agencies, housing and service providers, and stakeholders of the homeless community, to serve as the working body for the state's Interagency Council on Homelessness (Pennsylvania Housing Advisory Committee (PHAC)). The HPC replaces the previous Homeless Steering Committee for overseeing broader planning responsibilities and coordination of all resources of the state in a manner to best serve the homeless population. The HPC Committee will be able to identify those statewide policies for assisting homeless people, recommend the resources to eradicate homelessness conditions, and propose action steps to the PHAC so the Commonwealth may effectively assist the homeless population in gaining stability and limit its effect on the lives of homeless individuals and families.

The HPC serves as the working body to support the efforts of the Pennsylvania Interagency

Council on Homelessness, which addresses programs and policies to assist the homeless in PA. DCED and DHS/OMHSAS continue to chair this committee and the State PATH Contact is a member of this team. The HPC is still in transitional stages and is to meet quarterly. One meeting has been conducted to date.

Local Housing Option Teams

The PA Office of Mental Health and Substance Abuse Services provides technical assistance in formation of Local Housing Option Teams (LHOTs). Currently, there are 44 LHOTs operating in 54 counties (out of a total of 67 counties in the state). County team membership includes representatives from the County Office of Mental Health, Public Housing Authority and other public and private agencies. The groups meet regularly to plan for increased availability of accessible, affordable housing opportunities for people with mental illness. The major purpose of the LHOT is to bring together the key stakeholders in the community to identify the housing needs of people with disabilities and to take action to meet those needs.

Any local agency that is willing to dedicate time and administrative support to the LHOT may serve as facilitator. In many of the LHOTs, these roles are assumed by the County Mental Health Housing Specialist (who is also usually the county PATH coordinator if the county receives PATH funding). Many of these LHOTS are also involved in their Continuums of Care, thus providing more cooperation between providers and agencies.

III. State Level Information

F. Alignment with State Plan to End Homelessness

Narrative Question:

Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning and the process of updating and testing their emergency response plans.

Footnotes:

2017 Alignment with State Plan to End Homelessness

Previously, Pennsylvania only employed the 2005 Commonwealth-developed "Agenda for Ending Homelessness in Pennsylvania" to govern the work of the Interagency Council and guide the efforts of the Homeless Steering Committee and local Continuums of Care. While there has been no update to this particular document, other efforts have built upon it for a more comprehensive approach to end homelessness in the state.

The General Assembly of the Commonwealth of PA recognized the need to complete a comprehensive analysis of Pennsylvania's homelessness problem and developed a set of recommendations that would move the Commonwealth toward permanently reducing and eliminating homelessness. In March 2014, House Resolution 550 of 2014 directed the Joint State Government Commission to establish a bipartisan legislative task force and an advisory committee to conduct a study on the occurrence, effects and trends of homelessness in Pennsylvania and to report its findings and recommendations to the House of Representatives. The *Joint State Commission Report on Homelessness in PA – Causes Impacts and Solutions, A Task Force and Advisory Committee Report (HR 550)* was released in April, 2016. The report is attached for your convenience and may be viewed at http://jsg.legis.state.pa.us/publications.cfm?JSPU_PUBLN_ID=447.

Suggestions presented in the document specifically cite the PATH grant and SOAR program as resources for addressing homelessness. In addition, PATH employs data collection and application in its Homelessness Management Information System mandate. PA PATH is further consistent with the HR 550 in its provision of services and housing options to specialized subpopulations among those experiencing homelessness or at risk of homelessness including: co-occurring, justice-involved, veterans and transition-age youth.

PA has both state and county level disaster preparedness plans. Being as Emergency Medical Technician, the SPC has utilized background in mass casualty incident command, emergency medical services and preparedness planning to guide county providers in including their local emergency management agencies in the development of their individual protocols. In 2015, the SPC attended the PA Disaster Preparedness Summit and continues to acquire additional training from PA Emergency Management Agency and Emergency Medical Services outlets.

The SPC actively participates in all levels of disaster preparedness planning to stay current with protocols. Since the Fall of 2016, the SPC has represented OMHSAS on the evacuation team for Commonwealth Towers, the location of OMHSAS headquarters. By working directly with the OMHSAS COOP Coordinators, the SPC presented built, disseminated and activated the building evacuation plan. Drills are held twice a year with evaluation, discussion and modifications as needed.

The SPC will also be the OMHSAS lead for the August 2017 2-day Keystone 6 Mass Care Exercise. This training will focus on disaster shelter operation coordination in both Shippensburg, PA and Middletown, PA.

Pennsylvania's *"Agenda for Ending Homelessness in Pennsylvania"* is based upon three state-driven strategies that correlate with the HR 550. These strategies outline steps that will occur at both the state and local levels, including:

- Improve coordination between state agencies and promote targeting of resources consistent with the state vision and guiding principles. A central part of the Agenda is to assess the effectiveness of the current state and local housing and human service delivery systems, and to ensure that they support the above vision and guiding principles.

- Foster and support local efforts to end homelessness. Given the size and diversity of the Commonwealth, the health of the local network of homeless housing and service providers is a critical factor in successfully implementing the Agenda for Ending Homelessness in Pennsylvania. Since every region of the state is different, the Plan must be designed to support local participation, while accommodating regional differences. Training and technical assistance are needed to build local capacity, especially in areas of the state where resources are limited.

- Promote recovery-oriented housing and services for homeless individuals with serious mental illness, substance abuse and/or co-occurring disorders. The Commonwealth of Pennsylvania and its Office of Mental Health and Substance Abuse Services has embraced the recovery model for the provision of housing and services to individuals served through the mental health system, including homeless individuals and families. The goals and objectives for preventing and ending chronic and episodic homelessness reflect the state's commitment to the recovery model for all people with serious mental illness.

The PA Office of Mental Health and Substance Abuse Services provides technical assistance to counties throughout the State to form Local Housing Option Teams (LHOTs). Currently, 53 counties (out of a total of 67 counties in the state) have formed LHOTs in which representatives from the County Office of Mental Health, Public Housing Authority, and other public and private agencies meet regularly to plan for increased availability of accessible, affordable housing opportunities for people with mental illness. The major purpose of the LHOT is to bring together the key stakeholders in the community to identify the housing needs of people with disabilities and to take action to meet those needs. Most PATH providers participate in their local LHOT programs.

Any local agency that is willing to dedicate time and administrative support to the LHOT may serve as facilitator. In many of the LHOTs these roles are assumed by the County Mental Health Housing Specialist (who is also usually the county PATH coordinator if the county receives PATH funding) from the county department of mental health/intellectual disabilities.

III. State Level Information

G. Process for Providing Public Notice

Narrative Question:

Describe the process for providing public notice to allow interested parties, such as family members; individuals who are PATH-eligible; mental health, substance abuse, and housing agencies; and the general public, to review the proposed use of PATH funds (including any subsequent revisions to the application). Describe opportunities for these parties to present comments and recommendations prior to submission of the State PATH application to SAMHSA.

Footnotes:

2017 PA Process for providing public notice

The completed PATH application is distributed for review and comment both through the PA OMHSAS listserv and on parecovery.org. The application is posted for approximately 10 calendar days. After the response period closes, gathered information is compiled and incorporated into the PATH application as appropriate.

In addition, both the Consolidated Plan and the County Human Service Plans can include PATH in their service plan development for the homeless and seriously mentally ill population. Both provide public notice and allow interested parties, including family members, consumers, the general public as well as mental health, substance abuse, and housing agencies the opportunity to comment and provide recommendations.

The Consolidated Plan is available at each of the 67 County Commissioners' offices, the 6 regional offices of the Pennsylvania Department of Community and Economic Development (DCED) and Pennsylvania's 28 District Libraries. A summary of the Action Plan is published in the Pennsylvania Bulletin for public comment and public meetings are held to respond to questions and recommendations. The state recently further expanded its broad public participation process for the Consolidated Plan by providing opportunity for on-line public meeting. The Consolidated Plan Annual review is disseminated in the same manner and contains information on the PATH program.

Proposed PATH activities can also be included in County Human Service plans since PATH funds are allocated to County MH/ID programs by OMHSAS. All County MH/ID programs are required to hold advertised and announced public hearings on their proposed annual plans, and to document the meetings, attendees, and comments received. Stakeholders, including consumers, advocates, and other interested parties, often attend these public hearing forums and use these opportunities to provide comments and raise relevant issues. Also, PATH activities and proposed uses of PATH funds are described in the documents developed for discussion and approval by the members of the Pennsylvania State Mental Health Advisory Committees (Adult, Older adult, and Children's committees), that have the responsibility for development and approval of the Mental Health Services Block Grant application annually. At least 51% of the members on these advisory committees are mental health consumers and family members nominated by representative constituent organizations.

III. State Level Information

H. Programmatic and Financial Oversight

Narrative Question:

Describe how the state will provide necessary programmatic and financial oversight of PATH-supported providers, such as site visits, evaluation of performance goals, audits, etc. In cases where the state provides funds through intermediary organizations (i.e., County agencies or regional behavioral health authorities), describe how these organizations monitor the use of PATH funds.

Footnotes:

2017 PA Programmatic and Financial Oversight

There are essentially two primary methods used to provide programmatic and financial oversight of the PATH providers, the State PATH Contact and the County PATH Coordinators.

State PATH Contact (SPC)

Since 2001, Pennsylvania has employed a full time State PATH Contact. The SPC oversees all activities related to the PATH program. The SPC monitors county MH/ID programs who receive PATH funds as well as the local programs with whom they sub-contract. Monitoring is done through site visits, quarterly plan review and fiscal reporting, quarterly conference calls, technical assistance, ongoing phone and email contacts etc. In addition to reviewing services and budgets for compliance, the SPC also examines program strengths, goals and development of new programs. In addition, PA is planning to host a statewide PATH conference, which will include education, training and collaboration. A new monitoring technique that PA is anticipating employing is use of webinars with content chosen by PATH providers.

The SPC ensures PATH-funded programs truly understand and reflect the philosophy of service to the SMI homeless population. Site visits are conducted in a very structured manner and typically involve meetings with the County MH/ID Administrator (or designee), the County PATH coordinator, fiscal contact, CEO (or designee) of the contracted PATH agency, agency PATH coordinator and case managers who work with the PATH consumers. OMHSAS team visiting the counties for the site visits typically includes the State PATH Contact, a representative from the fiscal office and a representative from OMHSAS field offices. In addition to meetings with the county and PATH agency staff, the OMHSAS team also interviews consumers, reviews charts and visits other community agencies where PATH consumers receive services. A detailed report is prepared and provided to the county after each site visit. This report includes recommendations and when appropriate, a corrective action plan. The SPC conducts follow-up and monitoring to ensure ongoing compliance.

In April 2016, PA hosted the PA PATH Homeless Management Information System (HMIS) Technical Assistance Conference in State College, PA. Fifty PATH Coordinators, HMIS Directors and members of the OMHSAS management attended. Pivoting on the upcoming SAMHSA deadline for full HMIS implementation of June 30, 2016, the training highlighted everything from SAMHSA's participation policy, goals and expectations of PATH providers, HMIS data standards and elements and outreach to the technical topics including physical data entry, system requirements, staff coordination with HMIS directors and using reports for advanced planning and reporting. Clarification on these topics was enhanced by having two of SAMHSA's Homeless and Housing Resource Network trainers as well as a representative from ICF, a HUD TA provider, facilitate the training. The instructors were able to address participant concerns and questions from Continuum of Care and overlapping funding perspectives at once. In addition, having the HMIS Directors present allowed for immediate intervention from the programming side. Each participant was charged with implementing action steps before the June follow-up phone sessions. Feedback has been overwhelmingly positive with participants citing increased understanding and potential for better, more quantitative, outcomes.

County PATH Coordinators

To further ensure compliance, each county has a County PATH Coordinator. This county position is in place even where the county MH/ID offices sub-contract with other agencies to provide all PATH services. The county PATH coordinators work very closely with the contracted agencies to develop and implement new programs and provide oversight to the existing programs. Thus, Pennsylvania has a two-tiered oversight mechanism, one at the county MH/ID level and another at the state level.

III. State Level Information

I. Selection of PATH Local-Area Providers

Narrative Question:

Describe the method(s) used to allocate PATH funds to areas and providers with the greatest number of individuals who experience homelessness with serious mental illnesses or co-occurring substance use disorders (i.e., through annual competitions, distribution by formula, data driven or other means).

Footnotes:

2017 Selection of PATH Local-Area Providers

Pennsylvania always allocates a substantial amount of PATH funds to those areas that have the highest concentration of homeless individuals with a serious mental illness. These areas include the more urban and densely populated counties such as Allegheny County (which includes the City of Pittsburgh) and Philadelphia County (which includes the City of Philadelphia) as well as other urban counties in the state. These counties/areas have the highest concentration of literally homeless individuals.

PATH funds are allocated by the state to county MH/ID programs on an annual basis. In order to ensure program stability, once a county establishes a PATH program or adds PATH funded services to an existing program, funding to that county is continual as long as all compliance requirements are met.

When the PATH grant originally started in 1990, thirteen PA counties were awarded PATH funds based on the reported prevalence of homelessness in PA at that time. Since there were no state statistics available at that time, national studies and any available local resources were used to estimate the number of homeless individuals with a serious mental illness. Therefore, it was a combination of local and national sources that was used to select the original thirteen PATH counties which ranked highest, per capita, for the existence of individuals who were homeless and had a serious mental illness.

Since then, new PATH programs and services have been added through a competitive process through the issuance of Request for Proposals (RFPs). In FY 2009/2010, Pennsylvania added five completely new PATH programs in the state. In FY 2010/2011, additional funding was received. This time, RFPs were open to both existing as well as new counties/joinders. With the second RFP, 2 PATH programs were funded in counties that did not previously have a PATH program, while three PATH programs were funded in counties that already had PATH programs (who were able to demonstrate the need for more funding/programs for the PATH population). Since the reduction in PATH funding in FY 2012-2013, the State has not added any additional programs.

Many of the county MH/ID programs that receive PATH grant funds then sub-contract with local providers, who in turn offer the PATH services. Close coordination is maintained between the OMHSAS State PATH Contact, county PATH coordinators and local PATH providers contracted by the County MH/IDs. The Intended Use Plans will provide additional information on programs provided.

III. State Level Information

J. Location of Individuals with Serious Mental Illnesses who are Experiencing Homelessness

Narrative Question:

Indicate the number of individuals with serious mental illnesses experiencing homelessness by each region or geographic area of the entire state. Indicate how the numbers were derived and where the selected providers are located on a map.

Footnotes:

Location of Individuals with Serious Mental Illnesses who are Experiencing Homelessness – Indicate the number of homeless individuals with serious mental illnesses by each region or geographic area of the entire State. Indicate how the numbers were derived and where the selected providers are located on a map.

CoCs by REGION	Number of Homeless with SMI - 2017
1. Southeast PA	
Philadelphia County	1594
Delaware County	139
Montgomery County	67
Bucks County	106
Chester County	86
Total Southeast PA	**1992**
2. Eastern PA	
Previous Altoona/Central PA CoC (Adams, Bedford, Blair, Cambria, Centre, Clinton, Columbia, Cumberland Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lycoming, Mifflin, Montour, Northumberland, Perry, Snyder, Somerset, and Union Counties) and **previous Northeast PA CoC** (Bradford, Carbon, Lehigh, Monroe, Northampton, Pike, Schuylkill, Sullivan, Susquehanna, Tioga, Wayne, and Wyoming Counties) As of January 2015, merged into **Eastern PA CoC**	279
Berks County	165
Dauphin County	92
Lackawanna County	61
Lancaster County	47
Luzerne County	40
York County	44
Total Eastern PA	**728**
3. Western PA	
Previous Southwest PA CoC (Armstrong, Butler, Fayette, Greene, Indiana, Washington, and Westmoreland Counties) and previous **Northwest PA CoC** (Cameron, Clarion, Clearfield, Crawford, Elk, Forest, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, and Warren Counties) As of January 2015 merged into **Western PA CoC**	238
Allegheny County	390
Beaver County	27
Erie County	75
Total Western PA	**730**
PA TOTAL HOMELESS WITH SERIOUS MENTAL ILLNESS	**3450**

Note: See attachment for map of PATH providers

The data presented above was collected on a single night during the last week in January 2017, in most cases, the night of January 25, 2017. Each CoC in Pennsylvania provided the data that they assembled for submission to HUD on the 2017 HDX, the reporting software used

to report on Housing Inventory and Populations and Subpopulations for the McKinney-Vento/HEARTH Continuum of Care (CoC) application process. The number of homeless people with serious mental illness reported for each CoC includes all people with serious mental illness who were in an Emergency Shelter, Transitional Housing, or Safe Haven program and those who were unsheltered on the night of each CoC's 2017 Point-in-Time count.

The data collected shows a decrease from 2016 to 2017 of 408 individuals experiencing homelessness who report a serious mental illness from 3858 in 2016 to 3450 in 2017, a 10.6% decrease.

At the individual CoC level the CoC's that contributed most to this decrease are:

Philadelphia:	1762 in 2016 &1594 in 2017 – decrease of 162 individuals (9.5%)
Eastern PA:	395 in 2016 & 279 in 2017 – decrease of 116 individuals (29.3%)
Allegheny County:	495 in 2016 & 390 in 2017 – decrease of 105 individuals (21.2%)

Note: While the percentage decrease in Philadelphia is much lower than the others cited, because of the larger order of magnitude of the CoC, this increase has a larger impact on statewide numbers.

Although there was an overall decrease in the number of individuals experiencing homelessness who reported having serious mental illness, there were 3 counties that experienced an increase:

Chester County:	63 in 2016 & 86 in 2017 – increase of 23 individuals (36.5%)
Berks County:	109 in 2016 & 165 in 2017 – increase of 56 individuals (51.4%)
Luzerne County:	28 in 2016 & 40 in 2017 – increase of 12 individuals (42.9%)

The reasons cited for these increases are: new shelters either starting operation during the year or beginning to contribute data to the Point in Time count and improved HMIS data entry resulting in more people being coded as having a serious mental illness.

While the Homeless Subpopulations Chart in the HDX is the primary data source available at the present time, OMHSAS continues to recognize the following limitations:

1. This data is collected through a Point-in-Time count and does not reflect the total number of homeless individuals over the course of a year.

2. The data is based on HUD's very specific definition of homeless – those living in emergency shelters, transitional housing for the homeless, safe havens for homeless individuals and in places not intended for human habitation (unsheltered).

3. The data on the number of homeless who have serious mental illness is often self-reported by the individuals being surveyed or by shelter staff or outreach workers through observation. Some CoCs, Allegheny County, in particular, base their PIT results on HMIS data rather than interviews on the night of PIT. Their HMIS is based on actual assessments rather than self-reporting to determine the number of individuals with Serious Mental Illness in the CoC.

It is anticipated that the count of the number of individuals who are experiencing homelessness who have serious mental illness will continue to decline as a result of several HUD policy priorities:

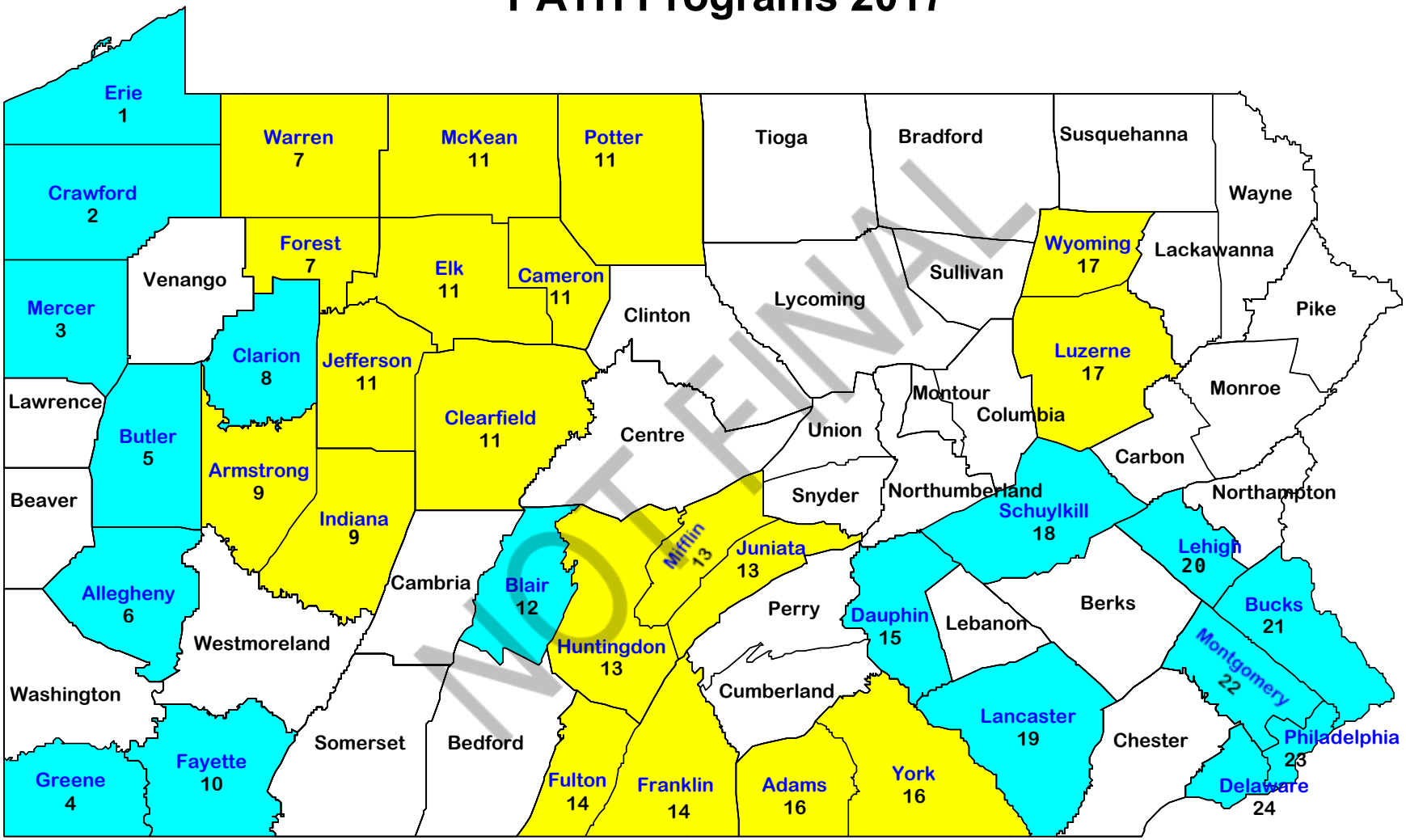
- HUD has encouraged CoC's to eliminate or reduce the amount of Transitional Housing in favor of creating more permanent housing resources, both Rapid ReHousing and Permanent Supportive Housing

- All CoCs are encouraged to prioritize those individuals with the most severe service needs and the longest length of time homeless for Permanent Supportive Housing.

- By January 2018, all CoC's must implement Coordinated Entry through which each household is assessed for vulnerability and length of time homeless, in order to offer housing to those who would benefit most from it.

All three of these policy priorities will result in increased access to permanent housing resources for individuals with serious mental illness and, should over time, continue to result in a reduction in the number of individuals with serious mental illness who are experiencing homelessness.

Pennsylvania
PATH Programs 2017



Individual County Program

Two or more counties combined for one PATH program

No PATH program

Please note: County numbering indicates individual PATH programs; counties sharing the same number are part of the same PATH program contract. PA has 24 total PATH programs.

III. State Level Information

K. Matching Funds

Narrative Question:

Describe the sources of the required PATH match contributions and provide assurances that these contributions will be available at the beginning of the grant period.

Footnotes:

Baxter, Michelle

From: Polcyn, Kent
Sent: Friday, June 16, 2017 8:53 AM
To: Baxter, Michelle
Cc: Sworen, Joseph; Polcyn, Kent
Subject: Matching Funds Confirmation

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Michelle,

This is to confirm that in state fiscal year 2017-2018 (July 1, 2017 - June 30, 2018) we will allocate a minimum of one dollar in state funds for every three dollars in federal PATH funds, consistent with the grant "Terms and Conditions." For the projected grant award of $2,366,093 we will allocate a minimum of $788,698 in state matching funds.

Kent Polcyn | Accountant
Department of Human Services | Office of Mental Health & Substance Abuse Services
Bureau of Financial Management and Administration
Commonwealth Towers, 12th Floor, 303 Walnut Street | Harrisburg, PA 17101
Phone: 717.787.3697 | Fax: 717.787.2866
kpolcyn@pa.gov | www.dhs.pa.gov

Mental Illness affects 1 out of every 4 persons. OMHSAS challenges you to change a life, save a life and commit to participation in a Mental Health First Aid Class.

III. State Level Information

L. Other Designated Funding

Narrative Question:

Indicate whether the mental health block grant, substance abuse block grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illnesses.

Footnotes:

2016 PA Other Designated Funding

The Mental Health Block Grant, Substance Abuse Block Grant, general revenue funds and PATH funds, all in combination, comprise much of the funding pool that county MH/ID programs use to provide services to PATH and other populations.

This coordination is very common in PA and has demonstrated the ability to offer a broader array of services. The State PA PATH Contact uses monitoring activities to ensure that PATH funds are being used in accordance with legislative expectations. PATH monies provide a very valuable supplement and support for 24 county MH/ID programs (encompassing 36 Counties) that offer services aimed at this population. These services include outreach, case management, and other PATH eligible services. As evident from the local Intended Use Plans, many PATH providers have developed very comprehensive programs for this population with a combination of PATH funds as well as other sources including the Mental Health Block Grant funds, State revenue funds, and local county funds.

III. State Level Information

M. Data

Narrative Question:

Describe the state's and providers' status on the HMIS transition plan, with an accompanying timeline for collecting all PATH data in HMIS. If the state is fully utilizing HMIS for PATH services, please describe plans for continued training and how the state will support new local-area providers.

Footnotes:

2017 PA Data

The Pennsylvania Department of Community and Economic Development (DCED) has established a Homeless Management Information System, known as PA HMIS, for the 54 counties included in the two rural regions of Pennsylvania. In addition, nine of the ten urban, or proprietary, counties/joinders have established their own HMIS system. The remaining proprietary county uses PA HMIS.

In FY 12/13, The Office of Mental Health and Substance Abuse Services (OMHSAS) entered into an agreement with DCED to begin working to further develop the PA HMIS to include PATH specific data elements. In August of 2013, the PATH data elements were fully integrated into the PA HMIS with many providers entering data into the system as early as September 2013.

All PATH HMIS software vendors are aware of and have modified their systems to be fully compliant with the new PATH HMIS data standards collection released by HUD and the other federal partners. Providers will be utilizing changed collection standards by the effective date of October 1, 2017.

Currently, 24 of the 24 PATH-funded counties (and their provider agencies) are utilizing an HMIS for PATH services. Of these 24 counties/joinders, 15 utilize the PA HMIS established by DCED and 9 utilize their own HMIS. OMHSAS will fully utilize HMIS for collecting PATH data by the end of FY16/17 for 23 of its counties/joinders. The last county just implemented HMIS for use in April 2017 and will need to need to utilize both HMIS and other methods for full data collection for the 2017 annual report. GPO is aware of this circumstance.

The State PATH Contact applied for and was granted technical assistance for the full implementation of HMIS by SAMHSA's June 30, 2016 deadline. In April 2016, PA hosted the PA PATH HMIS Technical Assistance (TA) Conference in State College, PA. Fifty PATH Coordinators, HMIS Directors and members of PA OMHSAS management attended. Pivoting on the upcoming SAMHSA deadline for full HMIS implementation, the training highlighted everything from SAMHSA's participation policy, goals and expectations of PATH providers, HMIS data standards and elements and outreach to the technical topics including physical data entry, system requirements, staff coordination with HMIS directors and using reports for advanced planning and reporting. Clarification on these topics was enhanced by having two of SAMHSA's Homeless and Housing Resource Network trainers as well as a representative from ICF, a HUD TA provider, facilitate the training. The instructors were able to address participant concerns and questions from Continuum of Care and overlapping funding perspectives at once. In addition, having the HMIS Directors, including the PA HMIS Director, present allowed for immediate intervention from the programming side. Each participant was charged with implementing action steps before the June follow-up phone sessions. Feedback has been overwhelmingly positive with participants citing increased understanding and potential for better, more quantitative, outcomes.

The various Continuums of Care (CoC) have made significant progress in upgrading their systems to meet changing HUD data quality standards and in achieving full participation; however, they still do not have full coverage. In addition, domestic violence programs are not covered by the HMIS so there will remain a need for a manual point in time count of a portion of homeless programs in each CoC. One of the major changes in the HMIS standards that were introduced with the implementation of Homeless Prevention and Rapid Re-housing Program (HPRP) was a designation of people who are not homeless but received homeless prevention services. This will enable the HMIS to also report on people with mental illness who are at risk of homelessness and therefore PATH eligible. PA HMIS has accommodated this pre-enrollment population; proprietary HMIS have either already augmented their system or have a plan in place to do so.

Continued Training

PA has several methods in place to address ongoing HMIS training. First, OMHSAS will contract with DCED to provide online and onsite trainings on HMIS. DCED has also offered and provided free hardware to provider agencies for HMIS implementation. In order to pay for HMIS system enhancements, OMHSAS will utilize federal PATH funds. The total cost for system enhancement will be divided among each PATH provider and subtracted from the total federal allocation.

Second, upon hire, each new PATH HMIS user with be trained on the respective systems. This will be facilitated by County PATH Coordinators and/or PATH supervisors. For PA HMIS users, DCED has compiled a comprehensive educational base, which includes webinars, desk guides, tutorials and a sand box training environment. Non-PA HMIS systems have been asked to produce user manuals for their respective systems.

Third, PA plans to include HMIS updates in quarterly statewide PATH calls, State PATH Conferences and various electronic communication. The SPC plans to have representatives from PA HMIS and other systems speak about HMIS integration at the next State PATH Conference.

In addition, the SPC will conduct random quality tests with HMIS reports to identify trends and issues. The SPC is also in the planning stages of building a mentor system for HMIS use. Future TA will also be considered as needed.

III. State Level Information

N. Training

Narrative Question:

Indicate how the state provides, pays for, or otherwise supports evidenced-based practices, peer support certification, and other trainings for local PATH-funded staff.

Footnotes:

2017 PA Training

In June 2017, OMHSAS sponsored a statewide PATH conference. The 3-day conference included a range of topics including evidence-based practices. Included topics were as follows: First Episode Psychosis, SOAR implementation and expansion, Combatting Youth and Young Adult Barriers through Natural and Community Supports, Youth and Young Adult Panel Discussion, PA Housing Update, Landlord Negotiations, Reasonable Accommodation, Question/Persuade/Refer, Peer Support use and expansion, PA Response to the Opioid Crisis, PATH Reporting Updates, Crisis Intervention Team use and benefits, PA Opioid Overdose Reduction Technical Assistance Center, HMIS updates/Helping HMIS Help You. An expo room provided opportunity for providers, PATH-related organizations and speakers to share effective practices and supply additional information on session topics. The SPC provided additional statewide updates and encouraged networking and information sharing among attendees. The state utilized PATH training monies to support the participation of PATH providers in the training.

Another way that PA provides and supports evidence-based practices is through staff. OMHSAS has a full-time staff person to oversee evidence-based practices (EBPs). This person is available to support the PATH providers on EBP-related issues. In addition, the SPC is creating a complete database of statewide PATH and SOAR contact information for more efficient distribution of materials.

In 2017, the SPC became certified as an instructor in both Question/Persuade/Refer (QPR) and Crisis Intervention Team (CIT). The SPC has made PATH providers aware of certification and potential use as a resource. In addition to being featured at the 2017 Statewide PATH Conference, both topics are encouraged in quarterly calls and email updates. The SPC also encourages all PATH contacts to take advantage of other training opportunities provided by PATH as well as other trainings and conferences sponsored by the State and respective Continuums of Care.

In September 2014, the State PATH Coordinator and another OMHSAS staff member attended the SSI/SSDI Outreach, Access and Recovery (SOAR) Leadership Academy. The OMHSAS Housing Coordinator also completed the Leadership Academy in March, 2016. This training certifies staff as trainers in the new online-based Fundamentals SOAR curriculum. PA has transitioned all new or refreshing SOAR providers to the Fundamentals model.

OMHSAS staff also leads PA's Peer Support efforts. Several methods are employed to assist qualified applicants pay for Certified Peer Support (CPS) training. The Office of Vocational Rehabilitation will help offset the cost of CPS training by paying $900 toward class for those whose career goal is to be a CPS. Providers, managed care organizations and counties also sometimes volunteer funds to assist individuals to pay the $1300 CPS course enrollment fee.

Technical assistance applications are also utilized to help the State provide, pay for or otherwise support evidence-based practices for local PATH-funded staff. The State PATH Contact applied for and was granted technical assistance for the full implementation of HMIS by SAMHSA's

June 30, 2016 deadline. In April 2016, PA hosted the PA PATH HMIS Technical Assistance (TA) Conference in State College, PA. Fifty PATH Coordinators, HMIS Directors and members of PA OMHSAS management attended. Pivoting on the upcoming SAMHSA deadline for full HMIS implementation, the training highlighted everything from SAMHSA's participation policy, goals and expectations of PATH providers, HMIS data standards and elements and outreach to the technical topics including physical data entry, system requirements, staff coordination with HMIS directors and using reports for advanced planning and reporting. Clarification on these topics was enhanced by having two of SAMHSA's Homeless and Housing Resource Network trainers as well as a representative from ICF, a HUD TA provider, facilitate the training. The instructors were able to address participant concerns and questions from Continuum of Care and overlapping funding perspectives at once. In addition, having the HMIS Directors, including the PA HMIS Director, present allowed for immediate intervention from the programming side. Each participant was charged with implementing action steps before the June follow-up phone sessions. Feedback has been overwhelmingly positive with participants citing increased understanding and potential for better, more quantitative, outcomes.

The SPC has encouraged all HMIS providers to create/maintain a user manual to provide both a reference piece as well as standard of training for new PATH providers. Some HMIS systems also have webinars, sand boxes and other training materials available for subscribers. PATH fund are used to pay for maintenance and TA for the PA HMIS system, which caters to the balance of state users.

To supplement all aforementioned methods, a new training technique that PA anticipates employing is use of webinars with content chosen by PATH providers.

III. State Level Information

O. SSI/SSDI Outreach, Access and Recovery (SOAR)

Narrative Question:

Describe how the state encourages provider staff to be trained in SOAR. Indicate the number of PATH providers who have at least one trained SOAR staff. If the state does not use SOAR, describe state efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner.

Footnotes:

2017 PA SSI/SSDI Outreach, Access and Recovery (SOAR)

PA has a strong SSI/SSDI Outreach, Access and Recovery program. With the growth of SOAR in PA, the State SOAR Team Lead has restructured the SOAR steering committee to implement the Fundamentals format and include other updates. To date, twenty (20) of the 24 PATH MH/ID counties and 1 non-PATH county have received SOAR training and several others are exploring potential for training. The State PATH Contact will continue to work with all PATH counties to have at least one SOAR trained staff within each PATH program across the state by the end of FY 16/17.

Nationally, PA's SOAR program was again ranked #1 in quality. PA's program was also recognized for consistently reporting over 100 benefit decisions for at least 3 years. While the national average days to benefit decision nationwide is 81 days, PA has an average of 79 days in rural SOAR programs and only 52 days in the Philadelphia SOAR program.

In 2015, PA's non-Philadelphia SOAR applications only numbered 68, with a 72% approval rate. In 2016, the same areas reported 146 applications with a 75% approval rate. 2016 represents a 115% increase in number of cases while increasing the approval rate almost 3%.

In the 2016 SOAR Outcomes, PA was recognized for several achievements: over 2000 decisions, over 1000 approvals, being in the top 10 approval rates, consistent capacity, and most improved capacity. Complete 2016 SOAR Outcomes are attached and a consolidate graph is below.

Initial applications:

State	Locality	2016 Decisions	2016 Approvals	2016 Allowance	2016 Average Days	Years of Data	New Cumulative Decisions	New Cumulative Approvals	Cumulative Allowance Rate
PA	Multiple sites	146	109	75%	79	7	346	244	71%
	Philadelphia	215	200	93%	52	9	1781	1745	98%

And appeals:

State	Locality	2016 Appeals Decisions	2016 Appeals Approvals	2016 Appeals Allowance Rate	2016 Appeals Average Days	Years of Data	New Appeals Cumulative Decisions	New Appeals Cumulative Approvals	Cumulative Appeals Allowance Rate
PA	State	9	4	44%	138	3	135	69	51%

While SOAR training historically focused on PATH-funded areas, the state SOAR team provided Fundamentals instruction to the first non-PATH county in February 2015. This training was comprised of 25 SOAR practitioners and had SSA representative in attendance. PA is inviting both Social Security Administration and Bureau of Disability Determination representatives to all SOAR trainings for added benefit to participants.
SPC duties include being the statewide Lead SOAR Trainer. In addition, the SPC continues to create a complete database of statewide PATH and SOAR contact information for more efficient distribution of materials and procedural updates. Quarterly SOAR conference calls will also be implemented to ensure statewide cohesion of SOAR process.

Various funding streams are being taken advantage of for SOAR training. Montgomery Co used CABHI grant funds to hire a full-time attorney to complete SOAR applications in coordination with the Your Way Home project.

In April 2016, Franklin/Fulton Co's PATH coordinator used leftover county grant money to fund a SOAR initiative. Funds paid for time for local service providers to complete the online course and to attend the Fundamentals training. In return, trainees agreed to complete and submit a calculated number of SOAR applications.

In the spring of 2017, Staunton grant funds were acquired by Greene Co to conduct western PA region SOAR trainings. As with the Franklin/Fulton project, time to complete the online application as well as Fundamentals was compensated. Unlike Franklin/Fulton, no agreements were made requiring any number of SOAR applications to be completed. To date, 2 trainings have been completed and a third is being scheduled.

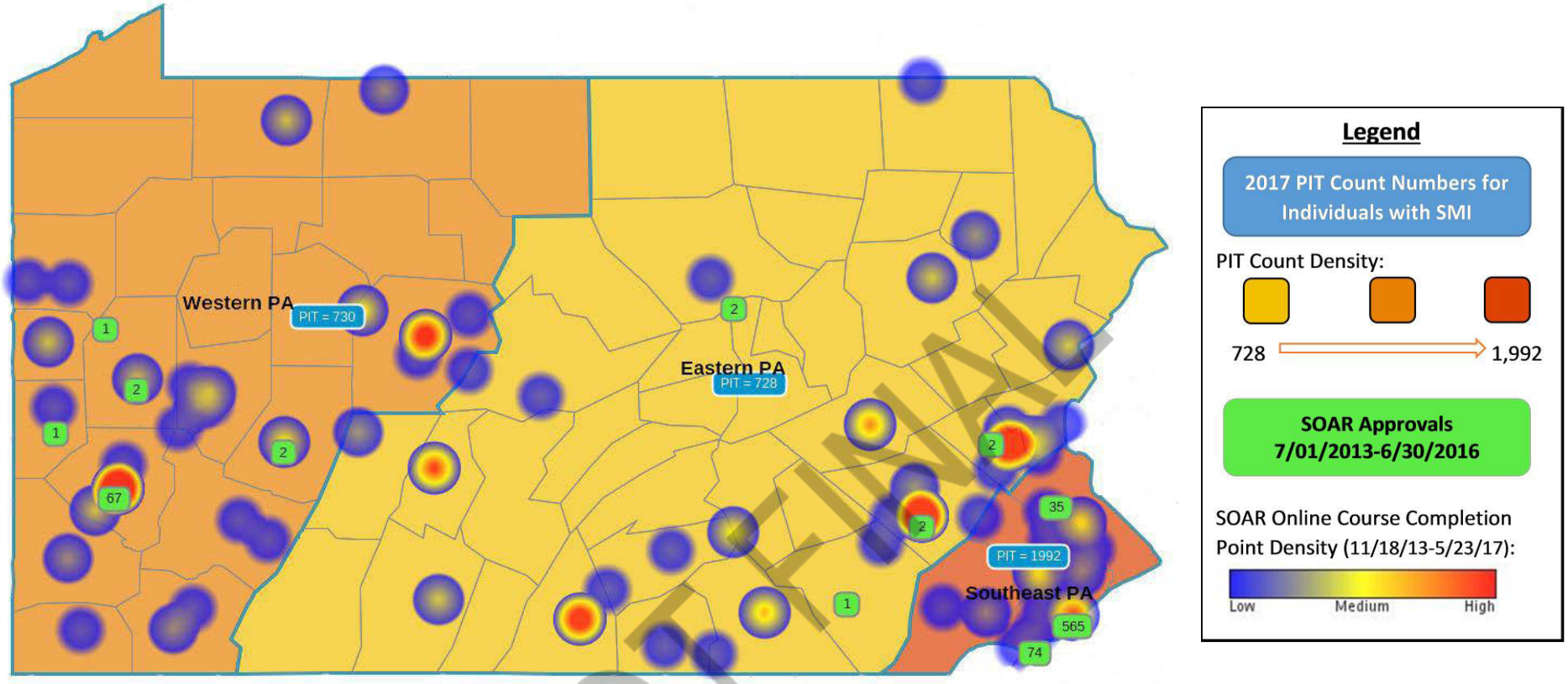
Having VA caseworkers trained to assist veterans with SOAR applications further enhances PA's efforts to expand services to the veteran community. In May 2017, the Department of Veterans Affairs (VA) released a new memorandum encouraging Veterans Health Administration (VHA) homeless programs staff to be trained in and use the SOAR model. PA has forwarded efforts to push SOAR use in the state's VA offices by conducting a SOAR 101 session with all homeless outreach workers at the Lebanon VA. As a result, a SOAR training cohort with that location has been initiated. Interest has also been expressed by the Altoona VA.

A regional representative from a veterans' service organization, The Veterans Multi-Service Center, has taken the online course and is currently attending Leadership Academy. This person will function as the central state representative on the regional SOAR training team.

The regional SOAR training team is being formed to expand PA's SOAR initiative. This tier of leadership will allow for more timely scheduling of Fundamentals, regionalized communications and a stronger overall SOAR presence in PA. To date, there are 2 western trainers and a central trainer. Other locations will be filled as space is available in Leadership Academy slots.

Allegheny County received one of six national technical assistance to advance SOAR use in the criminal justice environment. The TA will include all steps needed to implement, maintain and increase SOAR use at the Allegheny County Jail. This project will enhance SOAR progress already being made by the Bucks Co Jail in the eastern part of the state.

Pennsylvania SOAR and PIT Map: May 2017



Number of SOAR-Assisted Approvals by County					
	Prior to 2014	2014	2015	2016	**Total**
Allegheny	58 *(balance of state outcomes not collected by county prior to 2014)*	8	14	45	**67**
Armstrong			1		**1**
Beaver			1		**1**
Bucks		10	10	15	**35**
Butler		2			**2**
Chester		14	25	35	**74**
Indiana				2	**2**
Lancaster				1	**1**
Lehigh			1	1	**2**
Montgomery				2	**2**
Reading				2	**2**
Philadelphia	1180	150	215	200	**1745**

Average Approval Rates on Initial Applications		
	2016	**Cumulative**
Balance of State	75%	71%
Philadelphia (Homeless Advocacy Project)	93%	98%

SAMHSA SOAR Technical Assistance Center

SOAR WORKS
SSI/SSDI Outreach, Access and Recovery
Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)
March 2017

2016 SOAR Outcomes

SSI/SSDI Outreach, Access and Recovery (SOAR) helps states and communities increase access to Social Security disability benefits for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder. Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the SOAR Technical Assistance (TA) Center develops and provides systems planning, training, and technical assistance to support the implementation of SOAR nationwide.

2016 SOAR Superstars

Over 2,000 Decisions. Nine states had over 2,000 cumulative decisions: Ohio, Florida, Utah, California, Georgia, Michigan, Pennsylvania, New York, and Minnesota.

Over 1,000 Approvals. Twelve states had over 1,000 cumulative approvals: Florida, Ohio, California, Pennsylvania, Georgia, Utah, Michigan, Tennessee, North Carolina, Minnesota, New York, and Oregon.

Top Approval Rates. Our "Top 10" criteria require that states reported outcomes in 2016 and had at least 100 cumulative decisions. The average approval rate for these rock star states was **84 percent**! In order of average cumulative approval rate, the **Top 10** states are: Pennsylvania, Tennessee, Maryland, Arkansas, North Carolina, South Dakota, Washington, Rhode Island, Alabama, and Kansas.

Consistent Capacity. Eleven states consistently reported over 100 decisions each year for the past 3 years: Arkansas, Florida, Maryland, Michigan, Nebraska, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Virginia.

Most Improved Capacity. Colorado, Florida, Georgia, Minnesota, Nebraska, Nevada, New Jersey, Pennsylvania, Texas, and Virginia showed the most improvement in total decisions and approvals from 2015 to 2016. Collectively, these 6 states **increased their approvals from 935 approvals to 1,750 approvals** in only 1 year!

Most Improved Approval Rates. Louisiana, Massachusetts, Montana, and Wyoming showed the most improvement in their approval rates in 2016 from what they reported the previous year. Collectively, these 4 states doubled their average approval rate from **43 percent to 86 percent**!

Most Improved Days to Decision. Four states showed incredible reductions in their average days to decision. Alaska, Arizona, Texas, and Vermont collectively reduced their average days to decision from 120 days in 2015 to 64 days in 2016. That is an average reduction of **56 days**!

Overview

Over the last 11 years, the SOAR approach has been used to assist more than 57,000 people who were experiencing or at risk of homelessness with applying for Social Security's disability benefit programs, Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI).

Of these SOAR-assisted applications, **65 percent**, representing 31,356 persons, have been approved for SSI/SSDI upon **initial** application since SOAR began (Table 1)[1]. An additional 4,756 persons, whose applications were denied initially, were approved on reconsideration or appeal (Table 2). Taken together, since 2006, the SOAR approach is responsible for assisting **36,112** persons who were experiencing or at risk of homelessness to access Social Security disability benefits.

This includes 4,130 approvals on initial applications in 2016 alone. Decisions on SOAR-assisted initial applications were received in an average of **101** days in 2016 with an allowance rate of **67 percent**. This compares to the initial allowance rate of 28 percent for all persons aged 18-64 who applied for SSI or SSDI in 2014[2].

We estimate that in 2016 alone, SSI/SSDI for the individuals served by SOAR brought over **$317 million** into the economies of participating states and localities.

Appeals

States increasingly are using the SOAR approach to assist with applications in the appeals process, both with reconsiderations and hearings by an Administrative Law Judge (ALJ). In 2016, 1,216 SOAR-assisted decisions were rendered at the appeals level, with **60 percent** of all reconsiderations or ALJ hearings resulting in an allowance (see Table 2). SOAR-assisted appeals take an average of **196 days**, compared to the national average hearing office processing time of 570 days[3].

Funding and Sustainability

In 2016, 21 states reported that they were successful in securing new or sustaining funding for their SOAR programs, including:

- The existence of **170 full-time SOAR positions**.
- North Carolina secured funding for 4 new dedicated SOAR caseworker positions, including 5 funded by community hospitals. This brings the total to 31 full-time dedicated SOAR workers in the state.
- Eleven states (AZ, CT, IL, KS, MD, MI, NM, NV, PA, SC, and TN) reported that they used Cooperative Agreement to Benefit Homeless Individuals (CABHI) grants from SAMHSA to fund dedicated SOAR positions. South Carolina reported securing a SAMHSA CABHI grant that will in part fund four new SOAR Benefits Specialist positions, one in each HUD Continuum of Care region.
- The average salary for dedicated SOAR benefits specialists as reported by 20 states was $37,000/year.

Securing funding for dedicated positions remains a priority. Thirty-five states reported that it took on average 27 hours of staff time to complete each SSI/SSDI application.

Implementation of Critical Components

States with higher approval rates credit their success to their capacity for implementing the SOAR critical components[4] and their attention to submission of high quality applications. The five SOAR critical components of application assistance include using the SSA-1696 Appointment of Representative form, collecting and submitting medical records, writing and submitting a medical summary report, including physician co-signatures on medical summary reports, and conducting a quality review of applications prior to submission. Use of these components statistically increases the likelihood of an approval on initial application for those who are eligible[5]. Paying attention to SOAR critical components has other benefits as well:

- ***Better Communication with SSA and DDS.*** Based on data from 47 states, representing 5,572 applications, 98 percent of applications were submitted using the SSA-1696 Appointment of Representative Form as recommended by SOAR.
- ***Fewer Consultative Exams.*** Of those applications, only 20 percent required a consultative examination.

Special Populations

Veterans

SOAR worked closely with Veterans Affairs (VA), state, and local Veteran initiatives to ensure those eligible for SSA benefits were able to apply. Community collaborations included working closely with VA Medical Centers, Housing and Urban Development—Veterans Affairs Supportive

1 The SOAR TA Center requests voluntary submission of SOAR outcomes from states annually from July 1 through June 30 of each year. Unless otherwise noted, these are the data reported in this issue brief.

2 SSI Annual Statistical Report, 2015. SSA Pub. No. 13-11827. Washington, D.C.: SSA, January 2017

3 Hearing Office Average Processing Time Ranking Report FY 2017 (For Reporting Purposes: 10/01/2016 through 01/27/2017) (https://www.ssa.gov/appeals/DataSets/05_Average_Processing_Time_Report.html)

4 http://soarworks.prainc.com/article/soar-model-key-components

5 Based on data from January 15, 2005 to February 14, 2014 extracted from the SOAR Online Application Tracking (OAT) system. Data includes 4,200 application outcomes from 35 states.

Housing (HUD-VASH) programs, Supportive Services to Veteran Families (SSVF), and many others.

- Twenty-two states reported assisting Veterans with their disability applications.
- Three hundred and fifty Veterans were helped with their applications using SOAR.
- A December 2016 survey of SOAR and SSVF programs nationwide found that 223 of the 319 SSVF grantees that responded to the survey (70 percent) are actively engaged in using SOAR to help Veterans access SSA disability benefits. Nineteen percent of responding grantees have a SSVF-funded dedicated benefits or SOAR specialist, and more are exploring this option to help Veterans achieve income stability.

Veterans Spotlight

In San Francisco, the SOAR representative has reached out to the local VA Medical Center and receives referrals of eligible Veterans to the program. The SOAR program at Swords to Plowshares is funded by SSVF and works with Case Managers and Housing Specialists to secure permanent housing for Veterans while they are applying for benefits. Swords to Plowshares and the SSVF program have a close relationship with Case Managers and HUD-VASH Social Workers at the VA. Direct referrals to HUD-VASH are made for eligible Veterans.

Youth in Transition

Young adults and youth in transition face particular challenges in applying for SSA disability benefits. The challenge is compounded by the fact that this group is often too old for child services but may not be ready or eligible for adult services.

- Twenty-five states report working with 215 youth ages 18-24 to apply for SSA disability benefits. These initial applications were decided with a 71 percent approval rate in an average of 88 days.
- Appeals at the reconsideration and ALJ hearing level were also successful for this age group. Based on state reports, 32 youth were assisted with appeals with an approval rate of 53 percent in 128 days.
- These outcomes help dispel the myth that it is not possible to achieve approvals with this age group.

American Indians and Alaska Natives

American Indian and Alaska Native (AIAN) status does not preclude someone from receiving SSA disability benefits. SOAR and access to SSI/SSDI benefits can be a key step on the road to recovery by providing a stable source of income to AIAN individuals. SSI/SSDI supplements existing resources and provides additional health insurance and treatment options. Six states reported collaborations with AIAN communities this year.

AIAN Spotlight

Minnesota reported a new collaboration with their Tribal Nations. State SOAR Leadership attended tribal housing collaborative meetings and provided information about SOAR. Minnesota currently has two Tribal Nations who are SOAR providers.

Collaborations

Employment

SOAR seeks to end homelessness through increased access to SSI/SSDI income supports. For many persons, accessing these benefits is a first step toward recovery. SOAR extends beyond receiving benefits and also encourages employment as a means to increase income and promote recovery. Fifteen states reported collaborations with employment and/or work incentive programs. Employment tracking is still new for SOAR programs, but of the 27 communities that reported, **103 people were working at the time of their SSI/SSDI application** and reported total additional earnings of **$40,973**.

In May 2016, the SOAR TA Center invited the 12 states that received a CABHI-States Enhancement grant to participate in a year-long learning community and pilot. Through this program, participating sites received guidance on integrating the Individual Placement and Support (IPS) supported employment model and the SOAR process into their CABHI grant program. After completing this pilot program, states were better able to:

- Serve individuals needing income support services through the IPS and SOAR models as needed.
- Reduce the gap in income support services for those individuals seeking SSI/SSDI and/or employment.
- Reduce homelessness by creating a system with streamlined access to income support services.

Hospitals

Hospitals that serve uninsured individuals benefit when their patients obtain SSI and the Medicaid coverage that automatically accompanies the SSI benefit in most states. Medicaid can pay for ongoing health care and, in many states, can also provide retroactive payment for uncompensated care. Hospitals are also able to reduce the use of expensive emergency care services by linking patients to ongoing community treatment and support

providers. Collaborations with hospitals were reported by 16 states, for some or all of the following:

- Agreements with medical records departments for expedited records at no cost
- Easy access to needed assessments
- Dedicated benefits specialist positions within the hospital
- Grant funding to support local nonprofit SOAR programs
- Discharge planning in state hospitals

Criminal Justice

To connect individuals leaving correctional facilities or involved in criminal justice systems or specialty courts to needed treatment, it is critical to leverage state and federal investments, such as SSI and SSDI. These federal programs can promote access to services that increase the likelihood of post-release success and contribute to the reduction in recidivism. Collaborations with corrections were reported by 25 states and communities, including:

- Jail in-reach (13)
- Collaboration with parole and probation to coordinate services (5)
- Specialty courts and jail diversion programs (9)
- Re-entry programs (19)
- Training in state departments of corrections
- Kansas reports 11 SOAR-trained discharge planners in state correctional facilities
- One program in Miami, Florida reported in 2016 a total of 70 decisions in an average of 43 days with an allowance rate of 92 percent.

Projects for Assistance in Transition from Homelessness (PATH)

PATH and SOAR programs directly complement each other's work. The PATH program's objective to connect individuals to mental health services and stable housing is more easily accomplished when people who are homeless have access to the income and health insurance that comes with Social Security disability benefits. SOAR provides PATH case managers the tools necessary to expedite access to these benefits, resulting in improved housing and treatment outcomes. All 50 states report collaboration with the SAMHSA PATH program, including:

- Dedicated benefits specialists on PATH teams
- Eleven states reported funding over 70 dedicated or SOAR-trained positions using PATH funds
- SOAR training for PATH outreach and case management staff
- State PATH Contacts serving as SOAR coordinators and leaders

Cost Savings

Medicaid/Medicare Reimbursement

Once an individual is approved for SSI and Medicaid, treatment providers can retroactively bill Medicaid for services provided up to 90 days prior to the SSI protective filing date. This results in reimbursement for previously uncompensated care as well as payment for ongoing treatment. In 2016, 8 states reported over **$1.15 million in Medicaid reimbursement** for 132 individuals, or an average of **$8,746 per person**, as a result of SOAR. Some states are participating in the Medicaid Administrative Claiming (MAC) program, which helps to defray the cost of certain administrative activities related to providing Medicaid services. Two states reported receiving close to $14,000 in Medicare reimbursement this year for 6 individuals.

General Assistance

Some communities offer people who are disabled and have low incomes a monthly cash stipend to help cover essential living expenses while they apply for SSI. This general or interim assistance is provided while the SSI application is pending. Once approved, the state or county is reimbursed for the income provided out of the individual's SSI retroactive payments. Communities can use these funds to support others who need assistance or to fund SOAR efforts to transition people from public assistance to SSI. Seven states reported a total **General Assistance reimbursement of $168,643** for 96 individuals, an average of **$1,757 per person** in 2016.

Reimbursement Spotlight

$8,746 per person in Medicaid reimbursement

$1,757 per person in General Assistance reimbursement

For More Information

Learn more about training case managers through the SOAR Online Course and tracking outcomes with the SOAR Online Application Tracking (OAT) system on the SOAR website, https://soarworks.prainc.com.

Dislcaimer

The views, opinions, and content expressed in this document do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), SAMHSA, or the U.S. Department of Health and Human Services (HHS).

Table 1. 2016 SOAR-Assisted Initial Application Outcomes

State	Locality	2016 Decisions	2016 Approvals	2016 Allowance Rate	2016 Average Days	Years of Data	Cumulative Decisions	Cumulative Approvals	Cumulative Allowance Rate
Alabama	Multiple sites	19	15	79%	133	8	151	115	76%
Alaska	Anchorage	20	5	25%	100	8	116	68	59%
Arizona	Multiple sites	67	48	72%	74	6	241	147	61%
Arkansas	Multiple sites	122	117	96%	78	8	883	728	82%
California	Multiple sites	667	329	49%	83	various	3,683	2,065	56%
Colorado	State	137	80	58%	101	various	725	467	64%
Connecticut	State	19	9	47%	157	7	268	177	66%
Delaware	State	9	2	22%	141	8	302	214	71%
District of Columbia	Multiple sites	48	38	79%	138	6	244	174	71%
Florida	State	446	284	64%	68	various	3,929	2,657	68%
Georgia	Multiple sites	683	596	87%	154	8	2,906	1,902	65%
Hawaii	State	8	7	88%	172	5	29	25	86%
Idaho	Multiple sites	25	13	52%	79	5	163	93	57%
Illinois	Multiple sites	36	19	53%	90	6	308	201	65%
Indiana	State	4	0	0%	74	8	28	21	75%
Iowa	State	17	12	71%	218	6	90	59	66%
Kansas	Multiple sites	156	95	61%	100	7	855	648	76%
Kentucky	Louisville	15	11	73%	na	9	813	516	63%
Louisiana	Multiple sites	32	30	94%	113	7	320	206	64%
Maine	State	3	1	33%	na	5	10	8	80%
Maryland	Multiple sites	139	118	85%	81	7	829	702	85%
Massachusetts	State	15	15	100%	77	7	488	287	59%
Michigan	State	185	114	62%	102	8	2,687	1,613	60%
Minnesota	State	125	60	48%	122	9	2,074	1,356	65%
Mississippi	Multiple sites	23	20	87%	118	6	142	88	62%
Missouri	Multiple sites	31	17	55%	106	6	151	74	49%
Montana	Multiple sites	27	17	63%	129	5	136	57	42%
Nebraska	Multiple sites	185	113	61%	104	8	1,048	607	58%
Nevada	Multiple sites	61	40	66%	153	8	350	249	71%
New Hampshire	State	N/A	N/A	N/A	N/A	5	7	6	86%
New Jersey	Multiple sites	86	57	66%	115	8	498	300	60%
New Mexico	State	88	61	69%	132	8	560	377	67%
New York	Multiple sites	268	90	34%	192	various	2,085	1,227	59%
North Carolina	State	343	277	81%	99	10	1,789	1,455	81%
North Dakota	State	1	1	100%	N/A	2	4	4	100%
Ohio	State	621	308	50%	72	9	5,148	2,598	50%
Oklahoma	State	146	113	77%	90	9	807	590	73%
Oregon	Portland	201	126	63%	71	9	1,649	1,193	72%
Pennsylvania	Multiple sites	146	109	75%	79	7	346	244	71%
Pennsylvania cont.	Philadelphia	215	200	93%	52	9	1,781	1,745	98%
Rhode Island	State	6	5	83%	186	9	219	169	77%
South Carolina	State	43	33	77%	90	6	194	124	64%
South Dakota	Sioux Falls	19	13	68%	173	4	101	82	81%
Tennessee	Multiple sites	70	57	81%	119	9	602	489	81%
Tennessee cont.	Nashville	140	132	94%	46	10	1,057	1,033	98%
Texas	Multiple sites	74	45	61%	13	8	434	285	66%
Utah	State	12	6	50%	120	9	3,847	1,834	48%
Vermont	State	3	1	33%	68	2	9	4	44%
Virginia	State	225	166	74%	102	9	1,306	933	71%
Washington	State	37	21	57%	102	5	363	281	77%
West Virginia	State	20	15	75%	133	8	103	77	75%
Wisconsin	Multiple sites	95	46	48%	121	7	998	641	64%
Wyoming	Multiple sites	30	27	90%	115	5	203	141	69%
TOTALS		**6,213**	**4,134**	**67%**	**101**		**48.079**	**31,356**	**65%**

Table 2: 2016 SOAR-Assisted Appeals Outcomes

State	Locality	2016 Appeals Decisions	2016 Appeals Approvals	2016 Appeals Allowance Rate	2016 Appeals Average Days	Years of Data	Cumulative Appeals Decisions	Cumulative Appeals Approvals	Cumulative Appeals Allowance Rate
Alabama	Multiple sites	N/A	N/A	N/A	N/A	6	4	4	100%
Alaska	State	N/A	N/A	N/A	N/A	5	20	8	40%
Arizona	Phoenix	3	2	67%	125	6	53	31	58%
Arkansas	Multiple sites	100	99	99%	74	6	299	240	80%
California	Multiple sites	6	4	67%	59	5	339	144	42%
Colorado	State	3	3	100%	158	7	79	67	85%
Connecticut	State	3	2	67%	170	5	58	21	36%
Delaware	State	2	2	100%	N/A	1	2	2	100%
District of Columbia	Multiple sites	17	9	53%	154	6	78	43	55%
Florida	State	72	26	36%	25	7	470	246	52%
Georgia	Multiple sites	145	121	83%	81	6	614	294	48%
Hawaii	State	N/A	N/A	N/A	N/A	4	5	5	100%
Idaho	Multiple sites	7	2	29%	126	5	64	23	36%
Illinois	Multiple Sites	6	2	33%	na	5	37	21	57%
Indiana	State	3	0	0%	81	2	4	1	25%
Iowa	State	7	3	43%	85	6	45	22	49%
Kansas	Multiple Sites	61	33	54%	83	7	229	142	62%
Kentucky	State	8	4	50%	N/A	7	232	134	58%
Louisiana	Multiple sites	6	6	100%	241	6	116	73	63%
Maryland	Multiple sites	36	24	67%	192	7	216	160	74%
Massachusetts	State	7	1	14%	118	3	8	1	13%
Michigan	State	22	16	73%	415	7	684	468	68%
Minnesota	State	65	13	20%	330	6	278	167	60%
Mississippi	State	1	1	100%	7	5	8	4	50%
Missouri	State	6	5	83%	110	6	26	20	77%
Montana	Billings	3	3	100%	160	5	45	24	53%
Nebraska	Multiple sites	60	24	40%	197	7	397	170	43%
Nevada	Multiple sites	27	13	48%	464	6	158	120	76%
New Jersey	State	15	10	67%	124	7	142	90	63%
New Mexico	State	37	28	76%	222	6	116	67	58%
New York	State	128	104	81%	369	6	534	292	55%
North Carolina	State	71	46	65%	236	7	476	349	73%
Oregon	Portland	102	30	29%	N/A	7	497	244	49%
Pennsylvania	State	9	4	44%	138	3	135	69	51%
Rhode Island	State	1	0	0%	608	5	169	103	61%
South Carolina	State	9	6	67%	259	5	61	32	52%
South Dakota	Sioux Falls	4	3	75%	90	2	10	7	70%
Tennessee	State	13	8	62%	48	6	36	22	61%
Texas	State	22	6	27%	797	4	57	25	44%
Utah	State	4	4	100%	N/A	5	1589	501	32%
Vermont	State	3	1	33%	43	1	3	1	33%
Virginia	State	84	47	56%	192	7	292	171	59%
Washington	State	4	1	25%	211	1	4	1	25%
West Virginia	State	N/A	N/A	N/A	N/A	5	83	23	28%
Wisconsin	Multiple Sites	34	18	53%	111	6	205	101	49%
Wyoming	Multiple sites	N/A	N/A	N/A	N/A	5	9	3	33%
TOTALS		**1,216**	**734**	**60%**	**196**		**8,986**	**4,756**	**53%**

III. State Level Information

P. Coordinated Entry

Narrative Question:

Describe how PATH is engaged with the local coordinated-entry processes of the CoC(s) in the jurisdictions in which PATH operates and roles of key partners.

Footnotes:

2017 PA Coordinated Entry

In place of a statewide coordinated entry (CE) plan, each HUD CoC has either implemented or is in the process of creating a regional coordinated entry system. Various CoCs are currently running trials in anticipation of full implementation around January 2018. By coordinating entry we can prioritize housing and services for families and individuals based on vulnerability and severity of need. The neediest!?ABCpdf?!0individuals are considered for housing opportunities first. Therefore, some PATH services in Pennsylvania are only available to outdoor homeless and individuals living in shelters.

The PA-502 Continuum of Care for Delaware Country consists of 10 key homeless service providers and over 50 partner organizations. The Office of Behavioral Health is the Collaborative applicant for the CoC and is the lead agency for the HMIS. The OBH is also the grantee for PATH. The CoC is in the process of implementing phase 2 of the Coordinated Entry (CE) system. The CE system in Delaware County is a decentralized-coordinated system with four entry points located in areas of high need. The CE crisis response process developed for the CoC consists of 4 core components: ACCESS Help; ASSESS the situation, barriers and needs; ASSIGN a solution; and ENSURE stable housing.

With recent funding awards, another CoC is in the process of expanding the current CE System by additional Coordinated Entry locations and staff to provide full county coverage. The CoC will also implement a modified assessment tool and fully utilize the HMIS to permit improved assessment of needs of the homeless population and housing stability planning.

A third CoC uses a phased-assessment process with a series of situational assessment tools allowing assessments to occur over time and as necessary. The goals of the CoC CE system is to ensure that everyone who has a housing crisis is comprehensively assessed to determine their housing status and intervention needs. The goal is to divert households from homelessness by developing individualized stability plans. These plans are based on the consumer's own ability to divert from homelessness, the housing barriers, income potential, vulnerability and level of need, housing assistance program eligibility, mainstream resources needs and other service needs. Using up to 6 assessments helps to uncover the needs of each person and determine the intervention level for services including housing, income, education, employment, mental health, drug and alcohol, life skills, legal, children, financial, parenting and health. The assessment and other tools help to determine the best possible path and programming for all households to be permanently and stably housed as quickly as possible. Once a stability plan is developed, case management services are provided for all emergency shelter and transitional housing clients and includes the development of a service plan for each client. Referrals to mainstream resources such as PATH and the provision of appropriate supportive services for clients in emergency shelter and transitional housing are extremely important. These critical support services including case management, life skills, money management, parenting, mental health services, D&A services, employment and training are provided utilizing a myriad of Federal, State and local funding, to improve participant's ability to achieve self-sufficiency.

III. State Level Information

Q. Justice Involved

Narrative Question:

Describe state efforts to minimize the challenges and foster support for PATH clients with a criminal history, such as jail diversion, reentry and other state programs, policies and laws.

Footnotes:

2017 PA Justice Involved

Pennsylvania as a whole has several methods in place to minimize the challenges and foster support for PATH clients with a criminal history. Most programs employ elements of diversion, specialized forensic case management, forensic peer support, trainings and/or developing working relationships with the local jails, state correctional facilities, local probation and parole officers, as well as landlords. Endeavors revolve around both paroled and maxing out individuals in both the county jails and state correctional institutions.

As a result of information collected during PATH site visits, the PA State PATH Contact (SPC) has become involved with the statewide Forensics Interagency Task Force (FITF). The group's focus is to allay any avoidable hurdles in the reentry process. PA PATH Liaison chairs the Housing Reentry sub-committee in its efforts to streamline reentry methodology from PA Department of Corrections procedures to housing options and supports. The SPC chaired the Housing sub-group of the Reentry Committee and presented at the 24th Annual Forensics Rights and Treatment Conference Nov 30-Dec 1, 2016. The FITF core groups spoke on "Collaboration: The Essential Tools for System Change."

In 2017, the SPC completed the 40-hour Crisis Intervention Team (CIT) training in Franklin Co, PA. The SPC was then certified as a CIT trainer with the originators of the Memphis CIT model with focus on verbal de-escalation techniques and coordination with law enforcement to curb recidivism.

Allegheny County received one of six national technical assistance to advance SOAR use in the criminal justice environment. The TA will include all steps needed to implement, maintain and increase SOAR use at the Allegheny County Jail. This project will enhance SOAR progress already being made by the Bucks Co Jail in the eastern part of the state.

Justice involved programs differ based on local needs within PA counties. Lehigh Co has one of the premiere workgroups in the state. Lehigh County, with 48% of its enrolled PATH consumers being criminally involved and or having a criminal history, has developed a program called Team MISA (Mental Illness Substance Abuse). Team MISA is comprised of a variety of disciplines within the County, including the District Attorney's Office, Lehigh Valley Pre-Trial Services, MH/ID, SPORE, D&A, Lehigh County Prison (treatment, administration, and case managers), Probation/ Parole and the Public Defender's Office. The meeting is chaired by the first Assistant DA. The success of the group results from the collaboration and participation of department heads, as well as front line staff, at the table. The team meets weekly to discuss new referrals and any updates on ongoing cases that are involved in the criminal justice system. Members collect and present pertinent information from their office which the team discusses to develop the most appropriate plan to most appropriately address the individual's situation in the most clinically appropriate manner.

Other areas in the state are also forging their unique programs. The Center for Excellence has conducted several cross-county mappings to help areas identify and stimulate initiatives appropriate for localized areas. For example, in 2010, Delaware County's Office of Behavioral Health a Cross-System Mapping that was held for 45 county stakeholders. The mapped identified

a number of system gaps, produced priority action steps, and resulted in many of the newest forensic initiatives being proposed and/or developed in the county. The Cross-System Strategic Planning Committee is the entity responsible for tracking intersystem program development and training initiatives. OBH also participates in the Criminal Justice Advisory Committee (CJAC), DelCo Cares initiative, MH Court Planning Team, and also works with the Regional Forensic Liaison on DOC/SCI max-out planning, and with Forensic Liaisons at GW Hill Prison for inmate re-entry planning. All PATH clients with criminal histories can access those programs in which they are eligible. The following lists specific efforts in the County:

Forensic ACT (FACT) Team	The county is converting a CTT program to a FACT model with technical assistance from the University of Rochester Medical Center. The Rochester R-FACT model is an evidence-based forensic intervention model that collaborates with the MH Court.
MH Court	The county implemented a new specialty MH Court in FY 13-14 to address the needs of the SMI/justice-involved population. There is a strong working relationship between the criminal justice and behavioral health systems in this new venture.
Forensic Peer Support	The county developed a contract with Peerstar, LLC, to implement a forensic CPS program. This model is both a jail in-reach and community-based peer mentoring model that uses an evidence-based Yale Citizenship approach.
OBH Forensic Specialist	In FY 13-14, OBH hired a dedicated Forensic Specialist to help oversee the myriad of forensic initiatives targeted to the justice-involved population.
Behavioral Health Liaisons	OBH and Adult Probation/Parole jointly fund 4 behavioral health liaisons at the GW Hill prison to coordinate treatment in the prison and in the community at release.
DOC Max-out Tracking	OBH staff, in conjunction with the Regional Forensic Liaison, track and develop release plans for the C and D roster priority max-out cases returning to DelCo.

Along a different vein, Dauphin County opened a judicial center for centralized booking several years ago. Pre-Trial staff screen admissions and request a MH assessment from Crisis Intervention Program staff or, if active, targeted mental health case managers. Recommendations are made to Magisterial District Justices in determining bail, release or incarceration.

Additionally, Service Access and Management Inc. in Huntingdon/Mifflin/Juniata is currently providing specialized forensic case management services for local and state correctional facilities for the Tri County Area. The Service Access and Management Inc. Base Service Unit Housing Specialist has worked in coordination with the Mifflin County Human Services Department to develop 6 Forensic Master Leasing Units which have been at capacity serving individual in community reentry from institutional criminal justice settings. Individuals with criminal justice involvement have also been served in regular Master Leasing units and the Base Service Unit works in close coordination with probation departments and parole departments to monitor and support these individuals in maintaining community tenure.

Criminal Justice Advisory Boards (CJABs) are another venue for discussion of forensic programs. In Crawford Co, The Crawford County Mental Health Awareness Program (CHAPS) Executive Director is an active member of the County's CJAB and is able to share challenges and suggest solutions to judges, probation, and other stakeholders. Also, CHAPS staff actively participates in a Mental Health Forensic Subcommittee, where best practices, barriers and solutions are discussed. CHAPS has very positive working relationships with our police departments, probation offices, and District Justices.

CHAPS has had significant success working with forensic related individuals. Some examples include: master leasing units for diversion or returning to the community, coordination with the jail to ensure a smoother re-entry to the community, writing letters and appearing in court to testify on behalf of clients, which result in jail diversion, and immediate engagement upon release from jail (utilizing a Mental Health Court Model).

All these justice involved programs, despite difference approaches, share the same goal of reducing barriers for those reentering communities from incarceration. Without any formal tracking being completed FY 16, PA estimates that 60% of its PATH client have criminal justice history.

PATH Reported Activities

Charitable Choice for PATH

Expenditure Period Start Date: 7/1/2015 Expenditure Period End Date: 6/30/2017

Notice to Program Beneficiaries - Check all that apply:

- ☐ Used model notice provided in final regulation.
- ☐ Used notice developed by State (please attach a copy to the Report).
- ☐ State has disseminated notice to religious organizations that are providers.
- ☐ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☐ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA's Treatment Facility Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.
- ☐ _____ Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Footnotes: