

# I. State Information

## State Information

### Plan Year

Federal Fiscal Year 2016

### 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, Commonwealth Towers, 11th floor

City Harrisburg

Zip Code 17105-2675

### II. Authorized Representative for the PATH Grant

First Name Dennis

Last Name Marion

Agency Name DHS/Office of Mental Health and Substance Abuse Services

Mailing Address PO Box 2675, OMHSAS, Commonwealth Towers, 11th floor

City Harrisburg

Zip Code 17105-2675

Telephone (717) 787-6443

Fax (717) 787-5394

Email Address dmarion@pa.gov

### III. State Expenditure Period

From 7/1/2016

To 6/30/2017

### 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 Office of Mental Health and Substance Abuse Services

First Name Michelle

Last Name Baxter

Telephone (717) 346-0752

Fax (717) 772-7964

Email Address [mibaxter@pa.gov](mailto:mibaxter@pa.gov)

Footnotes:

# I. State Information

## Assurances - Non-Construction Programs

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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.

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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 Coastal 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.

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Name	<input type="text" value="Dennis Marion"/>
Title	<input type="text" value="Deputy Secretary"/>
Organization	<input type="text" value="DHS-OMHSAS"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

## I. State Information

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**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:

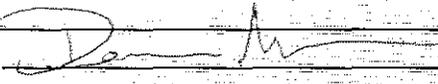
1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will 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.
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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.

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Name   
Title   
Organization

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Signature:  Date: 5/18/16

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 statements, 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 with 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 employees 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 employee 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 notification 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

### 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 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 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-Children 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.

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Name	<input type="text" value="Dennis Marion"/>
Title	<input type="text" value="Deputy Secretary"/>
Organization	<input type="text" value="DHS-OMHSAS"/>

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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 statements, 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 with 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 employees 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 employee 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;
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  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 notification 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

### 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 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 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.)
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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-Children 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   
Title   
Organization

Signature: 

Date: 5/16/16

#### Footnotes:



# I. State Information

## Funding Agreement

FISCAL YEAR 2016

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, 2017, 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 2016 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	<input type="text" value="Dennis Marion"/>
Title	<input type="text" value="Deputy Secretary"/>
Organization	<input type="text" value="DHS-OMHSAS"/>

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

# I. State Information

## Funding Agreement

FISCAL YEAR 2016

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- 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.

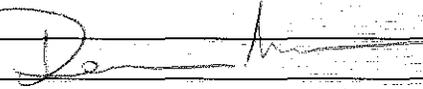
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Name	Dennis Marion
Title	Deputy Secretary
Organization	DHS-OMHSAS

Signature:  Date: 5/16/16

**Footnotes:**

# I. State Information

## Disclosure of Lobbying Activities

Are there lobbying activities pursuant to 31 U.S.C. 1352 to be disclosed?

Yes

No

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

[Standard Form LLL \(click here\)](#)

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Name	<input type="text" value="Dennis Marion"/>
Title	<input type="text" value="Deputy Secretary"/>
Organization	<input type="text" value="DHS-OMHSAS"/>

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

# I. State Information

## Disclosure of Lobbying Activities

Are there lobbying activities pursuant to 31 U.S.C. 1352 to be disclosed?

Yes

No

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

[Standard Form LLL \(click here\)](#)

Name	Dennis Marion
Title	Deputy Secretary
Organization	DHS-OMHSAS

Signature: 

Date: 5-16-16

Footnotes:

# I. State Information

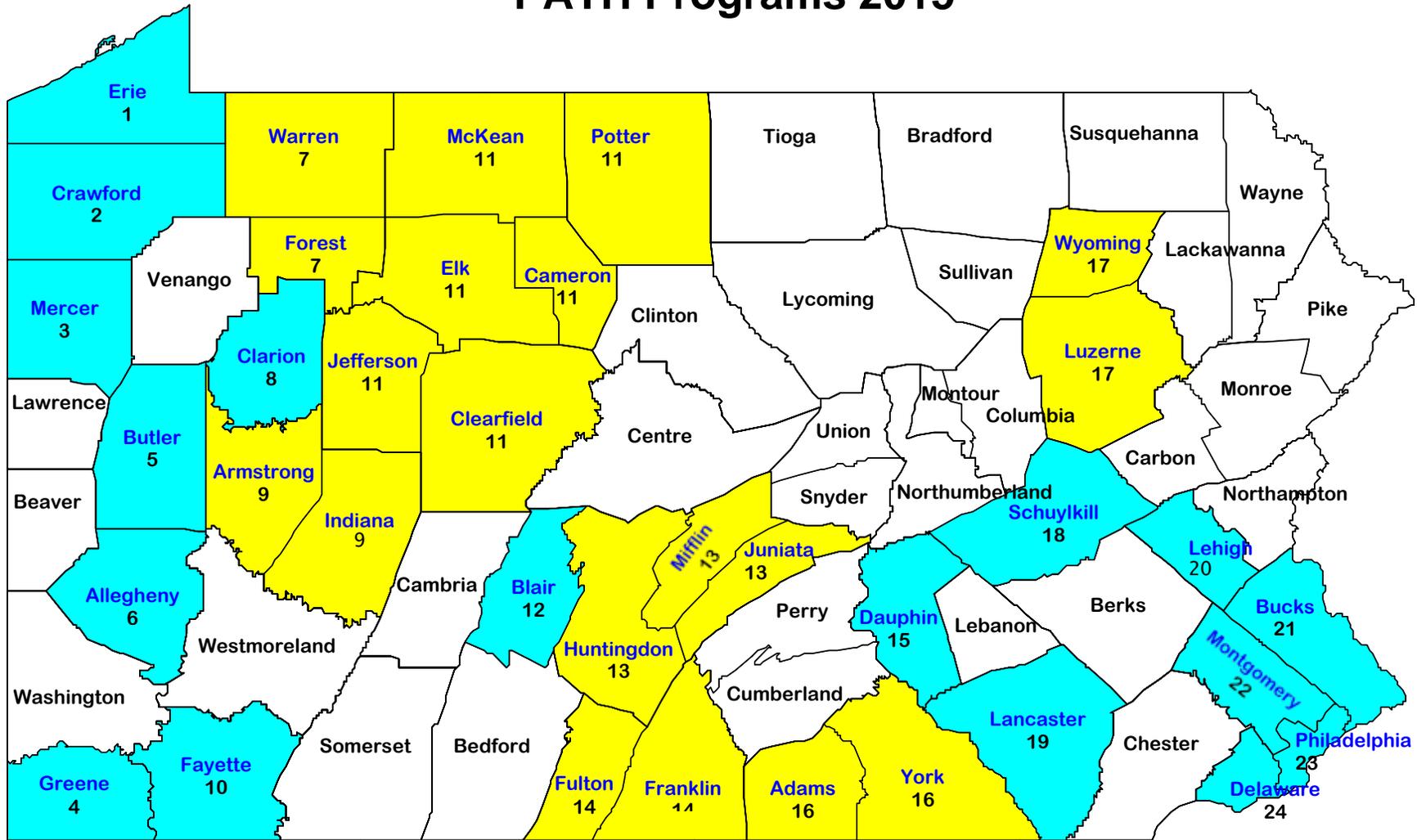
## State PATH Regions

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:

# Pennsylvania PATH Programs 2015



*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.

## 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 7/1/2016 to 6/30/2017

\* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

a. Personnel	\$ 49,034	\$ 0	\$ 49,034	
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Position *	Annual Salary *	PATH-Funded FTE *	PATH-Funded Salary	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	\$ 49,034	1.00	\$ 49,034	\$ 0	\$ 49,034	State PATH Coordinator

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
----------	------------	-------------------	-------------------	---------------	----------

b. Fringe Benefits	91.92 %	\$ 45,074	\$ 0	\$ 45,074	
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Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

c. Travel	\$ 0	\$ 0	\$ 0	
-----------	------	------	------	--

No Data Available

d. Equipment	\$ 0	\$ 0	\$ 0	
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No Data Available

e. Supplies	\$ 0	\$ 0	\$ 0	
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No Data Available

f1. Contractual (IUPs)	\$ 2,206,991	\$ 784,333	\$ 2,991,324	
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f2. Contractual (State)	\$ 0	\$ 0	\$ 0	
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No Data Available

g. Construction (non-allowable)				
---------------------------------	--	--	--	--

h. Other	\$ 0	\$ 0	\$ 0	
----------	------	------	------	--

No Data Available

i. Total Direct Charges (Sum of a-h)	\$ 2,301,099	\$ 784,333	\$ 3,085,432	
--------------------------------------	--------------	------------	--------------	--

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
----------	-------------------	-------------------	---------------	----------

j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
--	------	------	------	--

k. Grand Total (Sum of i and j)	\$ 2,301,099	\$ 784,333	\$ 3,085,432	
---------------------------------	--------------	------------	--------------	--

Allocation of Federal PATH Funds	\$ 2,352,724	\$ 784,241	\$ 3,136,965	
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Source(s) of Match Dollars for State Funds:

Footnotes:

## II. Executive Summary

### 3. Intended Use Plans (IUPs)

Expenditure Period Start Date: **07/01/2016**

Expenditure Period End Date: **06/30/2017**

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	\$175,098	\$58,336	140	140	0	0
Allegheny County - Community Human Services Corporation	Social service agency	Western Region	\$0	\$0	50	50	0	0
Allegheny County - Operation Safety Net	Social service agency	Western Region	\$0	\$0	571	200	0	5
Allegheny County - Three Rivers Youth, Inc.	Social service agency	Western Region	\$0	\$0	25	10	0	0
Armstrong-Indiana County	Social service agency	Western Region	\$41,050	\$18,775	0	0	0	0
Armstrong-Indiana County - Armstrong County Community Action Agency	Social service agency	Western Region	\$0	\$0	35	12	1	0
Armstrong-Indiana County - Indiana County Community Action Agency	Social service agency	Western Region	\$0	\$0	100	25	2	4
Blair County - Home Nursing Agency	Community mental health center	Central Region	\$42,708	\$14,236	95	85	0	0
Bucks County - Pennell Mental Health Center	Other mental health agency	Southeast Region	\$46,874	\$15,625	200	140	0	3
Butler County	Social service agency	Western Region	\$74,287	\$24,762	0	0	0	0
Butler County - Catholic Charities	Social service agency	Western Region	\$0	\$0	750	575	0	0
Butler County - The Grapevine Center, Inc.	Consumer-run mental health agency	Western Region	\$0	\$0	33	25	0	0
Cameron-Elk Behavioral and Developmental Programs	Social service agency	Western Region	\$58,431	\$26,724	149	50	2	2
Clarion County - Center for Community Resources	Social service agency	Western Region	\$31,577	\$14,442	0	0	0	0
Crawford County - CHAPS	Consumer-run mental health agency	Western Region	\$42,708	\$14,236	90	58	0	1
Dauphin County	Social service agency	Central Region	\$76,021	\$25,340	0	0	0	0
Dauphin County - Central Pennsylvania Supportive Services	Social service agency	Central Region	\$0	\$0	0	8	0	0
Dauphin County - Downtown Daily Bread	Shelter or other temporary housing resource	Central Region	\$0	\$0	140	100	0	0
Dauphin County Mental Health and Intellectual Disabilities Program	Social service agency	Central Region	\$0	\$0	240	200	0	12
Delaware County	Social service agency	Southeast Region	\$119,968	\$39,989	0	0	0	0
Delaware County - Horizon House	Social service agency	Southeast Region	\$0	\$0	200	150	0	0
Delaware County - Mental Health Association of Southeastern PA	Community mental health center	Southeast Region	\$0	\$0	110	20	5	23
Erie County - Erie County Care Management	Social service agency	Western Region	\$89,582	\$29,861	600	200	0	0
Fayette County - City Mission - Living Stones, Inc.	Other housing agency	Western Region	\$49,485	\$22,632	450	60	0	6
Forest-Warren - Warren Forest Economic Opportunity Council	Social service agency	Western Region	\$31,578	\$14,442	75	60	0	0
Franklin-Fulton County Mental Health/Intellectual Disabilities/Early Intervention	Social service agency	Central Region	\$49,485	\$16,495	100	40	18	13
Grapevine Center	Community mental health center	Western Region	\$0	\$0	0	0	0	0
Greene County Department of Human Services	Social service agency	Western Region	\$29,148	\$9,716	40	40	0	6
Huntingdon/Mifflin/Juniata - Service Access and Management, Inc.	Social service agency	Central Region	\$0	\$0	175	18	0	0
Huntingdon/Mifflin/Juniata County	Social service agency	Central Region	\$29,148	\$13,331	0	0	0	0
Huntingdon/Mifflin/Juniata County - Clear Concepts	Substance use treatment agency	Central Region	\$0	\$0	10	10	0	0
Lancaster County	Social service agency	Central Region	\$82,930	\$27,643	0	0	0	0
Lancaster County - Community Services Group	Community mental health center	Central Region	\$0	\$0	380	140	2	14
Lancaster County - Tabor Community Services	Social service agency	Central Region	\$0	\$0	35	30	1	2
Lancaster County Behavioral Health and Developmental Services	Social service agency	Central Region	\$0	\$0	294	2	0	0
Lehigh County - Lehigh County MH/ID/D&A /HealthChoices Program	Social service agency	Central Region	\$46,874	\$15,625	125	35	0	1
Luzerne-Wyoming County - Community Counseling Services	Community mental health center	Northeast Region	\$46,874	\$15,625	450	125	0	3
Mercer County	Social service agency	Western Region	\$46,874	\$21,438	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
Mercer County - Community Counseling Center	Community mental health center	Western Region	\$0	\$0	103	39	2	4
Mercer County Behavioral Health Commission	Social service agency	Western Region	\$0	\$0	25	21	0	0
Montgomery County - Montgomery County Emergency Services, Inc.	Community mental health center	Southeast Region	\$70,371	\$23,457	60	32	0	0
Philadelphia County	Social service agency	Southeast Region	\$847,468	\$289,639	0	0	0	0
Philadelphia County - Project HOME	Social service agency	Southeast Region	\$0	\$0	350	350	0	0
Philadelphia County - RHD (Cedar Park)	Community mental health center	Southeast Region	\$0	\$0	0	0	0	0
Philadelphia County - RHD (Kailo Haven)	Community mental health center	Southeast Region	\$0	\$0	0	0	0	0
Philadelphia County - RHD (La Casa)	Community mental health center	Southeast Region	\$0	\$0	0	0	0	0
Schuylkill County - Service Access and Management, Inc.	Social service agency	Northeast Region	\$31,578	\$10,526	210	80	2	0
York County - Bell Socialization Services	Social service agency	Central Region	\$46,874	\$21,438	0	0	0	0
Grand Total			\$2,206,991	\$784,333	6,410	3,130	35	99

**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 7/1/2016 to 6/30/2017

\* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>a. Personnel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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<b>b. Fringe Benefits</b>	0.00 %	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>c. Travel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>d. Equipment</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>e. Supplies</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>f. Contractual</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

**g. Construction (non-allowable)**

<b>h. Other</b>	\$ 175,098	\$ 58,336	\$ 233,434	
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Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 175,098	\$ 58,336	\$ 233,434	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 175,098	\$ 58,336	\$ 233,434	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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<b>j. Indirect Costs (Administrative Costs)</b>	\$ 0	\$ 0	\$ 0	
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<b>k. Grand Total (Sum of i and j)</b>	\$ 175,098	\$ 58,336	\$ 233,434	
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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 \$233,434 in state and federal PATH funds.

Estimated Number of Persons to be Contacted: 140 Estimated Number of Persons to be Enrolled: 140

Estimated Number of Persons to be Contacted who are Literally Homeless: 140

Number Staff trained in SOAR in Grant year ended in 2014: 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 2016 – 2017**

**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 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.

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

A. Operation Safety Net	\$ 152,139
B. Community Human Services	\$ 26,675
C. Three Rivers Youth	\$ 41,317
D. Allegheny County DHS	\$ 13,303
<b>TOTAL</b>	<b>\$ 233,434</b>

Included in Operation Safety Net's allocation is the PATH Contingency Fund. The amount for FY 2016 – 2017 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 7/1/14 to 6/30/15, 137 eligible PATH consumers benefitted from utilization of PATH funds.

76	Consumers – Utilities
38	Consumers – Rent
<u>23</u>	Consumers – Security Deposit
<b>137</b>	<b>Total Consumers</b>

### **PATH Providers Name and Addresses**

Mr. James Turner, (County PATH Coordinator)  
Allegheny County Office of Behavioral Health  
One Smithfield Street, 3<sup>rd</sup> Floor  
Pittsburgh, PA 15222

Ms. Rebecca Labovick  
Community Human Services  
2525 Liberty Avenue  
Pittsburgh, PA 15222

Ms. Tia Carter  
Operations Safety Net  
249 South 9<sup>th</sup> Street, 2<sup>nd</sup> Floor  
Pittsburgh, PA 15203

Dr. Freida Reid/Mr. Patrick Baker  
Three Rivers Youth  
6117 Broad Street  
Pittsburgh, PA 15206

### **Collaboration with HUD Continuum of Care Program**

As in previous years, all PATH providers are an integral part of the Continuum of Care Program. As mentioned in the CHS IUP, the CEO remains active on the Homeless Advisory Board. In addition, a county employee participates in the LHOT meetings regularly.

### **Collaboration with Local Community Organizations**

The County PATH Coordinator and PATH providers continue to maintain contacts/linkages to local organization on behalf of the PATH eligible consumers. For example, TRY has been expanding their outreach protocol to the streets and school districts in an attempt to provide services to the TAY population.

PATH consumers needing housing, financial assistance, addiction/rehabilitation services, etc., would be serviced by a PATH provider agency or linked up with the appropriate resources.

The County PATH Coordinator would utilize the PATH contingency funds to assist those in need of utility payments, rents, security deposits and “other” (as determined by the PATH Coordinator). Eligible consumers are allowed up to \$200.00 and can apply every two (2) years from the initial date of application approval.

### **Service Provisions**

The County PATH Coordinator is responsible for distribution of bi-weekly rental sheets to mental health providers. Based on the cost of rents, some mental health providers may have their own “in-house” contingency funds to help defray the rent/utility cost. Organizations such as the Urban League, Catholic Charities, LIHEAPP, Section 8 programs, etc., are other funding sources utilized.

As County PATH Coordinator, it is recognized that the gaps in services remain as an ongoing issue. With the recent budget stalemate in Harrisburg, numerous social service agencies were affected, which resulted in service provisions being on hold or delayed.

Other gaps continue to be: Lack of affordable housing; prolonged process of an SSI appeal; and inadequate medical insurance to defray the cost of medications. Consumers often times have to choose between purchasing medications or paying rent. As a result, they run the risk of being homeless.

Consumers suffering from dual-diagnosed conditions (MH/D&A) can be referred to halfway houses, MISA/CRR programs, NA/AA programs etc. DHS has a Drug & Alcohol Department, whereby, consumers can contact for assistance. However, the question remains, “Are there enough services to go around?” With the increase of drug use, D&A services are stretched to the maximum. Also, with the increase use of pain medications (over-the-counter), amongst the older, as well as the younger population, the epidemic can create potential homelessness.

Allegheny County PATH providers are in full gear in regards to the HMIS System. PATH providers have been encouraged to keep constant contact with the HMIS personnel for technical assistance. In addition, PATH providers are encouraged to participate in PATH conference calls and trainings on HMIS. County PATH providers recently attended a HMIS training at Penn State University.

### **Data**

As the current fiscal year is coming to a close, the PATH providers will be in full compliance to Allegheny County's HMIS System by 7/1/16. Providers will be encouraged to participate in any future trainings regarding HMIS.

### **Alignment of PATH Goals**

The PATH providers and County PATH Coordinator are focused 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.

### **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**

With Allegheny County being a Block Grant County, State PATH dollars are included within the Block Grants. Mental Health providers can utilize the State PATH dollars to further supplement PATH related services.

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

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

### **Housing**

PATH providers will do whatever is necessary to help consumers overcome barriers. Many of our residential programs have established a good rapport with certain landlords; with guarantees that the rent will be paid.

Allegheny County has 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.

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 of becoming homeless. This centralized intake system is available to anyone throughout Allegheny County.

### **Justice Involved**

The Justice Related Services (JRS) (funded through Allegheny County, DHS) works in conjunction with the jail, legal system, courts, etc. The program intervenes to minimize the jail time of many consumers. In addition, JRS case managers will complete housing referral (through Allegheny County Centralized Housing Referral) on behalf of those with criminal issues.

### **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 over twenty three years. This position averages an 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 2016-17, 137-140 consumers will need PATH contingency funds. Demographic data is maintained on the PATH applications. During the time frame of July 1, 2015 to March 31, 2016, the following data was recorded.

57	Female applicants	
20	Male applicants	
Age:	18-30	12 consumers
	31-50	30 consumers
	51-61	29 consumers
	62 →	6 consumers

### **Consumer Involvement**

Consumers are permitted to 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 are 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**

Allegheny County PATH Coordinator has approved 12 contingency fund applications for the TAY population during the period July 1, 2015 to March 31, 2016.

These funds were used for financial assistance with utilities and rental/security deposits. At the rate of \$200.00 per application, total PATH dollars spent was \$2,400.

The increased disparities that exist amongst this population include:

- a. Physical effects from D&A use
- b. Increased gun violence in Pittsburgh neighborhoods
- c. Teenage pregnancies
- d. Suicides
- e. Automobile fatalities
- f. Date rape

TAY consumers with mental health issues find these disparities more complicated to resolve. PATH providers will refer them to appropriate agencies for resolution.

### **Budget Narrative**

**Allegheny County Department of Human Services  
PATH Program  
Fiscal Year 2016-17**

<b>Line Item</b>	<b>Annual Salary</b>	<b>PATH Funded FTE</b>	<b>PATH Funded Position</b>	<b>Total</b>
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 2016-17**

<b>LINE ITEM</b>	<b>OSN</b>	<b>CHS</b>	<b>TRY</b>	<b>COUNTY</b>	<b>TOTAL</b>
Salary Path Funded	117,587	24,204	22,314	0	164,105
Fringe Benefits	0	866	4,011	0	4,877
Travel	0	0	1,300	0	1,300
Equipment	0	0	1,600	0	1,600
Indirect Cost	4,616	0	0	0	4,616
Contingency Fund	29,936	0	0	0	29,936
Rent Expense	0	400	10,164	0	10,564
Administrative Cost	0	1,205	1,928	0	3,133
County PATH position	0	0		13,303	13,303
<b>TOTAL</b>	<b>\$152,139</b>	<b>\$26,675</b>	<b>\$41,317</b>	<b>\$13,303</b>	<b>\$233,434</b>

Planning Period From 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 0	\$ 0	\$ 0	
No Data Available				

i. Total Direct Charges (Sum of a-h)	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
k. Grand Total (Sum of i and j)	\$ 0	\$ 0	\$ 0	

Source(s) of Match Dollars for State Funds:

Community Human Services will receive \$26,675 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	50	Estimated Number of Persons to be Enrolled:	50
Estimated Number of Persons to be Contacted who are Literally Homeless:	50		
Number Staff trained in SOAR in Grant year ended in 2014:	0	Number of PATH-funded consumers assisted through SOAR:	0

**Allegheny County  
Community Human Services Corporation  
PATH Intended Use Plan  
FY 2016-2017**

**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, are 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).

In order to ensure the highest quality of service provision, the agency has made revisions including: centralized/coordinated intake process, increased ability for self-referral, elimination of clean time requirements for housing services, new and 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 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](mailto:rlabovick@chscorp.org)

For 2016-2017, 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. Please reference the Budget Section at the end of this plan and the 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, remains active with the Oakland SHIP community health projects and offers a variety of trainings (inclusive of Mental Health First Aid – 8 hour certification course) to agencies within the HUD/Homeless continuum of care.

CHS' staffs, attend the Allegheny County Homeless Alliance and its subcommittees. 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-Office of Behavioral Health and Office of 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 most appropriately make and coordinate referrals.

## **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 Clinics are available on site. **The doctor 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 902 clinic.
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. **Carlow University School of Psychology/Duquesne University School of Nursing/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 housing services and at the Residences at Wood Street (Wood Street Commons).
12. **Metro Family Practice** provides medical care to many vulnerable populations. CHS and Metro have an established working relationship, are contracted collaboratively for a pilot permanent HUD Homeless housing project and are a referral source for LQBTQI individuals.
13. **UPMC Health Plan/Community Care Behavioral Health Organization, Metro Family Practice and CHS** work collaboratively and are contracted to provide shelter plus care permanent HUD homeless housing services to 25 medically compromised individuals.
14. **Allegheny Health Network** and CHS work collaboratively and are contracted to provide housing services to 4 medically compromised individuals in a pilot 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.

Third, 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.

Also, 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 LGBTQ 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.

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.

- CHS is vested in ensuring the highest quality of service provision. With this, the agency has made program revisions including: centralized/coordinated intake process, increased ability for self-referral, elimination of clean time requirements for housing services, new and expanded life skills and psycho-educational training/services, 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.

## **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.

## **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 also 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 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.

In order to ensure the highest quality of service provision, the CHS has made revisions including: centralized/coordinated intake process, increased ability for self-referral, elimination

of clean time requirements for housing services, new and 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 new 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. Internal and external agency programs relied on for the resource. 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.

### **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. Currently the outcome of the application remains unknown as it is in the appeal process. 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 2015-2016 and do not anticipate that an AmeriCorps Member will be present during the 2016-2017 year. External resources are utilized for SOAR specific referral, inclusive of Allegheny HealthChoices, Inc. and Mercy Behavioral Health.

### **Access to 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. Approximately 53.3% of individuals involved in the PATH program have criminal histories.

## 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.

Services throughout the agency 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.

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 has remained consistent at approximately 12-14 unduplicated individuals annually, which accounts for approximately 24% 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 \$6,400 of PATH funded salary. 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.

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.

**Client Information:**

The program expects to provide PATH funded services to approximately 50 unduplicated individuals during 2016-2017. 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 2015-2016 statistics regarding Ethnicity/Race/Gender/Age, these statistics have remained fairly consistent for several years:

ETHNICITY/RACE	UNDUPLICATED NUMBER OF CLIENTS	GENDER/AGE	UNDUPLICATED NUMBER OF CLIENTS
Black	20	Male	24
White	28	Female	24
Asian	1	Transgendered	1
		18-30 years of age	14
		31-34 years of age	5
		35-64 years of age	26
		65-74 years of age	3
		>75 years of age	1

2016-2017 statistics are expected to remain relative to the year 2015-2016. Unduplicated individuals served annually were anticipated at 50 per year and 49 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 5 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 a majority of representation of local community members. 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.

### **Budget narrative:**

For 2016-2017, 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.

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.

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

**Allegheny County  
Community Human Services Corporation  
FY 2016-2017 PATH Budget**

	Annual Salary	PATH- funded FTE	PATH- funded salary	TOTAL
<b>Position</b>				
Psychiatric Outreach Nurse	\$62,497.50	14.7%	\$9,187.00	\$9,187.00
Psychiatric Physician	\$125/hour	3 hrs weekly-sub contracted position	\$15,017.00	\$15,017.00
Sub-total			<b>\$24,204.00</b>	<b>\$24,204.00</b>
<b>Fringe Benefits</b>				
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			<b>\$866.00</b>	<b>\$866.00</b>
<b>Travel</b>				
Local Travel for Outreach	n/a			
Travel to training and workshops	n/a			
Sub-total			\$ -	\$ -
<b>Equipment</b>				
(list individually)	n/a			
Sub-total			\$ -	\$ -
<b>Supplies</b>				
Office Supplies	n/a			\$ -
Consumer-related items	n/a			\$ -
Sub-total			\$ -	\$ -
<b>Other</b>				
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			<b>\$1,605.00</b>	<b>\$1,605.00</b>
Total PATH Budget			<b>\$26,675.00</b>	<b>\$26,675.00</b>

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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Operation Safety Net PA will receive \$152,139 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	571	Estimated Number of Persons to be Enrolled:	200
Estimated Number of Persons to be Contacted who are Literally Homeless:	428		
Number Staff trained in SOAR in Grant year ended in 2014:	0	Number of PATH-funded consumers assisted through SOAR:	5

**Pittsburgh Mercy  
Operation Safety Net  
2016-2017 Intended Use Plan**

**Local Provider Description**

Operation Safety Net is Pittsburgh Mercy's award-winning, innovative medical and social service 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 for people who are homeless to access housing as well as the medical and social services that are necessary for them to improve their quality of life. Since its founding in 1992, Operation Safety Net has reached approximately 12,000 homeless individuals with more than 68,000 visits where they live - in camps along riverbanks, in alleyways, or beneath bridges and highway overpasses- and has successfully helped more than 1,500 individuals who were once homeless to find homes of their own. In 2015, OSN housed over 300 homeless individuals. In doing so, Operation Safety Net not only assists with providing health care and affordable housing, but also offers this vulnerable population hope, dignity, and a sense of community. Operation Safety Net reaches out to those in need by meeting people where they are in life.

Operation Safety Net is part of Pittsburgh Mercy which is a non-profit organization in Allegheny County. The amount of PATH funds received in 2015 was \$152,139.00, \$114,104.00(federal).and \$38,035.00 (state). The total grant amount includes the contingency fund which is allocated to PMHS. Our name as it appears in PDX is Allegheny: Operation Safety Net.

Pittsburgh Mercy  
1200 Reedsdale Street  
Pittsburgh, PA 15233

**Contact person for PATH provider is:**

Tia Carter  
Pittsburgh Mercy  
Operation Safety Net  
249 S. 9<sup>th</sup> Street  
Pittsburgh, PA 15203

**Collaboration with HUD Continuum of Care (CoC) Program –**

Operation Safety Net places high value on collaboration with Allegheny County and the members of the CoC. Meetings are held monthly with the CoC and a representative from OSN is always in attendance. Staff are members of the Homeless Advocacy Committee, Homeless Outreach Coordinating Committee and Homeless Advisory Board. It's through these committee's that we are able to give input on program specific such as PATH, and ways to improve processes such as coordinated intake. We also maintain partnerships with local churches and community organizations for assistance with household set up, clothing, food, hygiene items

and furniture. Operation Safety Net has established and maintained relationships with volunteers and donor needed to support other the mission of the organization.

OSN also is strongly represented on the Stand Down planning group, Veterans Boot Camp push to end Veterans Homelessness and leads the county's effort to end chronic homelessness by 2017.

### **Collaboration with Local Community Organizations**

Our PATH eligible clients are fortunate to have access to many of our in-house services that are associated with Pittsburgh Mercy. Outpatient behavioral health, Pittsburgh Mercy Family Health Center, Operation Safety Net housing programs, and street outreach services if our client's needs reengaged are all services that we provide. We have fostered relationships with substance abuse providers that provide in-patient or outpatient services to client's requesting those services. We have a PATH outreach team that identifies our street homeless individuals in need of services. We have a weekly provider's meeting in which out-reach teams from other agencies meet and discuss contacts and where some of our most vulnerable consumers have been spotted.

#### **Housing**

1. Western Psychiatric Institute and Clinic-Neighborhood Living Project
2. Allegheny County, City of Pittsburgh, and City of McKeesport Housing Authorities
3. Government subsidized senior housing
4. Allegheny YMCA- SRO
5. Various landlord and housing programs

\*\*OSN provides permanent, and rapid re-housing programs\*\*

#### **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. Mercy Behavioral Health
2. Western Psychiatric Institute and Clinic
3. Health Care for Homeless Mental Health Clinic

\*\*OSN has a on staff psychiatrist as well as rotating psychiatry interns\*\*

#### **Substance Abuse**

1. Mercy Behavioral Health
2. White Deer Run
3. Pyramid

#### **Employment**

1. Pennsylvania Career Link
2. Springboard Kitchen
3. Office of Vocational Rehabilitation

### **Additional Partners**

1. Project HELP
2. Allegheny County Health Department-HIV/TB testing
3. Focus
4. Mercy Behavioral Health Benefits Specialists
5. SOAR

### **Service Provision**

OSN case managers refer clients to services that are based off of need. We take advantage of the many of the free behavioral, physical and dental clinics; as well as linking clients to outpatient mental health facilities. PATH clients are also referred to service coordination, IDDT, or another higher level of care if the need is there.

PATH case manager maximizes use of PATH funds by connecting veterans to the VLP, PA Serves, and the other entitlements available to veterans. Through a thorough initial assessment needs such as lack of income, need for linkage to medical and behavioral health care are uncovered. Our case managers are trained in linking PATH clients to the SOAR program for assistance in obtaining social security benefits.

Current services available to clients with serious mental illness and substance use disorder include Pittsburgh Mercy Outpatient, Pittsburgh Mercy Family Health Center that has consulting psychiatry that often time is a bridge during the wait time it sometimes takes for the client to get into treatment. We have partnerships with several substance abuse inpatient centers such as Pyramid and Cove Forge as well as outpatient services through Pittsburgh Mercy. Trainings for case managers and other staff for evidence-based practices, or other essential trainings can and have been funded by Pittsburgh Mercy. OSN staff are encouraged to take advantage of the abundant number of trainings offered by our training and development department. In addition staff can participate in HMIS training offered by DHS on a as needed basis. Any mandatory roll-out information provided by DHS all staff are required to attend. We are not required to follow 42 CFR Part 2 regulations, we however do follow HIPPA laws and our HIM department follows proper policy and procedure regarding the release of client information to outside entities.

### **Gaps in Current Service System:**

Currently there continues to be a great deal of need for consumer access to obtain psychiatric evaluations. A major criterion to PATH is that the client be homeless and have a mental health diagnosis. There is a huge amount of client self-report and it takes some time to get the client linked with a psychiatrist for the evaluation to occur.

### **Services available to clients with serious mental illness and substance use disorders**

Access to care is OSN's primary goal, a high percentage of our clients are dually diagnosed. To ensure that all PATH clients are being served in an efficient manor we have implemented a tier system as to how clients will be classified. This will allow for case management as well as street

outreach staff to assist the needs of the most vulnerable as well as addressing the needs of others that are less severe. For those clients with serious mental illness and/ or substance use disorder we are assessing and seeking a higher level of care for those clients. We make many service coordination, IDDT, and Enhanced Clinical Service coordination referrals as well as referrals to inpatient facilities if the client requires and agrees to those services. Our case managers fill the void for any and all required services until the client's referral is fulfilled. We are linking all PATH-funded clients to Pittsburgh Mercy's benefits specialist, physical and mental health treatment and most importantly housing.

### **Training and Development**

Training and Development are an integral part of this organization's performance management system. Training and Development offers extensive training opportunities for staff in various subject matters. Staff are all trained in HMIS however ongoing training is fulfilled as needed. Staff attend and participate in all PATH HMIS trainings such as the most recent one held in State College PA.

### **Data**

Operation Safety Net is currently utilizing HMIS to enter and collect data however we are unable to pull reports from the system at this time. The PATH providers for Allegheny County are working with Andy Uphill, HMIS director for Allegheny County along with Jim Turner to ensure that are on track to fulfill the requirements for this essential piece. Staff will be trained on-going as new developments roll out and any new staff will be trained in HMIS and how it relates to PATH. By July 1, 2017 we will have the capability to pull PATH data from HMIS.

OSN utilizes a separate electronic database to maintain ongoing client records; each encounter with a client is documented. This database allows our staff and volunteers to access up-to-date client information, medical and psychosocial histories. Data from street outreach is also entered into the HMIS system.

### **Alignment with PATH goals**

Individuals enrolled in PATH, are those that have a behavioral health diagnosis and meet the definition of "literally" homeless. OSN street outreach contacts number between 150-200. 90% of clients are classified as "literally" homeless, while 10% of clients are at imminent risk of being homeless. Those clients classified as imminent are serviced through general OSN case management not PATH. PATH funds are used solely to provide direct service to adults who are literally homeless. PATH funding to Operation Safety Net is used to provide outreach, outreach to drop-in centers, intensive case management, housing placement, referrals to primary and behavioral health care, financial and rental assistance, client supplies, and appointment scheduling.

## **Alignment with State Mental Health Services Plan**

Through the use of PATH funds we are able to assist clients in securing funds for security deposits, rental assistance, and eviction preventions. This aligns with the State Plan to End Homeless as we are working to keep housed clients housed and those not housed reducing the barriers to finding safe, affordable housing. PATH funds allow for greater follow-up in assuring that PATH-funded clients are being linked to outpatient behavioral health services. Without PATH clients that don't meet other program requirements would remain on the streets not receiving services that are needed.

Pittsburgh Mercy utilizes crisis plans to address emergency planning as it relates to continuity of care. OSN case managers use these plans to incorporate how to best help our clients in cases of emergency. These plans are implemented for both PATH and Non-PATH clients.

## **Alignment with State Plan to End Homelessness**

Through the use of PATH funds PATH street outreach staffs identify the literally and chronically homeless. This is done through meeting clients in the areas that the call home, in alleyways, under bridges any area not designated for human habitation. Once the clients is engaged with our outreach workers, through fulfilling some of their immediate needs (sock, water, food) a trusting relationship is formed. Case management will prioritize these clients and assisting in finding housing, linking with resources, and providing the client with the necessary skills needing to maintain housing once found.

## **Other Designated Funds**

Operation Safety Net currently has Enhanced Case Management that receives funds through the mental health block grant. PATH funded consumers often times meet the criteria for this program and are referred to the program if more intensive services are needed. The funds are not specifically designated for PATH funded clients however is another resource that we provide that they can take advantage of.

## **SSI/SSDI Outreach, Access, Recovery (SOAR)**

We utilize the county-funded SOAR program through Pittsburgh Mercy, in assisting our consumers in obtaining social security benefits. PATH staff are trained on the criteria of a potential SOAR applicant and make it a point to link consumers up to the office if they meet the criteria. The point person is the referral source so that the consumer has a higher chance at obtaining benefits the first time applied. The number of PATH-funded consumers assisted in 2015-2016 was approximately 15% of the clients served in PATH SSO which averages to about five clients. Out of those five clients 1 has already been approved and the remaining four are still going through the process. Most clients being enrolled in PATH already have established

income. For those that do not it's working with them to help them obtain the documents in order to make SOAR successful.

## **Housing**

OSN continually strives to gain funding for housing and to develop relationships with landlords, housing resources, and programs. OSN maintains approximately 150 beds, and a ESG rental assistance program. OSN utilized all housing programs in the county with the goal of placing as many homeless clients into mainstream housing as possible.

Operation Safety Net is fortunate to have several housing programs that PATH consumers meet the criteria for. We utilize permanent supportive housing, emergency shelters, and transitional housing to house PATH consumers. In addition, we have access to all housing programs in Allegheny County. All housing programs referrals are funneled through the Allegheny County Link and that's one of the first things staff are completing with clients with the intent of securing housing.

## **Coordinated Entry**

Operation Safety Net does utilize coordinated entry; however this is not done for entry into PATH programs. We utilize coordinated entry in trying to obtain housing for PATH funded clients. Our coordinated entry is monitored through Allegheny County Bureau of Homeless Services. PATH client is encountered on street by street outreach team through several contacts is now prepared to meet with case manager. Case manager is able to enroll client into program and completed assessment. Housing is identified as a need, at that point the case manager is assisting client with contacting the Allegheny Link to be assessed and placed on waiting list for assessed level of housing. If emergency shelter is identified client is instructed to call every day to inquire about availability, if another level of housing is identified the case manager is the referral is the referral source and will be contacted when there is a vacancy.

## **Justice Involved**

Operation Safety Net has access to a forensic liaison. The liaison assists staff in coordinating care for clients that become incarcerated while enrolled as a PATH client. We also have built a network of landlords that are familiar with our population and our programs. We have access to an in-house service known as The Gatehouse which provides behavioral health services and support groups for clients with a criminal history.

Due to this field not officially being tracked in HMIS I estimate that approximately 25% of PATH consumers have a criminal history. This estimate is due to the fact that 50% of PATH funded-consumers are dually diagnosed. The lengths that are clients go through to obtain their drug of choice, often times gets them involved in the legal system.

## **Staff Information**

OSN staff is comprised of 62% Caucasian, 38% African-American, 42% Male and 58% female staff. Each year OSN provides internships to countless nursing, pharmacy, social work and medical students from different ethnicities, races, and cultural backgrounds. Recently staff has taken part in trainings on how to be sensitive in working with those in the LGBTQ communities.

OSN staff and volunteers are experienced in working with a culturally diverse street population. OSN staff has educational backgrounds in social services and are trained to deliver culturally competent services to this population.

Pittsburgh Mercy mandates Cultural Competency as a part of annual required trainings.

## **Client Information**

Operation Safety Net targeted population is the unsheltered street population. Over the past two years OSN's street population served was 56% African- American, 44% Caucasian, <4% Hispanic, Asian, or Pacific Islander; 15% female and 85% male. The projected number of clients who will receive PATH funded services (Street Outreach and Supportive Services) in FY 2016-2017 is estimated at 200 clients. This number is based upon the census of Allegheny County as the targeted population. Approximately 75% of OSN clients are defined as literally homeless. Only 35% of our outreached population makes up our PATH funded consumers. However, I would like to see this number increase. I plan to explore the workflow between PATH outreach and case management to ensure a smooth process. My goal is to have 50% of PATH consumers come from our street outreach teams.

## **Consumer Involvement**

Operation Safety Net currently employs several former clients. We encourage our clients to participate in our providers meetings and recently have implemented town hall meeting in which consumers are able to share concerns and make suggestions for what they would like to see change. Consumer and family involvement is welcomed at any time. Most of the PATH-funded clients enrolled have very little involvement with their natural supports. PATH case managers will begin implementing ways to reconnect clients to their families. The hope is through on-going behavioral health treatment the client will become less guarded and want to reconnect with family. Case managers are trained to provide in-depth assessments. OSN ensures that engagement and treatment are at the clients pace and ensures goals are set collaboratively between client and case manager. For the FY 2016-2017 the client run consumer advisory board will be brought to help start a conversation with consumers served and help to foster a healthier relationship between staff and persons served.

## **Health Disparities Impact Statement**

In FY 2015-2016, OSN was able to house three youth for a total of six months. During this time income, substance abuse and medical treatment was identified, and education and employment were all issues that were addressed. Approximately \$5,000 dollars was used through private donations at assisting the youth with housing.

Our street outreach team has seen a reduction in the number of youth ages 17 to 25 on the street. However the need is still great due to youth being identified as being street homeless for the first time and not knowing where to turn. The number of unduplicated youth we are expected to serve in FY 2016-2017 will approximately be 25. 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.

Case managers will 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. OSN staff will access for need, make appropriate referrals, connect with additional services and track progress towards goals.

## **Budget Narrative**

Operation Safety Net will receive a total of \$152,137.91 in PATH dollars from Allegheny County Office of Behavioral Health. The Office of Behavioral Health will coordinate and provide PATH oversight to this organization as part of it contract with PA DHS/ OMHSAS.

\$32,058.00 will fund a part-time physician experienced in mental and physical health. This individual will provide medical care to clients not connected to traditional medical care. This individual will work to connect client with ongoing medical care.

\$20,896.20 (includes Benefits) will fund a full-time case manager/outreach worker who will provide assistance to clients by engaging on the streets, and walk-in locations. The PATH case manager will be responsible for assessing and fulfilling client's immediate needs, connecting clients with professional appointments and securing income.

\$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. Supervisor is responsible for PATH outreach staffs ensuring that needs of the clients are being met.

\$41,682.42 (includes benefits) 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 outworker is the link between client and case manager.

\$29,936 will serve as the county-wide 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.

\$4615.96 will fund consumer supplies for birth certificates, id vouchers, bus tickets, water and socks.

**Pittsburgh Mercy**  
 Operation Safety Net  
 PATH Program  
 FY 2016-2017 Budget

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Medical Doctor	100,000.00	.15	32,058.00	32,058.00
Supervisor		.42	22,949.53	22,949.53
PATH Outreach Worker	29,562.00	1 FTE	41,682.42 (Benefits inclusive)	41,682.42
PATH Case Manager	14,820.00	1 FTE	20,896.00 (Benrefits Inclusive)	20,896.00
		Subtotal	\$117,585.95	117,585.95
<b>Travel</b>				
Local Travel for Outreach	N/A		xxxx	xxxx
Travel to training and workshops	N/A			
<b>sub-total</b>			xxxx	xxxx
<b>Supplies/Equipment</b>				
Consumer-related items	4615.96			
<b>sub-total</b>	4615.96			
<b>Other</b>				
Staff training				
Contingency Fund			\$29,936.00	\$29,936.00
Security deposits				
<b>sub-total</b>			\$29,936.00	\$29,936.00
<b>Total PATH Budget</b>			<b>\$152,137.91</b>	

4. Allegheny 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Three Rivers Youth will receive \$58,336 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	25	Estimated Number of Persons to be Enrolled:	10
Estimated Number of Persons to be Contacted who are Literally Homeless:	15		
Number Staff trained in SOAR in Grant year ended in 2014:	0	Number of PATH-funded consumers assisted through SOAR:	0

## **Three Rivers Youth PATH Intended Use Plan 2016-2017**

### **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 130 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, residential 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 is 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 will utilize information and resources from this forum to access additional services and housing opportunities. Consumers in need of Mental Health assessments and treatment will be seen through an on-site psychiatrist. Three Rivers Youth offers drug and alcohol treatment, therefore, referrals will be made, as needed, for these services. Three Rivers Youth participates in the Children's Homeless Fund and attends these meetings quarterly. Three Rivers Youth will continue to collaborate with agencies involved in the Children's Homeless Fund.

### **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 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.

Three Rivers Youth – The Hub will have a psychiatrist on-site to provide mental health assessments and ongoing medication monitoring as needed. Also, the Hub maintains collaborative partnerships with community mental health providers such as Mercy Behavioral Health and WPIC to provide for the mental health assessment and treatment for clients as well as providing these services on site, as needed. Additionally, as needed, Three Rivers Youth offers Drug and Alcohol assessments and will make referrals to the Drug and Alcohol department for treatment as needed.

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.

## **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 now has a behavioral health license and a drug and alcohol license to provide a greater scope of services to clients served that 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 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 Coordinator. 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. Additional outreach services have been provided on local bike trails where homeless individuals in the targeted age range have been observed.

### 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 their choice of community drug and alcohol facility or to be provided through Three Rivers Youth. The client also has the ability to have a Psychiatric Evaluation performed by the on-site 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. 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 build for Three Rivers Youth to work within the HMIS system was completed in January 2016. The Manager of Clinical Services oversees and manages the HMIS system at Three Rivers Youth. All clients served during this current fiscal year have been entered into the HMIS system and all

new clients will be 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 training in Allegheny County's 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 that is 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 will target street outreach and case management as priority services by reaching out to the most vulnerable adults who are chronically homeless. Three Rivers Youth will provide information where they can go to receive services such as education, resume writing, employment assistance, etc. and will provide 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. We provide Mental Health Assessments and Treatment to those who are in need of this service, assist in education endeavors, provide linkages to shelters and other mental health facilities, make referrals to Three Rivers Youth drug & alcohol program for Assessments and treatment if necessary, and provide ongoing training as needed.

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 different 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 will utilize 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 will reach 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.

### **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 Rivers 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.

### **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**

33% of the clients served in the PATH program have a criminal history. Three Rivers Youth 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 Assessments and treatment, Housing assistance, Education assistance, referrals to Mental Health Out Patient clinics, and Drug & Alcohol assessments and/or treatment.

### **Staff Information**

The current staffing pattern for the PATH program at Three Rivers Youth consists of a part-time Case Manager/outreach worker; and a part-time Clinical Director. Three Rivers Youth is in the process of hiring a new Case Manager/Outreach Worker, however, the most recent demographics included one male and one female; both African American.

The Clinical Director has a doctorate degree with significant experience in working with dual diagnosed young adults and at risk youth/young adults from various backgrounds and sectors. She is also trained in HMIS. She 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% are 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 had the opportunity to employ a PATH funded individual as a staff person.

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

Budget Narrative:

**Personnel:**

\$10,192 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:**

\$4,011 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.

**Travel:**

\$2,300 Provide mileage reimbursement to employees for utilizing their own vehicles to provide services to participants within the community or Allegheny County.

**Supplies:**

\$1,600 Costs associated with office supplies needed to do day to day business.

**Other:**

\$18,092 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. 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, max 4%. These include salaries and benefits of the indirect or support staff allocated in administrative support of the PATH funded program.

ALLEGHENY COUNTY

THREE RIVERS YOUTH

PATH Program

FY 2016-2017 Budget

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
Position A	\$31,2000	.25	\$10,192	\$10,192
Position B	\$46,000	.25	\$12,000	\$12,000
Fringe Benefits			\$4,011	\$4,011
Travel			\$1,300	\$1,300
Equipment			7,000	7,000
Supplies			\$1,600	\$1,600
Other-(occupancy)			\$10,164	\$10,164
Admin			\$1,928	\$1,928
Total			\$48,195	\$48,195

5. Armstrong-Indiana County

124 Armsdale Road

Kittanning, 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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 41,050	\$ 18,775	\$ 59,825	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 41,050	\$ 18,775	\$ 59,825	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 41,050	\$ 18,775	\$ 59,825	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 41,050	\$ 18,775	\$ 59,825	

Source(s) of Match Dollars for State Funds:

Armstrong/Indiana Co will receive a total of \$59,825.  
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 ended in 2014:	0	Number of PATH-funded consumers assisted through SOAR:	0

**Armstrong-Indiana Behavioral and Developmental Health Program  
Summary Intended Use Plan  
FY 2016-2017**

**Local Provider Description**

The Armstrong-Indiana Behavioral and Developmental Health Program (AIBDHP), located in rural West/Central Pennsylvania, is the county governmental 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 serves as the primary oversight entity for the Health Choices Program. In recent years, the AIBDHP has maintained administrative oversight for the PATH Program in each county. The AIBDHP currently partners 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 2016-2017, we anticipate receiving a Federal allocation of \$41,050 and a State match of \$18,775. Our total allocation for the Armstrong-Indiana Behavioral and Developmental Health Program will be \$59,825. The total allocation will be divided equally between each PATH provider, with each Community Action Program receiving an allocation of \$29,912.50. Along with this Intended Use Plan for the AIBDHP, plans will also be submitted from each respective Community Action Agency.

**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). The AIBDHP is not a member of the local PA-601 Western Continuum of Care, (CoC); however, a representative from the Armstrong County Community Action Agency and the Indiana County Community Action Program (our PATH Providers) are voting members of the PA-601 Western Pennsylvania

Continuum of Care. Even though the AIBDHP interaction with HUD's Continuum of Care program is limited, the AIBDHP PATH staff are members on each county's housing advisory board/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. Finally, the AIBDHP will be a patterning agency with the Coordinated Entry program is being developed and implemented by the PA-601 Western Continuum of Care to ensure that those in mental health institutions (state hospitals) are given priority for housing in each county.

### **Collaboration with Local Community Organizations**

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. It is through these partnerships and staff getting to know other staff that our consumers and families are able to quickly access services when needed. As a result, the overall quality of life of consumers and families has been greatly improved.

While building community partnerships is a priority for the AIBDHP, gaining stakeholder input and collaboration from those we serve is even more valuable. One avenue that our office continues to use to gain feedback and collaboration is the Community Support Program (CSP) meetings held monthly in each county. Consumers, family members, mental health staff along with other human service agency staff participate in these meetings. The environment provides an avenue for all involved to identify gaps in services, educate each other on services available, and continue an ongoing dialogue about the needs of mental health consumers in each county. In addition to our CSP meetings, the following other local meetings are held as well: Suicide Take Force meetings, Personal Care Home Risk Assessment meetings, Community Treatment Team meetings, Criminal Justice Advisory Board meetings, Joint Hospital Networking meetings, Housing Advisory/Consortium Meetings, and various child/adolescent meetings.

Along with local partnerships and attendance at local meetings, the AIBDHP participates in various HealthChoices 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
- Aging Services
- Probation and Parole Services
- Public Defender Services
- The Armstrong/Indiana 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
- Physical Health Care Providers

## **Service Provision**

### *Overview of the Armstrong-Indiana PATH Program*

To create the most coordinated and comprehensive services to PATH clients, the Armstrong-Indiana Behavioral and Developmental Health Program has partnered with the Armstrong County Community Action Agency and the Indiana County Community Action Program to operate our PATH Program. The Community Action Programs 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. Within each CAP are employed the AIBDHP's Behavioral Health Housing Liaisons (BHHL). There is one BHHL for each county. 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. The Behavioral Health Housing Liaisons (positions created using Health Choices reinvestment dollars along with PATH funding) located within each CAP will take over the full responsibility for case management and outreach to our

consumers. We believe this will reduce confusion and possible duplication of efforts by PATH staff. As the Community Action Programs will be responsible for the operation of the PATH Program, the AIBDHP will continue to maintain total oversight for the program and will work closely with the Housing Liaisons to monitor the program and provide supportive assistance as needed.

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.

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

#### Street Outreach:

Outreach to individuals who are homeless or are at risk of becoming homeless presents in Armstrong and Indiana Counties is challenging. Because of the rural nature and terrain of our counties, it is often difficult to locate those most in need. Often times clients “couch surf” from one situation to the next and are not present in common areas where outreach takes place. There is even a difference in the ability to find the homeless between our two counties. Indiana County has a homeless shelter where outreach can occur easily and quickly. Armstrong County lacks such a shelter, which increases the difficulty in finding the homeless. Despite the challenges presented by being rural counties, the AIBDHP and its PATH Program partners believe that street outreach is a priority and is conducted on a regular basis. In rural areas such as ours is truly a challenge. The Behavioral Health Housing Liaisons conduct homeless street outreach in areas such as local parks, stores, churches, drop-in centers, homeless shelters, domestic violence shelters, veteran service locations, hospitals and other community settings. Outreach in our counties also occurs through contacts/referrals from other social service agencies, corrections, and law enforcement. Many times outreach activities turn into education opportunities not only for consumers and family members, but for local providers as well. PATH staff distributes flyers and brochures in the community. They are also available to speak at various community venues including local housing meetings, county planning meetings, and Community Support Program meetings. The Housing Liaisons are also encouraged to visit each county’s consumer Drop-in Center to see if consumers know of other consumers in need. The Armstrong-Indiana Behavioral and Developmental Health expects our PATH providers to continue making street outreach a continued priority and encourage each housing liaison to increase/expand their outreach efforts.

#### Engagement and Education:

The Armstrong and Indiana Behavioral Health Housing Liaisons spend a great deal of time engaging those individuals they meet through their street outreach activities. Establishing a trusting relationship and ongoing rapport is so important to working with those who are homeless or at risk of becoming homeless. Often, homeless individuals present as exhausted and scared for their future and for the future wellbeing of their families. It takes a great deal of effort by the housing liaisons to build a trusting relationship with our PATH clients. One avenue to help build trust is through the education the housing liaisons offer clients. Education not only includes

informing individuals about what the PATH Program can offer, but also about all of the other human services available in each county that can assist in eliminating barriers clients face to not only finding housing, but maintain it. In addition to providing PATH clients with service education, they also conduct educational presentation in the community. Each liaison will present 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.

#### Case Management Services:

The third key part of our PATH program is the case management services offered by the Behavioral Health Housing Liaisons. 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 finding 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 into linking consumers with housing options and support services by completing referrals to those services. Service coordination is also a key service provided by the housing liaisons. They are responsible for ensuring that all service providers are working together and, more importantly with clients, to accomplish identified goals. In addition to these activities, 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.

#### *Maximization of PATH funds*

Throughout the years of overseeing the Armstrong-Indiana PATH Program, the AIBDHP has drawn from HealthChoices reinvestment funds and Community Hospital Integration Project Program (CHIPP) funds to help support PATH clients. Reinvestment funds have been used to help fund services such as a Master Leasing Program (which closed December 31, 2015). It is currently being 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 qualify 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 HealthChoices Managed Care Program. Most individuals in the PATH Program do qualify for HealthChoices.

## *Service System Gaps*

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 County Block Grant planning. Local Community Support Program meetings are also an avenue to facilitate discussions about systemic concerns and solutions. The Armstrong-Indiana Consumer/Family Satisfaction Team (AIC/FST) Program offers children/adolescents, family members and adults an opportunity to voice their concerns by participating in satisfaction surveys about all mental health and substance abuse services offered in Armstrong and Indiana Counties. Results are shared with consumers/family members, local providers, Value Behavioral Health, and the Office of Mental Health and Substance Abuse Services.

Despite the number of behavioral health services available to residents of Armstrong and Indiana Counties, gaps do remain. For example, currently no emergency shelter is available for Armstrong County residents. Also, there is a significant gap in services for individuals or heads of households who have credit issues and need budget counseling, 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 recovery. Another very clear gap in services 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 again, this year, focus a great deal of effort on trying to work with these individuals to help eliminate barriers they currently experience. The lack of affordable housing is often times a barrier as well in each county. Often times, 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. 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 rural nature of our two counties, individuals who have serious behavioral health needs have a wide array of services available to assist them in their recovery. 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

<u>Adult Mental Health Services</u>	<u>Child/Adolescent Mental Health Services</u>	<u>Drug and Alcohol Services</u>
<ul style="list-style-type: none"> <li>• Screening and Assessment Services</li> <li>• Psychiatric Evaluation</li> <li>• Medication Management</li> <li>• Partial Hospitalization</li> <li>• Inpatient Hospitalization</li> <li>• Intensive Outpatient Services</li> <li>• Mobile Medication Program (Armstrong initially)</li> <li>• Clozapine Support Services</li> <li>• Blended/Targeted Case Management</li> <li>• Psychiatric Rehabilitation (mobile and site based)</li> <li>• Peer Support Services</li> <li>• Vocational Services</li> <li>• Drop-in Centers</li> <li>• Consumer/Family Satisfaction Team</li> <li>• Supported Living</li> <li>• Community Residential Rehabilitation Services (Maximum and Minimum)</li> <li>• Intensive Permanent Supportive Housing Program (CHIPPS)</li> <li>• Long Term Structured Residence</li> <li>• Emergency PHARE housing</li> <li>• 24/7 Walk-in Crisis</li> </ul>	<ul style="list-style-type: none"> <li>• Screening and Assessment Services</li> <li>• Psychiatric Evaluation</li> <li>• Medication Management</li> <li>• Partial Hospitalization</li> <li>• Inpatient Hospitalization</li> <li>• Intensive Outpatient Services</li> <li>• Individual/Family/Group Therapy</li> <li>• Blended/Targeted Case Management</li> <li>• Behavioral Health Rehabilitation Services</li> <li>• Strength Based Treatment</li> <li>• Family Based Services</li> <li>• Multi-Systemic Therapy</li> <li>• Community Residential Rehabilitation Services</li> <li>• Residential Treatment Facilities</li> <li>• Early Intervention Services</li> <li>• Student Assistance Program</li> <li>• Consumer/Family Satisfaction Team Program</li> <li>• 24/7 Walk-in Crisis Services</li> <li>• 24/7 Mobile Crisis Services</li> <li>• 24/7 Telephone Crisis Services</li> <li>• Medical Assistance Transportation Program</li> </ul> <p><u>Early Intervention Services</u></p> <ul style="list-style-type: none"> <li>• Community</li> </ul>	<ul style="list-style-type: none"> <li>• Screening/Assessment Services</li> <li>• Inpatient Treatment</li> <li>• Intensive Outpatient Treatment</li> <li>• Outpatient Treatment</li> <li>• Support Groups</li> <li>• Recovery Support Services</li> <li>• Prevention and Education</li> <li>• Tobacco Prevention/Cessation Services</li> <li>• Drug Court (Indiana)</li> <li>• Drug-Free Communities Coalition</li> <li>• Student Assistance Program</li> <li>• Halfway Houses</li> <li>• Oxford House Program</li> <li>• Consumer/Family Satisfaction Team Program</li> <li>• 24/7 Walk-in Crisis Services</li> <li>• 24/7 Mobile Crisis Services</li> <li>• 24/7 Telephone Crisis Service</li> <li>• Medical Assistance Transportation Program</li> </ul>

Services <ul style="list-style-type: none"> <li>• 24/7 Mobile Crisis Services</li> <li>• 24/7 Telephone Crisis Services</li> <li>• Medical Assistance Transportation Program</li> </ul>	Development <ul style="list-style-type: none"> <li>• Social or emotional Development Screening</li> <li>• Self-Help or Adaptive Development Screening</li> <li>• Cognitive Development Screening</li> </ul>	
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*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. These trainings may be held at the state, local or regional level, and may cover a wide range of topics such as mental health, substance abuse, co-occurring disorders, intellectual disabilities, housing services, and cultural diversity training. In addition to training, the Armstrong –Indiana PATH provider staff will all be required to participate in local housing consortium meetings, regional meetings and state-wide housing conferences. All PATH staff is required to attend all relevant HMIS trainings and keep updated on any changes to the system. PATH Providers are encouraged to include the Behavioral Health Housing Liaisons on housing training notices. Finally, to help build a quality program, PATH staff is also included in any training offered by the AIBDHP which directly relates to evidence based practices and outcomes.

**Data**

The Armstrong-Indiana Behavioral and Developmental Health Program, as well as our contracted PATH Providers, are all registered and trained in the Pennsylvania Homeless Management Information System (PA HMIS). Currently, all PATH client information is entered into HMIS. PATH staff is 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 PATH staff will be required to attend any new training offered on the HMIS. Any new PATH staff 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 focusing our program 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 PATH staff (the Behavioral Health Housing Liaisons). The housing liaisons 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 they have adequate heat and food items to sustain them. Once the situation is no longer emergency in nature, 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 first address immediate concerns/things that need immediate action and then continue until housing and overall client stability is achieved. The liaisons continue providing 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 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 will not be successful.

### **Alignment with State Mental Health Services Plan**

The Pennsylvania Department of Human Services' 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. Through this planning process, counties were encouraged to demonstrate how they were going to shift the focus of housing services to become based on recovery and resiliency. This 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.

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. The AIBDHP has embraced these changes over the years and strives to come in alignment with the Office of Mental Health and Substance Abuse's overall housing initiative. The PATH Program we have developed in Armstrong and Indiana Counties captures the Commonwealth's plan for those most vulnerable to have access to safe, affordable and permanent housing with readily available and flexible services available to them as needed. The AIBDHP created the Behavioral Health Housing Liaison positions and a Contingency/Stabilization Fund to assist consumers in securing and maintain housing. The housing liaisons are the key PATH staff who work directly with consumers who are the most

vulnerable and are homeless or have an imminent risk of becoming homeless. The option to enroll in the PATH program is voluntary as is acceptance of any behavioral health support services. Once an individual agrees to participate with PATH, the liaisons provide education and intensive case management services to their clients to ensure they have everything they need to sustain their new housing. The PATH housing plans that the liaisons 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. The housing liaisons also have access to the AIBDHP's Contingency/Stabilization Fund. This fund can pay for things that the PATH Program may not cover such as household furnishings. The fund may also be used to help with back payment on utilities to avoid shut-offs, back rent to avoid eviction, first month rent, and security deposit payments. The goal of the fund is to fill in the gap where other housing funds end.

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 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. PATH staff is also asked to participate in local planning meetings to learn about new services that are developed and to educate others about the Armstrong-Indiana County PATH Program.

### **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. Once individuals begin working with the housing liaisons, 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. Data is collected on all individuals who are contacted and also enrolled into PATH services through the Pennsylvania Homeless Management Information System (HMIS). 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 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 housing liaisons (along with other staff from within their agencies) work with individuals who are involved 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.

### **Other Designated Funds**

Although Armstrong and Indiana Counties are not currently Block Grant Counties in the state of Pennsylvania, the Armstrong-Indiana Behavioral and Developmental Health Program does submit a plan addressing the mental health, intellectual disabilities and early intervention systems as the overall block grant. Housing and the prevention of homelessness addressed in this plan as being a major need in both counties. Establishing more Permanent Supportive Housing opportunities and preventing/eliminating homelessness of those we serve will continue to be a priority for the AIBDHP and will be included in future plans. It is our hope that additional funding can be secured to accomplish those goals and provide better housing opportunities for our county residents who have behavioral health challenges.

### **SSI/SSDI Outreach, Access Recovery (SOAR)**

In fiscal year 2015-2016, a total of 3 PATH staff were trained in SOAR. The Indiana Liaison who was SOAR trained will be leaving the program by the end of April. Her replacement has been hired and will start full time on May 2, 2016. The new liaison will be required to become SOAR trained as well. Similarly, both Community Action Programs will be having additional staff hired in SOAR as 2016-2017 progresses, including the supervisors over the behavioral health liaisons. Once all staff is trained, there will be four PATH staff (two in each county) to assist PATH clients with SOAR applications. To date, 4 PATH clients from Indiana County have participated in SOAR. One individual was just recently awarded benefits.

### **Housing**

The AIBDHP, the ACAA and the ICCAP believe strongly that those with mental illness and/or co-occurring issues deserve the right to live in quality, de-segregated housing. To help increase the number of housing services available to behavioral health consumers, the AIBDHP implanted a Mental Health Residential Reform Project in 2015. With the support of staff from the Western Region Program Office of the Office of Mental Health and Substance Abuse Services, the AIBDHP has worked with our residential provider to implement lengths of stay criteria on all MH residential beds. This will allow 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. In addition to the length of stay criteria,

consumers are now required to complete a Residential Transition Plan (RTP) with their plan manager. PATH staff 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. This transformation of our MH residential services is crucial to maximizing services and supports available for all consumers, including those who are homeless or at risk of becoming so.

In addition to the MH residential transformation, staff from the AIBDHP actively partner with local agencies that provide permanent supportive housing to help make sure homes are available for our consumers. It is our hope that these partners will be able to obtain more safe and affordable permanent housing in our communities. Our office will continue to delegate resources to providing the behavioral health support services such as mobile medication, supported living, and mobile psychiatric rehabilitation that are available to help consumers remain stable and retain their housing. With all of these resources working together, we anticipate our consumers have much more successful at leading full and productive lives in the community.

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 AIBDHP)	Armstrong & Indiana Counties
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
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	Indiana County Community Action	Indiana County

### **Coordinated Entry**

The AIBDHP is not currently part of a coordinated entry program. It is our understanding that the PA-601 Western Continuum of Care is in the process of developing this program, and will be rolling out the application to five counties to begin. The projected date of implementation is the fall of 2016 for this trial. Once in place, all information will then be collected through the HMIS. We will assist the Western CoC and the LHOTs in each county to develop our local programs, ensuring that behavioral health consumers are included in the entry program. The Coordinated Entry Program, once established, will be overseen and monitored by the PA-601 Western CoC's Coordinated Entry Committee.

### **Justice Involved**

The process of developing and implementing a Justice Related Services Program is underway in Armstrong and Indiana Counties. The program is being developed by the Armstrong-Indiana Behavioral Health Program. The program is intended to assist individuals with re-entry into the community after a correctional stay by providing appropriate, evidence-based, structured and fully integrated services. The JRS Program can also be used to divert incarcerations when appropriate. It is anticipated that the JRSP will provide specialized outpatient treatment and case management to the target population of those involved in the Criminal Justice System and those

with a behavioral health diagnosis. The treatment and program staff are to receive initial and ongoing training specific to working with the MH/CJS population. The program will be overseen and coordinated by a Justice Related Service Coordinator who will have knowledge of the behavioral health systems of care and the Criminals Justice System. Our PATH staff will be educated on the JRS system once it is operational. It is hoped that housing and PATH can become integral partners and components of this new program.

In addition to the new JRS Program being developed, our behavioral health housing liaisons 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 are 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 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 landlords are not willing to rent to them even if support services are involved. It is hoped that by educating landlords and prospective landlords about services to help sex offenders, more may become willing to offer rental units as housing options to this population. 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.

### **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. Both are also lifelong residents of their respective county and are very well versed in the human service field and services offered within each county. Both employees have received cultural competency and diversity training and are required to stay updated in both areas. One staff member has a proficient working knowledge of the Spanish language as well. Should the need for interpretative services arise, the AIBDHP has a positive working relationship with the Armstrong-Indiana Intermediate Unit as well as the Indiana University of Pennsylvania.

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 PATH staff is 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 staff, as with the PATH staff from the ACCAA, 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 PATH staff 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. All clients are treated equally.

### **Client Information**

Indiana and Armstrong Counties are lower income, predominately white counties (more than 95% Caucasian) in rural western Pennsylvania. 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 mental illness and live in Armstrong or Indiana counties. The overall projected number of those to be contacted is approximately 100-135 individuals, with at least 37 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 60%.

### **Consumer Involvement**

The Armstrong-Indiana Behavioral and Developmental Health Program strongly support and encourage consumer and family member involvement in all of our planning processes, including our PATH Program. The AIBDHP's Advisory Board has both a family and consumer representative that actively participate in guiding our program's vision and mission. 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. Those individuals who have been at risk of being homeless or have actually been homeless are key partners with AIBDHP on our housing planning and implementation of programs. Both Community Action Programs who operate our PATH Program are strongly encouraged to enlist the help of our consumers and family members in their decision making processes and planning. Furthermore, all PATH clients are encouraged to consider becoming peer specialists within our counties. With their vast experiences and knowledge of the systems of care in each county, any one of these individuals would be a great asset to any consumer needing assistance. Finally, the AIBDHP sponsors the Armstrong-Indiana Consumer/Family Satisfaction Team. This organization consists of consumers and family members who conduct satisfaction surveys with behavioral health consumers and their family

members. The team is a valued partner of the AIBDHP. The information collected by team members is used at all levels of quality management/improvement and program monitoring. The AIBDHP will continue encouraging consumer participation in all levels of planning and program evaluations.

Within our PATH Program itself, consumer input is gained throughout the process of assistance through program exit. PATH staff 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.

### **Behavioral Health Disparities**

The Armstrong-Indiana PATH Program will focus on the Transition Age Youth (TAY) Population during fiscal year 2016-2017. The TAY population has long been identified as an underserved population in both of our counties in a number of different human service programs. For 2016-2017, 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 19. 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:

<b><i>Direct Services:</i></b>	TOTAL	FY1	FY2	FY3	FY4
Number to be served	72	18	18	18	18
<b><i>By Race/Ethnicity:</i></b>					
African American	<20	<5	<5	<5	<5
American Indian/Alaska Native	<20	<5	<5	<5	<5
Asian	<20	<5	<5	<5	<5
White	<60	<15	<15	<15	<15
Hispanic or Latino	<20	<5	<5	<5	<5
Native Hawaiian/Other Pacific Islander	<20	<5	<5	<5	<5
Two or more races	<20	<5	<5	<5	<5
<b><i>By Gender:</i></b>					
Male	24	6	6	6	6
Female	48	12	12	12	12
<b><i>By Sexual Orientation/Identity Status</i></b>					
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 Service 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 work to develop the following plan to better serve the TAY population. Elements of this draft plan are provided below:

- Collaboration with local school districts: PATH staff will get to know local school district staff and what resources are available to help individuals complete their high school education once they are no longer homeless or at risk of becoming homeless.
- PATH service education: PATH staff will continue their educational and outreach efforts to inform people who fall in this population and those who support them, about services available in the community.
- Personal documentation retrieval: PATH staff 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: PATH staff is to be SOAR trained so that they will be able to assist clients in applying for Social Security benefits. PATH staff must also be knowledgeable about other resources and link clients to those.
- Support service education and referral: PATH staff 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.
- Tenant/renter education: The final component of the draft plan to better serve the TAY populations is to provide tenant education. Offering Prepared Rental Educational Programs that teach individuals how to become good tenants is crucial. Other education would include fair housing information, and how to successfully build and maintain a rental and credit history.
- PATH specific services: The PATH services provided will concentrate on outreach, engagement, education, and case management services. All elements have been more fully described under the Service Description Section of this plan.
- Early identification of PATH eligible TAY individuals: The AIBDHP Children/Adolescent Service System Program Coordinator (CASSP) works closely with AIBDHP's Quality and Care Management Coordinator (QMCM) 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 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 will be invited to participate in Interagency Service Planning Team (ISPT) meetings to discuss housing options and begin working to secure housing. The CASSP and QMCM Coordinator will work with our behavioral health providers to secure all behavioral health services for the individuals as well.

### **Armstrong-Indiana PATH Program Budget**

The budget presented below is a comprehensive budget for the Armstrong-Indiana PATH Program. PATH funding for the 2016-2017 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 2016-2017.

#### Personnel:

For the Armstrong County Community Action Agency, a total of \$17,533.00 in PATH funds is devoted to PATH Program Staff salary. Of the \$17,533.00, \$712.00 helps support the Director's salary by 2%. The remaining dollars (\$16,821) supports each PATH/Behavioral Health Housing Liaison at 35%. One PATH/Behavioral Health Housing Liaison position is supported for a cost of \$8,905.00. The other PATH/Behavioral Health Housing Liaison position is supported for a cost of \$7,916.00. All 3 PATH program staff are located at the Armstrong County Community Action Agency.

For the Indiana County Community Action Program, a total of \$16,062.00 is devoted to PATH Program Staff salary. This funding amount would cover the entire cost 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. 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 \$5,670.00 is being requested to provide the following fringe benefits for Armstrong County PATH Program Staff which include the director and two PATH/Behavioral Health Housing Liaison positions. Fringe benefits would have the following costs associated by category: Unemployment Compensation (\$352.00), ACC/HLTH Insurance (\$421.00), Workman's Compensation (\$75.00), Social Security (\$1,341.00), Pension plan (Director only: \$57.00), Health Insurance (\$3,425), Dental Insurance (\$148.00), and Vision Insurance (\$31.00).

For the Indiana County Community Action Program, the funding amount of \$7,064 is being requested to provide from the full-time fringe benefits of ICCAP's PATH/Behavioral Health Housing Liaison. Fringe benefits include the following costs: FICA (\$1,229.00), Workers Compensation (\$681.00), Pennsylvania Unemployment (\$508.00), Health Insurance (\$4568.00), Vision Insurance (\$35.00) and Life Insurance (\$43.00).

#### 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. A total amount of \$ 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 \$5,622.00. 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 each, not to exceed \$6,286; \$ 5,286 would be a one-time assistance to help consumers maintain housing and \$ 1,000 for security deposits. Total request for other expenses: \$6,286.00.

In-Kind:

For Indiana County only, In-kind services provided toward the PATH Program would include the following items as outlined below at a value of \$73,290.

County Match (on State allocation)

Administrative Expenses	\$ 6,981
Other travel	\$ 2,000
Additional Funding for Rental Assistance to Applicants (Reinvestment \$5,000 Housing Assistant Program \$ 59,309)	\$64,309

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 \$ 341,294 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

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing Liaison Case Manager/Admin. Costs ICCAP	23,278	.69 FTE	16,062	16,062
ACCAA PATH Director	35,610	.02 FTE	712.00	712.00
Housing Liaison Case Manager ACCAA	25,444	.35 FTE	8,905	8,905
Housing Case Manager ACCAA	22,617	.35 FTE	7,916	7,251
<b>Sub-total</b>			<b>33,595</b>	<b>33,595</b>
<b>Fringe Benefits</b>				
ACCAA			4,384	4,384
ICCAP			7,064	7,064
<b>Sub-total</b>			<b>11,448</b>	<b>11,448</b>
<b>Travel</b>				
Local Travel for Outreach				
ACCAA			1,951	1,951
ICCAP			400	400
Travel to training and workshops				
ACCAA			0	0
ICCAP			100	100
<b>Sub-total</b>			<b>2,451</b>	<b>2,451</b>
<b>Equipment</b>				
ACCAA				
ICCAP				
<b>Sub-total</b>			<b>0</b>	<b>0</b>
<b>Supplies</b>				
ACCAA – consumer related items			423.00	423.00
ICCAP			0	0
<b>Sub-total</b>			<b>423.00</b>	<b>423.00</b>

<b>Other</b>				
Staff training				
ACCAA			0	0
ICCAP			0	0
One-time assistance to maintain housing				
ACCAA			5,622	5,622
ICCAP			5,286	5,286
Security deposits				
ACCAA			0	0
ICCAP			1,000	1,000
Postage				
ACCAA			0	0
ICCAP			0	0
<b>Sub-total</b>			<b>11,908</b>	<b>11,908</b>
<b>TOTAL PATH Budget</b>	106,949		59,825	59,825

705 Butler Road  
Kittanning, PA 16201

Contact: Jeff Boarts

Contact Phone #: 7245483408

Provider Type: Social service agency

PDX ID: PA-067

State Provider ID: 4267

Geographical Area Served: Western Region

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Armstrong/Indiana: Armstrong County Community Action Agency will receive \$29,912.50 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	35	Estimated Number of Persons to be Enrolled:	12
Estimated Number of Persons to be Contacted who are Literally Homeless:	21		
Number Staff trained in SOAR in Grant year ended in 2014:	1	Number of PATH-funded consumers assisted through SOAR:	0

**Armstrong County Community Action Agency  
Local Provider Intended Use Plan  
FY 2016-2017**

**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 those 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. Armstrong County Community Action Agency is the umbrella agency for Employment Training, Housing Assistance Program, three Continuum of Care Programs (Transitional Housing, Permanent Supportive Housing, Armstrong/Fayette Rapid Re-housing Program), Rapid Re-housing Emergency Solutions Grant (ESG), Rapid Re-housing for Supportive Services for Veteran Families, Utility Assistance Programs, Food Stamp Outreach, Medical Assistance Transportation, Head Start, Weatherization, Food Bank, Child Care Information Services, Fatherhood Initiative, Child Mentoring Program, and Homeowners Emergency Mortgage Assistance Program. Our agency also provides services in Child and Adult Care Food Program, the Summer Feeding Program and Emergency Food and Shelter.

This comprehensive list of human service programs are offered under our agency umbrella in our office complex to provide ease and convenience to our consumers in obtaining services keeping their best interest in mind. This allows for the direct one-on-one contact with all programs provided by ACCAA, therefore lessening the consumer's travel to multiple locations for service. Throughout the agency's history, ACCAA's delivery of services, in the one-stop-shop style, has been successful in order that consumers can get all they need in just "one convenient stop". We are all about serving the consumers in the most efficient and cost effective manner while assisting them to lessen their dependence on governmental programs and become self-sufficient.

Our agency is in the process of compiling our Community-wide Needs Assessment for a three year period. This process is a part of the overall agency Strategic Plan. In the fall of 2015, the Needs Assessment process of gathering data began to identify the top needs of our county residents. Affordable housing ranked high as one of the top needs in our rural county. ACCAA concentrates its' efforts and services around the need that is identified in the needs assessment process in order to tackle the problems or gaps in service that are present. This process is a part

of the overall strategic plan of ACCAA that is an effective tool in identifying and clarifying problems while identifying appropriate interventions that can be directed towards developing and implementing feasible solutions.

Our Housing department has many years of experience in providing rental assistance and housing services to the consumers of Armstrong County. They have a combined experience of over 55 years. They have developed a good working rapport with the landlords and have extensive knowledge of rental properties. In 2009, the Armstrong County Community Action Agency was funded for the American Recovery and Re-Investment Act (ARRA) funds for the Homelessness Assistance and Rapid Re-Housing Program (HPRP). In FY 2013-2014 and 204-2015, ACCAA was awarded the Emergency Solutions Grant (ESG) that continues to provide for housing needs of our consumers in Armstrong County.

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 to serve Armstrong County residents. The amount of the PATH funding will be \$29,912.50.

The Armstrong County Community Action Agency is currently a user in PDX (PATH Data Exchange) and our Provider Name is 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, the agency started many years ago holding quarterly housing/homelessness meetings on the local level. This group called the Armstrong County Homeless Advisory Board which is similar to a Local Housing Options Team (LHOT) that is so important to any Continuum of Care Program for the homeless. Their role is to assist in assessing needs and helping in problem resolution. In addition, this group has proven invaluable in collaborating information sharing and collaborating efforts. Our agency attends the

monthly Western CoC meetings either in person or by a Web-Ex meeting. ACCAA is committed to and remains actively involved in the Western Continuum of Care.

The Western Continuum of Care is currently working together to have a centralized intake available to all participating members for each county's implementation for the fall of 2016. This Coordinated Assessment System is the CoC's approach to organizing and providing services to persons experiencing a housing crisis within a specific geographic area. The written standards have been established to ensure that persons experiencing homelessness who enter programs throughout the CoC will be given similar information and support to access and maintain permanent housing.

### **Collaboration with Local Community Organizations**

The Armstrong County Community Action Agency operates a number of homeless programs on behalf of the County of Armstrong and the Armstrong County Board of Commissioners. We operate three COC Programs for the homeless. In addition, ACCAA manages and operates the Pennsylvania Homeless Assistance Program (HAP) grant for the County. This money can assist in rental assistance, utility help, case management, and emergency shelter assistance. In addition, the ACCAA has a small amount of HAP funds that they use for Bridge Housing. In the last few years, the Armstrong County Community Action Agency was awarded the Supportive Services for Veteran Families (SSVF) Program that expands our case management, employment assistance and rapid re-housing services targeting veterans and their families.

The ACCAA acts as the clearinghouse for the Federal Emergency Management Agency's Emergency Food and Shelter Program in behalf of the County. This funding stream has dwindled significantly through the past several years. Other programs operated by the Armstrong County Community Action Agency's Housing Department that significantly impacts homelessness prevention is the Dollar Energy Fund and the Central Electric Family Fund. This private fuel fund can assist low income consumers in paying their heating and/or electric bills. ACCAA also provides services through the Homeowners Emergency Mortgage Assistance Program (HEMAP) to assist consumers who receive a mortgage foreclosure notice (Act 91).

In FY 2013-2014 and FY 2014-2015, the Armstrong County Community Action Agency was awarded the Emergency Solutions Grant (ESG). This money has assisted in homelessness prevention activities by making rental assistance as well as utility payments for consumers approaching eminent eviction. In addition, this program has allowed the agency to rapidly re-house and establish the homeless persons in their own rental unit.

In FY 2014-2015, the ACCAA applied for the Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund (PHARE) in behalf of the County of Armstrong, which is being utilized to temporarily house the literally homeless individuals in Armstrong County for a period of up to two months. The PHARE Program houses the people and the caseworker from the referring agency works with their consumer to secure permanent housing and to assist them in continued treatment with other agencies. This is temporary shelter for up to two months.

The ACCAA PHARE Caseworker inspects the apartments weekly and readies the apartment for the next tenant after a consumer moves out and into permanent housing. Contact is made with the tenants, sometimes on a daily basis, since the ACCAA PHARE Caseworker is primarily working in the building. Referrals are sent from various agencies in the county, which include Children Youth and Families, Family Acts, Family Psychological, Holy Family, Armstrong/Indiana/Clarion Drug and Alcohol Commission, and Family Counseling Agency. Constant contact between both case managers ensures that the consumer moves to permanent housing successfully.

ACCAA was instrumental many years ago in establishing the Armstrong County Homeless Advisory Board. ACCAA is the founder and moderator of this quarterly meeting of many local community organizations and social service agencies who come together to collaborate and solve homeless issues in Armstrong County. Case managers from the different agencies know each other from participating in the Homeless Housing Advisory Board and they contact our case managers, either by phone or by a walk-in visit, when they have a consumer with a housing issue. With many years of working together, the agencies develop a professional rapport and that is positively an asset to the delivery of human services in Armstrong County.

Representatives on the advisory board include 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, and Children, Youth and Family. Also participating is the Career Track, Aids Alliance, Laurel Legal Services, Armstrong County Memorial Hospital, Armstrong County Jail, HAVIN, Adagio Health, Family Behavioral Resources, Family ACTS, Armstrong/Indiana Consumer & Family Behavioral Resources, Lutheran Senior Life, Laurel Legal Services, Southwestern PA Legal Services, Career Link, Butler VA, Salvation Army Kittanning and Salvation Army Vandergrift to name a few.

The Armstrong County Community Action Agency has a long history of collaborating with other agencies to solve housing issues county-wide. ACCAA worked with the Armstrong-Indiana Behavioral and Developmental Health Program in a program called the Consumer Housing Contingency Fund which assists with essential household needs, security deposits, utility assistance, rental assistance for eviction notices, other emergency needs. The fund has assisted consumers in finding housing and paying for necessary housing items.

The Armstrong County Community Action Agency collaborated with our county's abused victim's shelter, HAVIN, in gaining grant assistance in the Emergency Solutions Grant (ESG) Our Housing Department currently works with the Family and when consumers are facing homeless or near homelessness. Housing Liaisons will work with the consumers along with Family Counseling, Unity Opportunity Center and PEARSTAR LLC, for peer to peer services. We also continually work with housing assistance, referrals from 211, 911, churches, other social service agencies, the Armstrong County Jail, Fatherhood Initiative Program, St. Vincent DePaul, Armstrong School District and the Community Action Agency outreach staff.

## **Service Provision**

Armstrong County Community Action Agency will provide PATH funded housing services to eligible homeless Armstrong County Behavioral and Developmental Health Program consumers who meet the “literally homeless or the at-risk of homelessness” definition. Housing services related to the planning of housing, costs associated with matching eligible homeless consumers with appropriate housing services, assistance in applying for housing assistance, improving the coordination of housing services, and rental assistance for the consumer to get them established in housing.

PATH funds will be used for one-time rental assistance and security deposits, when needed. We have found through our experience that almost every landlord requires both the first month’s rent and security deposit before the consumer moves in. Therefore, it is necessary to incorporate the flexibility of being able to use the PATH funding for both one time rental assistance and security deposits, if needed. We plan to serve twelve (12) PATH consumers with rental assistance and/or security deposit payment in this 2016-2017 PATH Program year.

We will also collaborate with other housing resources that assist the homeless under our agency umbrella, such as the Emergency Solutions Grant, Housing Assistance Program, Continuum of Care Programs, Supportive Services for Veteran Families, and PHARE, if needed, to serve the PATH consumers. We also plan to serve at least forty-five (45) other PATH consumers with PATH funded services that will help them locate housing and be referred to mainstream resources.

Transportation will be provided to consumers that don’t have access to our county’s bus transit system. If the consumer has an active Access Card for medical appointments, they can be transported through ACCAA’s Medical Assistance Transportation Program. The Housing Liaisons will transport consumers to the Armstrong County Human Services Department (formerly known as the County Assistance Office), Armstrong County Housing Authority, Social Security Office, Probation/Parole Department, local banks for opening checking/savings accounts, St. Vincent DePaul for personal items, or the Salvation Army clothing store. The Liaisons will transport to any other places where issues may arise that they need transported to on any given day. The Housing Liaison can transport consumers to a local discount department store in order to purchase household goods that are approved in an emergency situation or any other location that it is deemed necessary to fulfill their Individual Service Plan.

A portion of the travel budget will be used to transport those consumers without transportation. This ability assists consumers to breach a major barrier in Armstrong County surrounding transportation. Other than Town and Country Transit Authority, there is no other no other means of public transportation in the area. The services provided by Town and Country Transit Authority are limited as they only service the mid-county region of Armstrong County. This region only encompasses a 6-8 mile radius in the Kittanning and Ford City area.

The Housing Liaisons will provide one-on one case management as a priority service. They will also collaborate with ACCAA’s Housing Department to ensure that the consumer, who is most

vulnerable, has their needs met. Consumers who are categorized most vulnerable are those who are literally homeless or at risk of homelessness, have a serious mental illness, or have a serious mental illness and a co-occurring substance abuse disorder. The Housing Liaisons will also attend, when requested, the Housing Department's weekly case management meetings with our agency's Homeless Advisory Board. The Homeless Advisory Board discusses and reviews cases and makes recommendations concerning the barriers of the consumers or reports progress to the group.

For those individuals who are dealing with co-occurring mental health and substance abuse disorders, the Housing Liaisons will locate resources and make referrals to both mental health and addiction treatment and education centers. If needed, the Housing Liaisons can also help the consumer find a local doctor for additional medical needs identified if they do not have a doctor to address the need.

The Housing Liaisons will also make referrals in order to help the consumer obtain emergency food help, obtain emergency clothing, sign up for the ACCAA county-wide food bank, for Medical Transportation Program services and for any other needed services. Emergency food help can be given out of the emergency food pantry that was established a year ago at our agency office complex. The Housing Liaisons will also locate resources and make referrals to the local mental health agencies, addiction treatment and education centers for those dealing with serious mental disorders and substance use disorders, and assist the consumer finding a local doctor for any additional medical needs that are identified.

The Housing Liaisons will conduct street outreach once a week by driving to local locations that are known to be frequented by homeless individuals in our attempt to make contact with them. One of the key disadvantages to being a rural county is that many of the homeless persons are actually living doubled up and are not out in the community. This is one of the obstacles we face on a daily basis. Some of the areas we target are local parks with gazebos that offer shelter from the elements, laundromats, hospitals, river front parks, Crooked Creek State Park, under bridges, at playgrounds, grocery stores or Wal-Mart where homeless persons tend hang out. Also identified as places where the homeless go are the local McDonalds, Valley Dairy, or other fast food restaurants.

Lack of affordable housing is a major gap in the current service system. Consumers cannot find housing that they can afford to pay. The problem is surmounted by the Marcellus Shell Drillers and Gas Drillers in Armstrong County occupying all the available housing and paying top dollar for the rentals. In some instances, payment six months in advance is made on these rentals by the Gas Drilling Companies to guarantee their workers have a place to stay. Our consumers are pushed aside and it makes it much more difficult to locate available and affordable housing. The Housing Liaisons will assist the consumers look for rentals to increase their chances of finding housing.

Another gap in the service system is that there is not a low-income, homeless shelter in existence for the homeless in the county. There is also a gap in services for the veterans in Armstrong County in the area of housing vouchers. There are limited HUD-VASH Vouchers offered through the Butler VA for Armstrong County veterans to apply. Homelessness has become an

increasing problem in Armstrong County, especially for those individuals and families experiencing one of the following difficulties: mental health difficulties, poor credit, budget mismanagement, a past criminal history, drug and alcohol concerns, past landlord issues, and lack of employment.

Many PATH consumers experience two or more of the aforementioned difficulties; therefore, their barriers compound into seemingly insurmountable hurdles. Upon entry into the PATH program, the Housing Liaison assesses the consumer's difficulties and creates an Individual Service Plan (ISP). The ISP allows the Housing Liaisons to then plan on how to tackle each of the consumer's difficulties individually to greatly increase the consumer's chances of successfully obtaining stability and independence.

The Armstrong County Community Action Agency will support evidence based practices, trainings for local PATH funded staff, and trainings and activities to support migration of PATH data in the Homeless Management Information System (HMIS). One of the Armstrong County Community Action Agency Housing Liaisons has been trained in the HMIS system and is currently utilizing the system for the PATH Program. The PATH Supervisor has HMIS credentials. The other PATH Housing Liaison will be trained in HMIS in 2016. Housing Case Managers in the Housing Department are trained and actively uses the HMIS system. Data is entered in a timely manner into the HMIS the system to keep the consumer information up-to-date. The ACCAA PATH staff is always available to attend trainings or webinars that are necessary in order to make the program an effective and efficient one for the PATH consumers. PATH funding will primarily be used to pay for staff training to support evidence-based practices.

The ACCAA is not required to follow 42 CFR Part 2 Regulation since we do not operate any substance abuse programs.

## **Data**

Armstrong County Community Action Agency's PATH Program Housing Liaison staff utilizes the PA Homeless Management Information System (PA HMIS) and has a database to back-up, store, and organize consumer information. They will provide PATH services and will have all data entered into the system and database. PATH staff is trained and authorized to use the PA HMIS System now that HMIS has been updated and the PATH program is incorporated into its system. We are fully implemented in HMIS and we are following the newest data standards released by SAMSHA.

Community Action PATH Program Staff and Housing Department also attend the monthly on-line training opportunities offered by the Department of Community and Economic Development as provided. The Housing Liaison enters the data into the HMIS system within one week of enrollment. Any new staff will be thoroughly trained through webinars, on-line training, peer-to-peer support within the department and attend all meetings as required. We have support through David Weathington, Department of Community and Economic Development, Economic

Development Analyst 1, and PA-HMIS Administrator, Brian Miller. If any questions or issues arise within the HMIS Program, contact will be made with him, as necessary.

### **Alignment with PATH goals**

The goal of PATH is to house individuals who are experiencing either imminent risk of homelessness or who are “literally homeless” and are experiencing mental health issues with or without a co-occurring substance use disorder. The goal is to reduce or eliminate homelessness. The PATH Program will assist those who have persistent and pervasive health disparities to connect them to mainstream resources for treatment. Street Outreach, Case Management and other services not supported by mainstream resources are allowable in the PATH Program. With these goals in place, it assists the consumer in feeling protected since permanent housing has been located and treatment can begin. The combined efforts of the Housing Liaisons and the consumer ensure that the consumer has an active role in improving their mental health and live a more meaningful and secure life.

### **Alignment with State Mental Health Services Plan**

PATH was created under the McKinney act for individuals with co-occurring mental health or substance use disorders, those who are homeless or at risk of becoming homeless. Our PATH Program mimics the state’s plan to end homelessness for those with mental illness by housing individuals who have mental health diagnosis with or without a co-occurring substance abuse disorder. Also, they are experiencing a housing crisis that leaves them either at-risk of homelessness or literally homeless. We outreach to these individuals through our community and involve them in mainstream resources such as emergency housing until a more permanent residence can be provided. Using the Housing First initiative, we make sure that the consumer is in a stable living environment before we refer them to mental health treatment. With the combined participation of the Housing Liaisons, the consumer and the mental health professionals, the consumer’s ability to maintain their stable housing status greatly increases in comparison to the outcomes of similar consumers, who try to maintain their housing status independently.

In regard to the Armstrong County Hazard Mitigation Plan, The Armstrong County Department of Public Safety required assistance in updating the Armstrong County’s Multi-jurisdictional Hazard Mitigation Plan (HMP) in accordance with the Disaster Mitigation Act of 2000 (DMA 2000). Delta provided technical assistance in completing the hazard mitigation planning process ensuring key federal requirements were met, while also including public and private stakeholders in the process to incorporate their feedback into the final plan. Delta conducted a hazard vulnerability assessment (HVA) of all of the County’s assets to determine how various hazards would affect different municipalities in the County.

After conducting the HVA, Delta assisted the County in developing a mitigation strategy composed of goals, objectives, and actions designed to reduce county and municipal vulnerability to identified hazards. As a result of this project, Armstrong County and its

municipalities received a FEMA-approved Multi-jurisdictional Hazard Mitigation Plan in 2014, strengthening their comprehensive emergency management programs and making the jurisdictions eligible for pre-disaster mitigation project funding.

Our agency was a participating member of the county planning group that worked on developing the Armstrong County Hazard Mitigation Plan. We in involved in the planning phases from the very beginning through the final phase of the plan development. Our staff persons who were involved assisted in the group discussion and decision-making process in regard to goals, objectives, and actions developed to reduce our county's overall exposure to identified hazards.

Armstrong County Community Action Agency was designated by the 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.

HUD Office of Housing Counseling has established a new Disaster Recovery Website to utilize featuring new toolkits for Housing Counseling Agencies and other resources for housing counselors in the event a disaster strikes the community.

### **Alignment with State Plan to End Homelessness**

The Pennsylvania Interagency Council on Homelessness proposed an "Agenda for Ending Homelessness in Pennsylvania" in November of 2005 implementing a 10 year plan. The ACCAA intends to follow this plan as close as possible. ACCAA's efforts to support ending homelessness is warranted by holding a quarterly Homeless and Housing Advisory meetings where members are from many social service agencies, who work with consumers who have mental health issues and are homeless or at risk of homelessness. Ideas are presented and carried out, if applicable, to the consumer. These caseworkers work hand-in-hand with the Housing Liaisons and the housing department staff at ACCAA using the "Housing First" model. Ideas and programs are shared among the social service agencies and their staff to work towards removing barriers for the consumer.

The Housing Assistance Program, PATH Program, the Continuum of Care Programs, Supportive Services for Veteran Families, Armstrong County Housing Authority, and Family Unification Vouchers all work toward ending homelessness and eliminating barriers in Armstrong County. Coordinating multiple programs to be sure that the consumers receive our support is crucial. With these collaborative efforts it fosters support to end homelessness.

By removing barriers and working slowly one-on-one with the consumer, we hope to increase their income by working with local employers to find part-time or full-time employment. Case management is essential in the success of PATH consumers. Staff will advocate for additional new housing opportunities when available. In addition, ACCAA has worked closely with

HAVIN (local abuse shelter). There is a constant contact between case managers in order to assess their consumers and make referrals to permanent housing and mainstream resources including mental health services.

### **Other Designated Funds**

We do not receive any other designated funds for those consumers who are experiencing homelessness and have serious mental illness, except for the PATH grant funding. We do serve these consumers through the Housing Assistance Program, Continuum of Care (CoC)-Transitional Housing, CoC-Permanent Supportive Housing, CoC-Armstrong/Fayette Rapid Re-Housing, Supportive Services for Veteran Families (SSSVF), SSVF Emergency Solutions Grant (ESG) and the Housing ESG Program.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

Armstrong County Community Action Agency currently has SOAR trained staff, including a Housing Liaison in the PATH Program. Armstrong County Community Action Agency plans to SOAR train the remaining PATH staff and the Housing Department staff in FY2016-2017. We plan to assist as many PATH consumers, throughout the 2016-2017 year, with SOAR applications as the need arises. To date, a situation where SOAR could assist a consumer has not yet arisen. However, we have assisted two individuals with the regular Social Security Disability (SSDI) process.

### **Housing**

Armstrong County Community Action Agency has been responsive to the homeless and imminently homeless individuals. Upon being interviewed by one of the Housing Liaisons and the Housing Department Staff, there is a collaborative effort by all the parties involved to find the best solution available for the consumer to solve their needs. The Western Continuum of Care has adopted 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. 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.
- 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 – The 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.
- PHARE Housing(Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund)—Emergency housing stay for up to two months by referral only from mental health agencies, counseling agencies, drug and alcohol and Armstrong County Community Action Agency Housing Program.

## **Coordinated Entry**

The Coordinated Entry is being developed by the Western Continuum of Care and has a Coordinated Assessment Committee that is active in devising a coordinated entry application to use throughout the Western Continuum of Care. They will be rolling out the application to five (5) counties to use at first. During this trial period, any updates or system corrections will be updated. Once everything is corrected, the entire Western COC will begin using the coordinated entry application. Their projected date of implementation is fall of 2016. Eventually, all information will be entered through the HMIS-(Homeless Management Information System). Armstrong County Community Action Agency is an active member in the Western COC, since FY1999-2000, while it was formerly known as the Southwest Regional Continuum of Care. Since then, the Northwest Continuum of Care and Southwest Continuum of Care have merged to become the Western Continuum of Care and we actively participate in the Western COC. The Coordinated Entry Committee will oversee the system's operation and monitor/modify the process as needed.

## **Justices Involved**

The Armstrong County Community Action Agency works in conjunction with the Armstrong County Probation or Parole Department of the Armstrong County Jail on a continual basis in regard to locating housing for persons who have criminal backgrounds. When probation or the Armstrong County Jail has someone who is being released that needs immediate housing placement, contact is made with the Armstrong County Community Action Agency's Housing Department. ACCAA proceeds to do an in-take application for housing assistance. The Housing Department then makes referrals to the PATH Program. Consumers must be eligible having a mental health diagnosis and be at risk of homelessness or be literally homeless.

The Housing Liaisons and the Housing Case Managers work in conjunction with each other to locate housing for the consumer as well as to mainstream resources. The Probation/Parole office is a standing member on our Armstrong County Homeless Advisory Board and is aware of the resources available. Contact is made over the telephone or in person with the Parole or Probation Officer as needed to be sure that the consumers are following all directions or restrictions. Our agency has had a long standing respected relationship with landlords from the various housing programs offered at ACCAA. Therefore, through this relationship, the landlords have learned the plight and see the needs of the low-income people that we serve and assist with housing. ACCAA has served 54% of the PATH population in FY2014-15 who had a criminal history.

## **Staff Information**

The demographics of the Armstrong County Community Action Agency's PATH Program staff are currently 100% Caucasian females. They all have cultural competence 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 disorders and illnesses. Regarding any language barriers, there are contacts through the Armstrong School District who can be called upon for translation services if the need arises. Staff will attend any training opportunities that are available in cultural and health disparities to ensure continued social competency.

## **Client Information**

The target population to be served by the PATH program will be emancipated minors and those aged 18 or older. To qualify for the PATH program a consumer must either have a mental health diagnosis or be experiencing pervasive symptoms that might allude to a possible mental health condition. A consumer must also either be "at risk of homelessness" or be "literally homeless." Path consumers who are considered "at risk of homelessness" are persons who are doubled up with family or friends and can no longer stay or have an eviction notice due to arrears in rent or utility payments. Path consumers who are considered "literally homeless" are persons who are sleeping in areas not meant for human habitation, persons who are staying in supervised public or private facilities that provide temporary or emergency living accommodations, person who are

in transitional or time limited housing programs, and persons being released from prison or other institutional environments without a place to stay.

Plans to assist consumers who fit these definitions include contacting at least thirty-five (35) individuals to see if PATH can assist them in any way. We plan on enrolling at least twelve (12) of those consumers into the PATH program. The over-all approximation of consumers that would receive any PATH funded services is forty-five (45). The percentage of clients PATH clients served who fit the “literally homeless” definition will be 60%.

### **Consumer Involvement**

The agency’s PATH Program Staff will be working with the local mental health agencies to serve the needs of the PATH consumers. The families of the PATH consumers will be involved in the overall process of helping them through their barriers. The Armstrong County Community Action Agency sponsors a Homeless & 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. The Homeless Advisory Board is a very active group and it also provides important updates on new or innovative program services or updates on existing programs to keep the group abreast of all of the changes taking place within our programs. This group makes recommendations to the Armstrong County Community Action Agency’s Board of Directors and asks for guidance in providing services.

The agency’s PATH Program Staff also strives to survey PATH consumers at the time of departure from the program to identify any areas where improvements can be made, and listen to suggestions the consumers have regarding the effectiveness of the PATH Program.

### **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 the 18-30 year age range that have a serious mental illness (SMI) and/or co-occurring substance abuse disorders, and who are homeless or at imminent risk of becoming homeless. Armstrong County’s TAY population has increased difficulty 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 Homeless 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 technological inclination 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. Armstrong County Community Action Agency is also currently in the process of building an interactive web page. These communication and service methods enable the TAY consumers to communicate with ACCAA and, through this, the Housing Liaisons to build rapport with the consumers.

Once a TAY consumer has been established within the program, 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. The total amount of PATH funds expected to be expended on rental assistance services for the TAY population is \$1,794.72 which is utilizing roughly 30% of our rental assistance services budget. With this estimate we have prioritized the service needs of the TAY population for this grant and propose to serve the following numbers of consumers:

	Total	FY1	FY2	FY3	FY4
Direct Services:					
Number to be served	56	14	14	14	14
By Race/Ethnicity	Total	FY1	FY2	FY3	FY4
African American	< 20	< 5	< 5	< 5	< 5
American Indian/Alaska Native	< 20	< 5	< 5	< 5	< 5
Asian	< 20	< 5	< 5	< 5	< 5
White	< 48	<12	<12	<12	<12
Hispanic or Latino	< 20	< 5	< 5	< 5	< 5
Native Hawaiian/Other Pacific Islander	< 20	< 5	< 5	< 5	< 5
Two or more Races	< 20	< 5	< 5	< 5	< 5

By Gender	Total	FY1	FY2	FY3	FY4
Male	16	4	4	4	4
Female	40	10	10	10	10

By Sexual Orientation/Identity Status

	Total	FY1	FY2	FY3	FY4
Lesbian	unknown	unknown	unknown	unknown	unknown
Gay	unknown	unknown	unknown	unknown	unknown
Bisexual	unknown	unknown	unknown	unknown	unknown
Transgender	unknown	unknown	unknown	unknown	unknown

If the consumer does not have an income, the consumer is still eligible for case management services and referral services within 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 Human Services Department (Welfare office), Probation and Parole Office and the Social Security Office. This is very important because many TAY individuals may not have a copy of their Birth Certificate. If they also need to get their Social Security card, Identification Card or if a Birth Certificate is needed. TAY individuals may also need more assistance signing up for programs or understanding programs due to inexperience with social services. The Housing Liaisons will be available assist them with signing up for and/or understanding programs as needed.

### **Service Use**

Services and activities will be designed and implemented in accordance to the TAY population's needs. As the table shows, we expect that the mass majority of the TAY individuals will be Caucasian to match the statistics for the mass majority of the population in Armstrong County. We also expect that their cultural preferences will be similar. Finally we expect that the mass majority of the population will also be English speaking, also in reflection to county statistics. Service completion rates will be consistent with the access to services projections noted in the table.

### **Outcomes**

Access and service use data will be collected and entered into the HMIS system. It will be used to manage grant implementation activities to improve the behavioral health outcomes of the TAY population.

### **Budget Narrative**

The PATH funding received by Armstrong County Community Action Agency 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 Kimberly Pivetta, Director; Kaila Mulvey and Lauren Wheeler are the Housing Liaisons. A breakdown of the costs associated with the Armstrong PATH Program is provided below:

#### Personnel:

Of the \$17,533.00 of PATH funds devoted to salary costs, \$712.00 helps support the Director's salary by 2%. The remaining dollars (\$16,821) supports each PATH/Behavioral Health Housing Liaison at 35%. One PATH/Behavioral Health Housing Liaison position is supported for a cost of \$8,905.00. The other PATH/Behavioral Health Housing Liaison position is supported for a cost of \$7,916.00. All 3 PATH program staff are located at the Armstrong County Community Action Agency. The director will responsible to oversee the program and completing all reports.

The PATH/Behavioral Health Housing Liaisons 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 \$5,670.00 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	(\$10.00)	
	PATH/BHHL #1	(\$171.00)	
	PATH/BHHL #2	(\$171.00)	
			<b>Total: \$352.00</b>
ACC/HLTH Insurance:	Director	(\$17.00)	
	PATH/BHHL #1	(\$214.00)	
	PATH/BHHL #2	(\$190.00)	
			<b>Total: \$421.00</b>
Worker’s Compensation:	Director	(\$3.00)	
	PATH/BHHL #1	(\$38.00)	
	PATH/BHHL #2	(\$34.00)	
			<b>Total: \$75.00</b>
Social Security:	Director	(\$54.00)	
	PATH/BHHL #1	(\$681.00)	
	PATH/BHHL #2	(\$606.00)	
			<b>Total: \$1,341.00</b>
Pension Plan:	Director only		<b>Total: \$57.00</b>
Health Insurance:	Director	(\$420.00)	
	PATH/BHHL #1	(\$2405.00)	
	PATH/BHHL #2	(\$420.00)	
			<b>Total: \$3,245.00</b>
Dental Insurance:	Director	(\$8.00)	
	PATH/BHHL #1	(\$73.00)	
	PATH/BHHL #2	(\$67.00)	
			<b>Total: \$148.00</b>



Armstrong County Community Action Agency PATH Program  
FY 2016-2017 Budget

	<b>Annual Salary</b>	<b>PATH- funded FTE</b>	<b>PATH- funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
PATH Director	\$35,610.00	.02	\$712.00	\$712.00
Housing Liaison Case Manager	\$25,444.00	.35FTE	\$8,905.00	\$8,905.00
Housing Case Liaison Manager	\$22,617.00	.35FTE	\$7,916.00	\$7,916.00
<b>sub-total</b>			<b>\$17,533.00</b>	<b>\$17,533.00</b>
<b>Fringe Benefits</b>				
FICA Tax			\$1,341.00	\$1,341.00
Unemployment			\$352.00	\$352.00
Retirement			\$57.00	\$57.00
Life Insurance			\$421.00	\$421.00
Health/ Dental/ Eye Ins			\$3,424.00	\$3,424.00
Workman's Comp			\$75.00	\$75.00
<b>sub-total</b>			<b>\$5,670.00</b>	<b>\$5,670.00</b>
<b>Travel</b>				
Local Travel for Outreach			\$1,088.00	\$1,088.00
Travel to training and workshops				
<b>sub-total</b>			<b>\$1,088.00</b>	<b>\$1,088.00</b>
<b>Supplies/Equipment</b>				
Consumer-related items				
<b>sub-total</b>				
<b>Other</b>				
Staff training				
One-time rental assistance			\$5,622.00	\$5,622.00
Security deposits				
<b>sub-total</b>			<b>\$5,622.00</b>	<b>\$5,622.00</b>
<b>Total PATH Budget</b>			<b>\$29,913.00</b>	

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>a. Personnel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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<b>b. Fringe Benefits</b>	0.00 %	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>c. Travel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>d. Equipment</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>e. Supplies</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>f. Contractual</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>g. Construction (non-allowable)</b>				
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<b>h. Other</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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<b>j. Indirect Costs (Administrative Costs)</b>	\$ 0	\$ 0	\$ 0	
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<b>k. Grand Total (Sum of i and j)</b>	\$ 0	\$ 0	\$ 0	
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Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Armstrong/Indiana: Indiana County Community Action Program will receive \$29,912.50 in federal and state PATH funds.

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:	60		
Number Staff trained in SOAR in Grant year ended in 2014:	2	Number of PATH-funded consumers assisted through SOAR:	4

**Indiana County Community Action Program, Inc.**  
**Local Provider Intended Use Plan**  
**FY 2016-2017**

**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-one 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: \$ 29,912.50

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 for the employable and Project PHD for the disabled. In addition, the agency operates the Pathway Homeless Shelter with funding through H-ESG.

ICCAP is Indiana County's Local lead Agency/811 contact, and the Continuum of Care contact for the county. ICCAP's Community Services Director, (resigned the first week in April), had been active on the PA Western Region CoC Governing Board, the Southwest Regional Homeless Advisory Board, the Coordinated Assessment Committee, and on our local Housing Consortium (LHOT). Since her resignation, the Shelter Director is now serving on the HUD Continuum of Care's Southwest Regional Homeless Advisory Board (RHAB), and local Housing Consortium along with the Executive Director; vice chair of the Housing Consortium. The Executive Director has also requested to be on the PA Western Region CoC Governing Board to continue Indiana County's representation.

## **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. A key management member of the IRMC staff serves on the ICCAP Board of Directors. 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, 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. Agency staff regularly attends meetings of the Community Support Program.

### **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 are also able to assist consumers entering the Oxford House step down unit 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**

Indiana County Community Action Program serves as the county's primary point of contact 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 referred to Pathway; Alice Paul House (domestic violence shelter) residents; and county residents facing housing crises. Additional outreach is provided through written resources such as flyers,

brochures and staff at ICCAP's 18 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 PATH Housing Liaison 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, and the housing counselor) occurs as needed. Formal meetings and discussion of specific client issues take place at more formal bi-weekly housing staff meetings.

The Housing Liaison provides outreach at the local drop-in center, the consumer run coffee shop, and the Pathway Homeless Shelter; in addition she travels to any place reporting a homeless consumer--a park, store, or church. She works closely with the Representative Payee Program staff. In addition, many eligible clients simply walk in to the agency's main office seeking assistance. The Housing Liaison 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.

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 assessment; counseling; intensive outpatient services; attend a co-occurring disorders group; and/or the relapse prevention group. The Open Door also provides a 24 hour crisis line and evaluation for inpatient services.

The Housing Liaison attends local CSP meetings; and will be getting trained as a SOAR advocate. (Note: ICCAP just hired a new Housing Liaison which will be starting full time May 2, 2016. Our former Housing Liaison was a trained SOAR advocates). PATH funding will be used to provide training to PATH staff on PATH related topics and evidence-based practices.

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 ICCAP is not required to follow 42 CFR Part 2 Regulation since our program does not operate any substance abuse 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 new supervisor and the liaison will be trained in HMIS. Currently 100% of PATH client information is entered into the PA HMIS system.

Our new Housing Liaison recently attended the training in State College, PA and will continue to be trained on HMIS as training is available. She will also be working with staff currently using the HMIS system for other housing programs to train. The Housing Liaison will be responsible for entering client data in the HMIS system and the new Community Services/Resource Director will be responsible for supervision of the Housing Liaison, pulling information for reports, etc. Note: Our Community Services/Resource Director resigned the first week in April. Therefore, we are in the process of hiring a new director who will oversee the PATH program. The Director will also be trained to utilize the HMIS system.

## **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 Housing Liaison 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. We will continue to provide rental assistance, limited transportation, referrals and other services needed to help our residents. ICCAP fully supports the overall PATH Goals of the Armstrong-Indiana Behavioral and Developmental Health Program.

## **Alignment with State Mental Health Services Plan**

ICCAP, in working with the Armstrong-Indiana Behavioral and Development Health Program (BDHP) intends to and continues 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. PATH's Housing Liaison, 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 plan and Assessment application process, the Liaison will continue to help consumers access and apply for needed services; coordinate the delivery of services; provides follow-up and monitors progress towards 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”. All agencies/organizations having a vacancy in one of their housing programs or rental units will send out an email across the state posting their housing opening. With all homeless being entered into HMIS system the goal is that those most vulnerable will be housed first. Once implemented, ICCAP and the Housing Liaison will be implementing the Coordinated Plan and using the Application/Assessment tool for all that are homeless or imminently homeless.

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.

### **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.

### **Other Designated Funds**

Indiana County in the state of Pennsylvania is not a Block Grant county. The Indiana County Community Action Program does, however, have other funds designated to assist those who experience homelessness and also have a serious and persistent mental illness. Those funds include the following:

- HUD Grants Yearly (\$126,000)
- Housing Assistant Program (\$152,894)
- Emergency Solutions Grant Rapid Re-Housing (\$62,400)

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

Our new Community Services/Resource Development Director and the Housing Liaison will be SOAR trained when training is locally available. ICCAP is also planning on having another case manager working with homeless individuals trained as a SOAR advocate. ICCAP had two

PATH funded trained in SOAR during the grant year ending in 2016. In grant year 2015-2016, a total of 4 PATH funded consumers assisted through SOAR. One of those four were granted benefits just as this plan was being written.

## **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, Project PHD, homeless case management. The Housing Liaison position has become an added position member of the ICCAP Housing team in April 2013.

The Liaison uses a housing assessment to identify barriers to housing and then work 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.

## **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

application which is to be implemented in the fall of October 2016. 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 Housing Liaison works very closely with one of ICCAP's Homeless Shelter staff who also works at the Indiana County Jail. Together, they help consumers who have gone through the justice system access and apply for needed services. Both the Housing Liaison and our shelter staff person (representing Indiana jail) attend monthly 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. The percentage of PATH clients who also have a criminal history is approximately 20%.

### **Staff Information**

The program is staffed by a full-time Housing Liaison, housed in the main office at 827 Water Street, Indiana. PATH program staff are currently 100% Caucasian females. The Liaison is supervised by the Community Services/Resource Development Director and will be part of the agency housing team. The liaison has a Bachelor's degree and experience in mental health; this experience will be supplemented through supervision. The liaison will attend SOAR trainings, 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; the program supervisor does have training in this area. In addition, we rely on the nearby Indiana University of Pennsylvania 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 Housing Liaison 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 60%. Based on FY 2015-2016 data, 89.36% of the individuals enrolled in the PATH program were white, 6.38% were African American, 2.13% were Multi-Racial, and 2.13% were Native Hawaiian or Pacific Islander. Of those enrolled, 51.06% were male and 48.94% were female. Finally, of all those enrolled, 34.04% of individuals fell in the category of being Transition Age (ages 18-30). The remaining 65.96% were over the age of 31.

### **Consumer Involvement**

The Housing Case Manager will regularly attend the monthly Consumer Support Program (CSP) meetings in Indiana County to solicit program improvement suggestions and assure that consumers are informed about the PATH program. In addition to the CSP, the Armstrong-Indiana Consumer and Family Satisfaction Team will be utilized to provide vital feedback concerning current housing needs and is also available to assist in creating surveys to assess future housing feedback.

Indiana PATH staff seeks out and welcome family involvement when working with PATH clients. What staff observes is that of those who are referred to the program (mostly through our agency’s emergency homeless shelter, Pathway), most lack any type of family support and rely on the support of our staff to assist them. However, for those who are still involved with their families, PATH staff strongly encourages ongoing communication and support with their family members. Necessary releases are signed so that families can be involved and informed as to progress made in helping the clients move forward with their recovery and self-sufficiency.

### **Health Disparities Impact Statement**

It is projected that 30% 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 Housing Liaison 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
<b>Direct Services: Number to be served</b>	16	4	4	4	4
<b>By Race/ Ethnicity</b>					
African American	<20	<5	<5	<5	<5
American Indian/Alaska Native	<20	<5	<5	<5	<5
Asian	<20	<5	<5	<5	<5
White	<12	<3	<3	<3	<3
Hispanic or Latino	<20	<5	<5	<5	<5
Native Hawaiian/Other Pacific Islander	<20	<5	<5	<5	<5
Two or more Races	<20	<5	<5	<5	<5
<b>By Gender</b>					
Female	8	2	2	2	2
Male	8	2	2	2	2
<b>By Sexual Orientation/Identity Status</b>					
Lesbian	unknown	unknown	unknown	unknown	unknown
Gay	unknown	unknown	unknown	unknown	unknown
Bisexual	unknown	unknown	unknown	unknown	unknown
Transgender	unknown	unknown	unknown	unknown	unknown

### 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 \$16,062 is being requested to provide from the full-time salary (69% 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 Is 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 \$7,064 is being requested to provide from the full-time fringe benefits of ICCAP's PATH/Behavioral Health Housing Liaison. Fringe benefits include the following costs: FICA (\$1,229.00), Workers Compensation (\$681.00), Pennsylvania Unemployment (\$508.00), Health Insurance (\$4568.00), Vision Insurance (\$35.00) and Life Insurance (\$43.00).

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 \$6,286; \$ 5,286 would be a one-time assistance to help consumers maintain housing and \$ 1,000 for security deposits. Total request for other expenses: \$6,286.00.

In-Kind:

In -kind services provided toward the project include the following items as outlined below at a value of \$73,290.

County Match (on State allocation)

Administrative Expenses \$ 6,981

Other travel	\$ 2,000
Additional Funding for Rental Assistance to Applicants (Reinvestment \$5,000 Housing Assistant Program \$ 59,309)	\$64,309

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 \$ 341,294 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.

**BUDGET TABLE**  
Indiana County Community Action Program, Inc.

PATH Program  
FY 2014-2015 Budget

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing Case Manager/ Admin costs	23,278	.69 FTE	16,062	16,062
<b>sub-total</b>			<b>16,062</b>	<b>16,062</b>
<b>Fringe Benefits</b>				
Fringe Benefits			7,064	7,064
<b>sub-total</b>			<b>7,064</b>	<b>7,064</b>
<b>Travel</b>				
Local Travel for Outreach			400	400
Travel to training and workshops			100	100
<b>sub-total</b>			<b>500</b>	<b>500</b>
<b>Equipment</b>				
(list individually)				
<b>sub-total</b>				
<b>Supplies</b>				
Office Supplies				
Consumer-related items				
<b>sub-total</b>				
<b>Other</b>				
Staff training				
One-time assistance to maintain housing			5,286	5,286
Security deposits			1,000	1,000
Postage				
<b>sub-total</b>			<b>6,286</b>	<b>6,286</b>
<b>Total PATH Budget</b>			<b>\$29,912</b>	

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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 42,708	\$ 14,236	\$ 56,944	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 42,708	\$ 14,236	\$ 56,944	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 42,708	\$ 14,236	\$ 56,944	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 42,708	\$ 14,236	\$ 56,944	

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Home Nursing Agency will receive \$56,944 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 95 Estimated Number of Persons to be Enrolled: 85

Estimated Number of Persons to be Contacted who are Literally Homeless: 11

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

## **Blair County Human Services Office – PATH Intended Use Plan**

Home Nursing Agency  
201 Chestnut Ave.,  
Altoona, PA 16601  
PDX: Home Nursing Agency  
**2016-2017**

### **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.

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 \$56,944 during 2016-2017 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 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 for the PA Eastern Continuum of Care Collaborative. In the last funding round for HUD, we received the maximum points allowed on renewal applications for our RHAB/CoC participation. 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.

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).

## **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 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 one of the free clinics 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
Intensive Case Management	Home Nursing Agency
Resource Coordination	Home Nursing Agency
Children's Case Management	Home Nursing Agency
Outpatient Psychiatric Clinics	Primary Health Network
Crisis Center	UPMC Altoona



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 nearing 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.

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.

When we receive a referral or a telephone inquiry from a military family, the first thing we do is contact our local Veteran Affairs to make sure that they have access to all military benefits that are available to them. PATH staff will work with our local Veterans Administration staff to identify available resources and learn the referral process for members of the military, veterans and their families. Homeless staff from the Altoona Veteran's Administration has attended our Blair County Local Housing Options team meetings and HNA staff attends VA round-table meetings to coordinate housing efforts on a quarterly basis. We will also review current inventory of existing SAMHSA toolkits and ensure awareness of these toolkits by PATH staff for use with Veterans who are experiencing housing issues.

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 between the hours of 9:00 AM and 2:00 PM 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 homeless 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. PATH staff is involved with the local Community Support Program (CSP) and encourage participation of people receiving PATH services. 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 on evidence based practices, such as: Motivational Interviewing, Supportive Employment and Supportive Housing.

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.

## **Data**

HNA has been utilizing HMIS for at least 7 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. PATH staff recently participated in a one and half day training on HMIS technical assistance provided by Homeless and Housing Resource Network.

HNA has been utilizing HMIS for the last 7 years. We recently attended an on-site training for HMIS technical assistance and are educated on new definitions and reporting measures. We plan to implement these in 2016-2017. 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 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. Our new PATH Housing Coordinator will be trained at the next available training. 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 two HUD funded permanent housing programs 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 which serves as a day/drop in center focusing on socialization goals. HNA has a small social rehabilitation program that we are looking to expand over the fiscal year.

### **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. . 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.

### **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.

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.

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

HNA has recently hired a new PATH Housing Coordinator and are planning to have him SOAR trained in 2016-2017. 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 HUD funded facility for homeless individuals in the mental health system. 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. In 2016-2017 HNA plans to have all housing staff including the PATH coordinator 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 individuals 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 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 and are in the discussion phase of a coordinated entry program. We are also in the discussion phase of implementing The Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) in our own housing continuum within HNA. With PATH being our “clearing house” to all of our other housing programs, staff would be able to assess and prioritize the most vulnerable of our homeless population.

### **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**

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 48 years. Blair County has a population of about 125,593, 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. In our last annual report, HNA PATH staff served: 71 individuals in PATH; 38 male, 33 female, 23 report having a co-occurring substance abuse disorder, 62 identify as Caucasian, 8 identify as African American and 1 identifies as being two or more races. The majority of the people served were between 18 and 49 years of age with 3 between the ages of 18-23, 11 between 24-30, 37 individuals between 31-50, 19 between 51-61 and 1 being over the age of 62. Two of the enrolled individuals were veterans.

About 12% 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 12% 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 economic changes in the community. HNA projects to contact 95 individuals and enroll 80 into our PATH program based on the economic situation of our area. This is an increase from actual served in the 15-16 fiscal year and will be possible with the new staffing pattern in PATH.

### **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 which currently 7 people who have identified themselves as individuals who have received mental health treatment. 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 6 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.

### **Budget Narrative**

See attached for the 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 28% of the personnel expenses.

Travel:

The travel has increased and totals \$2,324 for the year. This allows us 4,000 miles for the year for direct PATH services and 300 miles for training and in-service. The mileage is reimbursed at .54 per mile.

Supplies

Our office supply cost is minimal and we approximate rent of \$1,314 per 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:

Administrative Expenses are at 4% of the PATH allocation which is \$2,278. 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** \$56,944. With the current Budget, this would leave us in a deficit of \$1,392 which we will have no problem expending throughout the fiscal year without new staffing plan.

BUDGET TABLE

Blair County  
Home Nursing Agency  
PATH Program  
FY 2016-2017 Budget

\*Please add additional rows as necessary

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>PATH TOTAL</b>
<b>Position</b>				
Housing Coordinator	27,359	1	27,359	27,359
Housing Supervisor	37,869	.35	13,254	13,254
<b>sub-total</b>	65,228	1.35	40,613	<b>40,613</b>
<b>Fringe Benefits</b>				
FICA Tax				3,638
Health Insurance				4,873
Retirement				2,437
Life Insurance				406
<b>sub-total</b>				<b>11,354</b>
<b>Travel</b>				
Local Travel for Outreach	2,777 miles			1,500
Travel to training and workshops	300 miles			162
<b>sub-total</b>	3,077 miles			<b>1,662</b>
<b>Equipment</b>				
Cell phone	900			900
Record Retention	250			250
Books, dues				
<b>sub-total</b>				<b>1,150</b>
<b>Supplies</b>				
Office Supplies				
Rent for Office Space	1,314			1,314
Consumer-related items				
<b>sub-total</b>				<b>56,093</b>

<b>Other</b>				
Administrative Expenses	2,243			2,243
Staff training				
One-time rental assistance				
Security deposits				
<b>sub-total</b>				<b>2,243</b>
<b>TOTAL</b>				<b>\$58,336</b>
<b>Total PATH Budget</b>				<b>\$56,944</b>
				<b>(1,392)</b>

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>a. Personnel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>c. Travel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>d. Equipment</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>e. Supplies</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>f. Contractual</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>g. Construction (non-allowable)</b>				
<b>h. Other</b>	\$ 46,874	\$ 15,625	\$ 62,499	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 46,874	\$ 15,625	\$ 62,499	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 46,874	\$ 15,625	\$ 62,499	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
<b>j. Indirect Costs (Administrative Costs)</b>	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 46,874	\$ 15,625	\$ 62,499	

Source(s) of Match Dollars for State Funds:

PennDel Mental Health Center will receive \$62,499 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 200      Estimated Number of Persons to be Enrolled: 140  
 Estimated Number of Persons to be Contacted who are Literally Homeless: 60  
 Number Staff trained in SOAR in Grant year ended in 2014: 0      Number of PATH-funded consumers assisted through SOAR: 3

**Penndel Mental Health Center  
Projects for Assistance in Transition from Homelessness  
Intended Use Plan  
2016-2017**

**Local Provider Description**

The contracted agency for the Bucks County PATH program is Penndel Mental Health Center (PMHC), located at 919 Durham Road, Penndel PA 19047. PMHC is a nonprofit agency that provides mental health services to individuals who reside in the southern region of the county. The services provided by the agency for individuals who are diagnosed with severe and persistent mental illness, include housing outpatient treatment, Partial Hospitalization, Targeted Case Management, Community Treatment Team, Forensic Support Program, and Peer Support. The PATH program works with adults over the age of 18, many of whom are “literally” homeless or in imminent danger of becoming homeless. Bucks County is located in southeastern Pennsylvania.

The PATH program will receive \$62,499.00 in federal and state funds for the fiscal year 2016-2017.

**Collaboration with HUD Continuum of Care**

The PATH program staff are members of the Housing Continuum of Care of Bucks County (HCoC-BC) and participate on a number of subcommittees including the Local Housing Options Team (LHOT), Data Management, and SSI/SSDI Outreach Access and Recovery (SOAR). Through the HCoC-BC and its various subcommittees, the PATH program contributes to the ongoing formulation of the mental health housing plan and will assist in the HCoC-BC strategic plan. PATH also provides data and reports utilization of funding and supports provided in the HCoC-BC's HUD annual homeless assistance application.

In terms of specific collaboration with HCoC-BC members, PATH staff participated in the annual HUD unsheltered homeless point in time count at the end of January 2016 during which 30 unsheltered individuals experiencing homelessness were identified. PATH has continued to provide support for the Code Blue emergency shelter effort run by the Advocates for the Homeless and Those in Need (AHTN) which ran from December 1, 2015 through March 31, 2016. PATH is a referent for the Bucks County Housing Link program which is Bucks County's centralized intake and assessment program for the homeless. PATH has assisted the Housing Link by completing intake assessments, which includes completing the Service Prioritization and Decision Assistance Tool (SPDAT) thus expediting the intake process for individuals who are referred. PATH also collaborates with the Bucks County Housing Group on several projects, including a Shared Living Program and a four unit Shelter Plus Care program.

In January 2015 the County Commissioners created the Bucks County Housing Advisory Board (HAB), which includes seven public and fourteen private community stakeholders. The HAB

engaged in a year long process which developed a strategic plan to ensure the housing stability of Bucks County residents experiencing homelessness, most at risk of becoming homeless, or who are challenged by housing affordability and options. This plan is currently under the review of the Bucks County Commissioners and is expected to be released early summer 2016. This plan is expected to include strategies and recommendations to include the following:

- Transformation of the County's housing crisis response system
- Delivery of consumer-driven and appropriate services and supports to maintain permanent housing stability
- Strengthening coordination, efficiency and effectiveness across systems, sectors and programs
- Expansion of housing opportunities throughout Bucks County. In PATH's collaboration with the HCoC-BC, coordination with the HAB's overarching goals will occur.

As the strategic plan is rolled out in Bucks County the Bucks County Department of MH/DP and the PATH program will coordinate our program development efforts.

### **Collaboration with Local Community Organizations**

The PATH program continues to work closely with a number of local organizations. Chief among them would be those organizations that directly address the homeless. This includes the Bucks County Emergency Shelter and the Bucks County Housing Group. Together these two organizations provide the vast majority of shelter beds and housing related programs in the county. PATH also collaborates with organizations such as AHTN (Advocates for the Homeless and Those in Need), which operates the Code Blue Shelters in the lower end of the County and Sunday Breakfast Mission, which has a men's shelter in Philadelphia, which is accessible to residents of Bucks County. The Mission has a Bucks County Outreach Worker who will often collaborate with PATH on more difficult cases. Additionally, PATH has also developed a relationship with The Mental Health Association of Southeastern Pennsylvania's Bucks County Homeless Outreach, Support and Transition team (HOST) program which does outreach to homeless individuals throughout the county. PATH also assists HOST with resources, technical assistance and funding for some of their participants.

PATH has also begun work with the Bucks County Veterans Assistance Team, which is a new workgroup of the HCoC-BC, which works to collaboratively address the needs of homeless veterans. When an individual identifies themselves as a veteran PATH will reach out to the local veterans groups that assist the homeless. PATH will continue to work in concert with the Disabled American Veterans and the Philadelphia area VA which has a homeless outreach team. With regard to accessing behavioral crisis services, PATH works closely with Lenape Valley Foundation's Crisis Services and the Mental Health Unit of Lower Bucks Hospital which serves this area of the county. These organizations address the majority of psychiatric emergencies in the lower end of the County and these situations can often involve homelessness as a major component. These programs also coordinate with PATH to assist individuals who present to crisis, and are in need of housing support. In addition PATH works with mental health providers such as Lenape Valley Foundation, Penn Foundation, Family Services Association and Northwestern Human Services. PATH also has relationships with drug and alcohol treatment

facilities such as Aldie, Livengrin and Gaudenzia House, which provides non-hospital detoxification, non-hospital rehabilitation and assessment. PATH works with other providers of housing such as Recovery Houses, Community Residential Rehabilitation (CRRS), Personal Care Boarding Homes, Motels, and Rooming Houses.

PATH works in collaboration with the above providers to ensure continuity and coordination of care and services for individuals who are homeless. PATH will continue to build relationships with local community organizations and provide direct service and technical assistance.

PATH has also worked with the Bucks County Community Support Program in producing a Homelessness Survival Guide, which has been distributed to providers of both the behavioral health system and housing provider system.

### **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

PATH case managers are mobile and meet the individual wherever they are. The PATH program is also designed to be easily accessible with the only eligibility requirements being that the individual have a mental illness or co-occurring disorder and be homeless or in imminent danger of becoming homeless. The predominant form of engagement is through motivational interviewing so that the individual's readiness for change informs the communication between the PATH worker and the individual, rather than the individual being forced to address something he/she may not want or be ready for.

In an effort to expand resources and utilize the expertise of other programs, PATH works with other agencies which also provide outreach such as AHTN, The Sunday Breakfast Mission, The Synergy Project, and MHASP's HOST Team. PATH partners with these agencies in providing services and to meet specific needs. These partnerships may include splitting the cost of a motel or covering moving costs. PATH has also worked with the HOST team in addressing encampments in the area and sharing manpower and financial resources. In this way PATH is able to maximize its services to the homeless. PATH also seeks out funding from other sources such as the United Way and wrote and was awarded a grant for \$3,150.00, which went towards funding for emergency motel stays.

- Describe any gaps that exist in the current service system

Bucks County continues to be challenged with the availability of affordable and accessible housing. The Bucks County HAB has been tasked with creating a plan to address this need. Presently PATH workers experience challenges with locating housing options for Transition Aged Youth (TAY), individuals with forensic histories, and those who have a co-occurring mental health and substance abuse histories.

The one emergency shelter in Bucks County is most often at capacity and has a typical wait period of six to eight weeks. Access for single males is limited and TAY individuals most often do not feel comfortable at the shelter. During the winter months the Code Blue shelters have

been able to accommodate additional individuals but once the weather becomes warmer many resort to living in encampments, abandoned buildings or cars.

TAY, especially those who have aged out of residential placement continue to present a challenge for Bucks County. There is a need for supportive housing that helps to usher these homeless youth into adulthood and gives them the tools to eventually live on their own. There are several newer service opportunities available for TAY, which will be described in further detail in number eleven.

- Provide a brief description of the current services available to clients who have both a serious mental illness and a substance abuse disorder

Bucks County's residential program designed to specifically serve individuals with a mental health substance abuse diagnosis is Penn Foundations Village of Hope program. This program has a total of sixteen beds, which includes eight beds for males and eight beds for females. While this program is the ideal program to serve individuals with a co-occurring diagnosis it certainly is not the only program capable of supporting people with a co-occurring history. Bucks County MH/DP residential programs will also work to develop individualized residential recovery plans inclusive of substance abuse service needs.

Generally PATH refers individuals who are in need of drug and alcohol rehabilitation to Aldie Counseling or Livengrin or Gaudenzia for assessment. Aldie Counseling, Livengrin, the Southern Bucks Recovery Center and Gaudenzia House also have inpatient, outpatient and detoxification programs available. With regard to case management, the Council of SEPA provides intensive case management to individuals who have substance abuse issues. Some individuals may qualify for case management through mental health agencies as well.

- 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 migration of PATH data into HMIS

PATH case managers are required to have 20 hours of training annually. This training includes evidence-based training in areas such as cultural competence, trauma informed care, co-occurring disorders, supported employment, and motivational interviewing. PMHC provides the funding for these trainings.

In January 2016, two of the three PATH workers attended a training on Critical Time Intervention and in June 2016 PATH employees will be invited to attend a full day conference focused on meeting the needs of TAY.

With regard to HMIS training, the Bucks County Department of Housing and Community Development has provided ongoing technical assistance to the Bucks County Department of MH/DP and the PATH program in an effort to support full implementation of HMIS for all PA PATH programs by July 1, 2016. Additionally the PATH program attended the statewide PA HMIS PATH training in April 2016.

- Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations

Not applicable.

## **Data**

The PATH program currently participates in PA HMIS. The DCED is the HMIS system provider for Bucks County and is able to provide ongoing training and support to those County agencies that currently participate in HMIS. Over the past year the Department of Bucks County Housing and Community Development has provided ongoing support to the PATH program in the form of local trainings at no cost to the participating agencies and technical support from their HMIS Coordinator.

Recent attendance at the Statewide PA HMIS required training provided the Bucks County PATH program with additional insight in ways to make data entry in PA HMIS and their agency electronic health records more achievable.

## **Alignment with PATH goals**

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

“The goal of the PATH Program is to reduce or eliminate reduce homelessness for individuals with serious mental illness or co-occurring serious mental illness and substance use disorders or who are at imminent risk of becoming homeless.”

The Bucks County PATH program is a seasoned program and is well aware of the overarching goals of PATH programs nationwide. PMHC’s PATH program will continue to focus efforts to reduce and eliminate homelessness for individuals with a serious mental illness and substance use disorder with a heavy focus on street outreach, case management and other services as individually identified. The Bucks County PATH program has a 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.

PATH also provides the following services:

1. Screening and diagnostic treatment
2. Staff training
3. Habilitation and rehabilitation
4. Case Management
5. Outreach
6. Referrals for primary health care, job training, educational services and other relevant housing services
7. Supportive and supervisory services in residential setting

8. Housing services to include: Minor renovation, expansion and repair of housing, security deposits, one time rental payments to prevent eviction, and costs associated with matching eligible homeless individuals with appropriate housing

### **Alignment with State Mental Health Services Plan**

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 mental illness with a co-occurring substance abuse disorder. 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 whether that is in an abandoned building, a wooded area, a psychiatric hospital or prison. The PATH program helps the individual overcome barriers to housing such as a lack of income including employment, inadequate mental health and substance abuse treatment, lack of affordable housing, and the lack of transportation.

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. PATH can also render financial assistance in several ways; PATH can provide help with move in costs by providing security deposits or first month’s rent, assistance with rent arrearages to prevent eviction or funding the cover application and inspection fees. In these ways the PATH program is in alignment with the State MH plan to create more opportunities for safe and affordable housing.

In recognition of the critical need to integrate disaster preparedness and emergency planning for all residents, the Bucks County Department of MH/DP has 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). Presently this staff chairs the Mental Health sub-committee of this task force. Together these workgroups coordinate trainings for emergency preparedness and planning for our volunteer response teams and mental health program employees for the southeast region, which includes employees of the PATH program.

Bucks County has identified several upcoming trainings that PATH employees will be encouraged to attend. This includes the following:

- “Working with the Community in the Wake of Violent Events, Advanced Skills Training”, June 2, 2016
- “Skills for Psychological Recovery”, date to be determined
- Regional Disaster Response Drill, fall 2016

All of the above opportunities will assist PATH employees to increase staff competencies and support effective responses to disasters and emergencies and enhance planning development in

this area. MH/DP staff who assists in the coordination of the above events is aware of the required measures needed to contact the State Behavioral Health Coordinator for planning and emergency response needs.

### **Alignment with State Plan to End Homelessness**

In the report Homelessness in Pennsylvania: Causes, Impacts, and Solutions the Joint State Government Commission found that a number of factors were associated with homelessness: the lack of affordable housing, domestic violence, unemployment, insufficient job training, poverty, mental illness and substance abuse.

With specific regard to mental illness, the report found that 20 to 25 percent of the homeless population in the United States suffers from some form of severe mental illness. Of those who are chronically homeless it is estimated that 30 percent suffer from a serious mental illness and two thirds have a co-occurring disorder or other serious health problem.

The PATH program is designed to reach out and engage the homeless mentally ill by going out to where they live and engaging them in a thoughtful and respectful manner, establishing a rapport and building trust. The PATH program at Penndel Mental Health Center has two case managers, one of whom is a trained Peer Specialist who meet with the consumer wherever they may be, a car, an abandoned building, an encampment in the woods, and work to assist the individual in building the life they want. PATH workers connect these individuals to needed benefits such as Medicaid, Medicare, SSI/SSDI, employment and vocational training, emergency food and shelter.

The program performs both “in reach” and “outreach.” In reach refers to the contact PATH makes with other organizations that come in contact with the homeless, such as the local crisis intervention center, hospitals and other community action agencies. PATH workers inform these agencies about the program and about the things PATH can provide for the homeless clients that are encountered. In reach helps to expand and maximize the impact that PATH has in a county where if a homeless person doesn’t want to be found they probably won’t be found. The in reach efforts have led PATH workers to numerous encampments and individuals who need PATH help and assistance. In reach greatly helps in our outreach efforts where the PATH workers go out and look for homeless individuals, individuals who in a county like Bucks which is largely rural are difficult to locate.

PATH works to help eliminate the barriers to housing that are talked about in the report, PATH workers will assist clients locating employment or vocational training, PATH workers will assist clients through SOAR in obtaining social security benefits, PATH workers also will connect clients to Mental Health and Substance Abuse treatment. PATH works with clients who come out of the State Prison system through the County’s SCI Max-Out Program, inmates who are completing their sentences are connected with PATH several months before their release date and PATH will work with the Correctional Institution to transition the inmate back to his home community. This often involves locating housing, reestablishing Social Security and Health Insurance, and reconnecting the client to Mental Health or Substance Abuse Treatment. The PATH program of Bucks County is definitely in alignment with the goals of the State plan to end

homelessness in that PATH directly addresses a number of factors that the State found contribute to homelessness, specifically: poverty, lack of employment or training, and lack of Mental Health and Substance Abuse Treatment, and the elimination of chronic homelessness.

### **Other Designated Funds**

Bucks County MH/DP has continued to designate funds towards enhancing the PATH program. It is anticipated that \$162,850.00 of Block Grant funds will continue to be identified for PATH in addition to \$6,892.00 of county funds.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

At the current time all PATH staff have been trained in SOAR techniques. Three SOAR applications had been initiated to assist individuals to obtain SSI/SSDI benefits over the past year. One applicant received benefits while the other two did not complete the application process; PATH staff were unable to locate these individuals to do so. As new staff are hired they will be scheduled to take the online training and participate in relevant webinars provided through SAMHSA's Homeless and Housing Resource Network (HHRN).

### **Housing**

PATH begins with an assessment of an individual's strengths and needs. Through conversations with the PATH participant, past housing successes are explored in addition to the person's stated preferences. In an emergent housing situation, the PATH worker will try to secure an emergency shelter or provide funding to prevent an eviction from occurring. Sometimes a motel may be utilized for a few days as a bridge from one housing situation to another. Once an individual is established in stable housing, the PATH worker will help the individual organize required paperwork and verifications, such as a birth certificate, social security card, and photo identification and assist him/her to apply for health insurance, food stamps, cash assistance, etc. The PATH worker will also identify housing resources that may be available and assist him/her to apply for these programs. At this juncture, PATH will begin looking at more permanent housing options with the individual. The individual's personal preferences as well as financial resources, ability to live independently, and behavioral health and physical health needs are considered and will play a role in the type of housing that is available. If the individual needs a more supportive housing option, PATH will make referrals to Community Residential Rehabilitation Services (CRRS) or Supported Living Programs (SLP). If the individual is able to live more independently, an option such as Bucks County Housing Group's Shared Living Program may be an appropriate resource. The Shared Living program is an arrangement where two or three individuals share an apartment and utility expenses in order to increase rent affordability. PATH also makes referrals to the extensive network of recovery houses in the area for individuals who are diagnosed with mental health and co-occurring substance abuse disorders.

Agencies and providers that are primary sources of housing for PATH are:

- Bucks County Emergency Shelter
- Lenape Valley Foundation Acute Respite Care Program
- Penn Foundation Village of Hope MH/DA SLP
- Penn del Mental Health Center CRR and PSH
- COMANS – Residential Program (CRR’s and SLP)
- NHS Human Services of Bucks County – (CRRS and SLP)
- Days Inn Motel – Emergency Housing
- Village Lodge Motel – Emergency Housing
- Bucks County Housing Group – Shared Living Program
- Sunday Breakfast Rescue Mission Shelter

### **Coordinated Entry**

Bucks County operates a system called the Housing Link, which is the County’s coordinated housing entry program. Residents experiencing homelessness or a housing crisis may contact the Housing Link via an 800 number. The Housing Link Call Center staff will screen all callers with a brief interview to determine the households’ general eligibility for housing assistance. The results of the brief interview will be sent to the Housing Link Coordinated Assessment 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 as well as a referral to available resources and housing options. Agencies involved in the Housing Link include Family Services Association, Bucks County Housing Group, Bucks County Opportunity Council, and the Keystone Opportunity Center. PATH is a participant as one of the referral agencies and often assist with completing the required SPDAT assessment in the field and forwards the information to the assessment center. This is often needed as the homeless individual may not have transportation or even a phone where they can be contacted. The Housing Link is a collaboration of the above agencies and is under review for additional support through the Department of Housing and Community and the Human Services Department.

### **Justice Involved**

PATH collaborates with the Bucks County Department of MH/DP with State Correctional Institute (SCI) Max-Out Program. The county identifies individuals who are completing their term of incarceration at an SCI and are returning to their home communities, often with no resources for support. PATH will engage with these individuals when they have 3 to 6 months remaining on their sentences and begin the development of a reentry plan. PATH assists individuals in the transition back into the community by arranging behavioral health treatment, locating and funding temporary or permanent housing, and assisting with re-establishing benefits such as social security income. PATH also works with individuals being released from the county jail system or who may be involved with Probation/Parole. If the individual allows PATH

to contact their Probation or Parole officer, and will work with them to assist the client in addressing their situation.

Over the next year PATH will identify ways to strengthen their collaboration with the Forensic Service Program, which is a tract within PMHC's Community Treatment Team. Services include individual and group therapy, case management, housing support and peer support.

### **Staff Information**

The staffing of PATH is consistent with PATH demographics and consist of a 79 year old Caucasian male, a 57 year old African-American male, and a 46 year old Caucasian male. The 46 year old is a Certified Peer Specialist who has the lived experience of homelessness. In keeping with PMHC policy, all individuals are treated with dignity and respect and PMHC has recently begun agency wide training in Trauma Informed Care, so that the entire Agency will better understand and recognize the Trauma individuals have experienced.

### **Client information**

In terms of demographics the vast majority of PATH participants are Caucasian equaling over 70%. Approximately 20% identify as African-American and 4% identify as Hispanic or Latino. The remaining individuals identify as being two or more races. In terms of gender, 51% of the individuals identify as female. With regard to age the majority of individuals are between the ages of 31 to 50 years of age, and approximately 50% present with co-occurring substance abuse. We anticipate contacting between 175 and 200 individuals this upcoming fiscal year. We also expect to enroll about 140 individuals with 50-60 being literally homeless.

### **Consumer involvement**

PATH has a Board of Directors that includes a member with mental illness and family members of individuals who are also receiving behavioral health services. The board is regularly apprised of the activities of the PATH program. One of the PATH case managers is also a Certified Peer Specialist and utilizes his lived experience with homelessness and behavioral health issues. As mentioned above, PATH has also worked with the Bucks County Community Support Program in producing a Homelessness Survival Guide.

It has been a goal of PATH to create an alumni group of former PATH participants who will be asked to provide feedback regarding their service experience. The PATH mentors will reach out to current PATH individuals offer support and assistance. Several former clients have also provided assistance during the annual Point-in-Time count.

## Health Disparities Impact Statement

- The unduplicated number of TAY individuals who are expected to be served using PATH funds

In the last PATH annual report, 17 TAY individuals were enrolled out of 138 (about 12% of the total). It is hoped that PATH can increase outreach to 20-25 TAY individuals

- The total amount of PATH funds expected to be expended on services for the TAY population

It is expected that the amount of PATH funds expended on TAY individuals will be 10 - 12 percent of the total

- The types of services funded by PATH that are available for TAY individuals

The type of services available to TAY individuals mirrors the services available to adults; linkages to benefits such as social security, health care, employment, education, emergency housing, etc. PATH continues to work with TAY serving agencies mentioned below.

- 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

At present the PATH program does not specifically seek out the TAY population and serves TAY along with adults. As with the adult homeless population in Bucks County, the most difficult aspect of serving the TAY is identifying their location. Over the past several years, PATH has developed contacts with community organizations that serve the homeless adult population and this “in reach” strategy has allowed PATH to locate and serve those individuals who live “off the grid” in encampments, abandoned houses, under bridges, etc.

Because Bucks County is such a large geographic area, pure street outreach is difficult. Employing a referral driven strategy or “in reach” should also be a more effective strategy for locating homeless youth. Cultivating referrals from teachers, residential programs, probation officers, and Children and Youth will help to connect youth with PATH outreach. Additionally, Bucks County has a dedicated shelter for youth, through the Valley Youth House’s Synergy Project. This program offers assistance for runaway, homeless, nomadic & street youth and can connect youth with shelters/housing or help youth with basic necessities (such as food and clothing).

Once outreach contacts are established, PATH will work to reduce the barriers to housing by meeting the clients where they are, establishing trust and rapport and making appropriate and safe referrals to resources and services; in particular, programs which serve and advocate for youth. Developing partnerships with such organizations and establishing a referral network is

especially important for TAY as they may not have the knowledge or sophistication to navigate the service system. PATH can be a valuable source of information and support in this regard.

Within the past few years Bucks County's efforts to focus on the unique needs of serving and supporting TAY and young adults has gained momentum. Available to Medical Assistance eligible youth, the Transition to Independence Program (TIP) assists youth between the ages of 16-26 years of age plan for their future and build upon their strengths. Additionally the MH CRR program has identified 9 beds specifically for TAY.

Now in its second year, Bucks County continues numerous initiatives with its Now Is The Time – Healthy Transitions Grant. Some key components of this grant include the development of a Youth Shared Living Program, Youth Mental Health First Aid train the trainer series, and the expansion of a TAY specific HiFi team. More recently a full day conference has been developed that will focus on engaging and retaining youth in service and identification of early onset mental health conditions.

**Budget narrative** – see below

**Personnel:**

This component of the budget is **\$41,246**. The personnel costs that are supported by PATH dollars represent 5% of the Director’s salary, 20% of the Coordinator’s salary, and 40 % of two case manager salaries.

**Fringe Benefits:**

Fringe benefits are calculated at 23.75% @ of total salaries (equal **\$9,796**) and include FICA, unemployment compensation, health and dental benefits, accidental death & disability/life insurance as well as short term/long term disability.

**Travel:**

The costs for travel are at **\$2,945**. The costs for staff travel include local travel for outreach and travel to training and workshops. Client travel includes the cost of vehicle fuel, maintenance and repairs.

**Supplies:**

The total budget for supplies for 2016-2017 is **\$1,641**. This includes \$641 for office supplies necessary to run the program. Client-related supplies (\$1,000) include those supplies necessary for clients to be able to occupy housing on a successful basis.

**Other:**

The total budget figure for one-time housing rental assistance, security deposits, assistance in obtaining housing, and staff training for 2016-2017 is **\$4,467**.

**Indirect Cost:**

Administrative cost at 4% of total direct costs **\$2,404**

**Total Federal PATH Allocation.....\$62,499**

Bucks County Department of Mental Health/ Developmental Programs  
 Pennadel Mental Health Center, Inc.  
 PATH Program  
 FY 2016-2017 Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
<b>Position</b>				
Dir-Path Program	\$ 83,646	.05	\$ 4,182	
Coordinator	51,061	.20	10,212	
Case Manager	38,570	.40	15,428	
Case Manager	28,561	.40	11,424	
<b>Subtotal</b>				\$ 41,246
<b>Fringe Benefits (@ 23.75%)</b>			\$ 9,796	
<b>Subtotal</b>				9,796
<b>Travel</b>				
Staff travel: local travel for case mgrs.			\$ 300	
Client travel-motor vehicle/repairs/maint.			2,645	
<b>Subtotal</b>				2,945
<b>Supplies</b>				
Office supplies			\$ 641	
Client-related supplies			1,000	
<b>Subtotal</b>				1,641
<b>Other</b>				
One-time housing rental assistance			\$ 1,063	
Security deposits			1,400	
Assistance in obtaining housing-client travel exp.			1,058	
Staff training			946	
<b>Subtotal</b>				4,467
<b>Total Direct Charges</b>				\$ 60,095
<b>Indirect Costs State Administrative Cost @ 4%</b>				2,404
<b>Total</b>				\$ 62,499

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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 74,287	\$ 24,762	\$ 99,049	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 74,287	\$ 24,762	\$ 99,049	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 74,287	\$ 24,762	\$ 99,049	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 74,287	\$ 24,762	\$ 99,049	

Source(s) of Match Dollars for State Funds:

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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**BUTLER COUNTY HUMAN SERVICES**  
**2016-2017 COMPREHENSIVE PATH INTENDED USE PLAN**

**124 West Diamond Street**  
**Butler, PA 16001**

**Local Provider Description:**

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. Historically, PATH funds have been contracted to Catholic Charities and Center for Community Resources, Inc. to support our permanent supportive housing programs but effective July 1, 2016 we intend to support Catholic Charities and the Grapevine Center with PATH funding to be more in align with PATH goals and reach a larger number of eligible individuals.

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 2016-2017 is \$99,049, with \$74,287 in federal funds and \$24,762 in state funds. Catholic Charities will receive \$86,413 and the Grapevine Center, Inc. will receive \$12,636.

**Collaboration with HUD Continuum of Care (CoC) Program:**

Butler County is one of twenty counties to make up the new Western CoC 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. There are five representatives from Butler County's Local Housing Options Team (LHOT) on this regional committee, including the PATH County Contact, the Director of Service Integration and Community Action Director with Butler County Human Services.

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.

In addition, Butler County Human Services, Catholic Charities, and the Grapevine Center are active participants in the Community Homelessness Assessment, Local Education, and Networking Group (CHALENG) that is led by our local VA Medical Center. The VA Homeless Coordinator is an active member of our LHOT and it is common practice for our PATH providers to work directly with him, especially in regard to street outreach, to address the needs of homeless veterans in our community.

PATH providers also participate in coordination activities with other service providers on a daily basis. These organizations include Butler County Human Services, The Grapevine Center, Child Care Information Services, CareerLink, 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.

PATH providers also work directly with the Service Integration Committee (SIC), 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, to 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.

### **Collaboration with Local Community Organizations:**

In order to effectively serve PATH-eligible clients, the staff of Catholic Charities and the Grapevine Center strives to connect individuals to appropriate treatment and support services in the community. These connections to key services 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 and the Grapevine Center partner with in serving PATH-eligible clients:

- Salvation Army, the Lighthouse Foundation, and five (5) 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 (26) different food cupboards across the 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.
- Catholic Charities and the Grapevine Center staff assist 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, 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. Eligible clients are also assisted in applying for SSI/SSD through the Social Security Administration, as well as the local Veterans Administration Hospital for treatment and services when appropriate.
- 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.
- PATH eligible clients) are provided with assistance in accessing 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, the Lighthouse Foundation, Center for Community Resources, Inc. and Victim Outreach Intervention Center. Unfortunately, the various housing programs in Butler County are often full with waiting lists. In these instances, PATH service providers work with PATH eligible clients to identify other possible housing options, including family members, friends, housing with roommates, subsidized housing units, or independent permanent housing.

- 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.
- 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.

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. Additional referrals to the various programs mentioned above, are made with the permission of the person being served.

### **Service Provision:**

#### **Street Outreach and Case Management:**

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 regular basis. Outreach in Butler County is done on a weekly basis, with teams from Catholic Charities and the Grapevine Center alternating weeks. If an organization identifies a homeless individual or family while conducting outreach,

they are responsible for continuing to work to engage the individual or family and provide them with initial case management services until they are connected with housing through the Central Intake Department at Catholic Charities.

**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, PATH services are fully integrated into our local service continuum for individuals and families who are homeless or at significant risk of becoming homeless. This is one of the major target populations for Butler County Human Services and as such, significant resources, including funds from PATH, MH Base, HAP, CSBG, PHARE, Act 137, ESG and HUD CoC, are combined to ensure we have a comprehensive, quality array of services available. Specific services include connection to Veterans Administration, Social Security Administration, local medical assistance office, Office of Vocational Rehabilitation, furniture assistance, resume building/job search, life skills building and many more. 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. These services are funded by other resources within our system.

**Describe any gaps that exist in the current service systems.**

Currently in Butler County's homeless service system, the primary gap is safe affordable housing. This gap has become a major priority for Butler County Human Services, the recipient of PATH funds in Butler County. The Local Housing Options Team held a Housing Summit on November 2015 where housing needs were identified in our community. Butler County Human Services has taken this information to begin building a strategic plan over the next several years and has contracted with a nonprofit agency to complete a housing plan which will assist in identifying our current gaps, foreseen gaps and priorities now and moving forward. In addition, the LHOT is working on various strategies to build public/private partnerships to increase the stock of safe, affordable housing that is available to the people we serve. A few examples include that we are currently working to re-establish a landlord association for Butler County and to work with developers to implement various housing options that mimic recovery and supportive housing. The objective of the SW RHAB and of the Butler County Local Housing Team is to identify the gaps within our homeless service system and to work collaboratively to address these gaps.

**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 and the Grapevine Center will ensure that PATH-funded staff are appropriately trained and that they participate in ongoing training opportunities, including evidenced-based practices, in order to perform their jobs as effectively as possible. The organizations do this in a variety of ways which include: support of internal training done by senior staff for new staff, registration for free and paid trainings both onsite and through webinars and travel to trainings such as the 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 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.

### **Data:**

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). The PA HMIS administrators are David Weathington and Brian Miller.

### **Alignment with PATH Goals:**

**See Service Provision – Street Outreach and Case Management**

### **Alignment with State Mental Health Services Plan:**

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 Care 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.

### **Alignment with State Plan to End Homelessness:**

**See Service Provision – Outreach and Case Management**

### **Other Designated Funds:**

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 addition, Butler County does have an Assertive Community Treatment Team (ACT) which includes a housing specialist. The ACT is designed to work intensively with individuals with serious mental illness and the housing specialist is responsible for assisting participants that are identified as being homeless or at significant risk of becoming homeless.

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.

### **SSI/SSDI Outreach, Access and Recovery (SOAR):**

Currently, Catholic Charities and the Grapevine Center have no staff members trained in SOAR. Catholic Charities has lost SOAR trained staff as a result of staff turnover over the past several years and the Grapevine Center is newly funded for PATH. We acknowledge that increased emphasis is being placed on SOAR, will assign all PATH funded staff to take the online training and hope to work with the PATH state contact to arrange communication with our local social security office who is resistant to acknowledging the SOAR process. To date, three PATH funded consumers have been assisted through SOAR, and one person had been awarded benefits.

### **Housing:**

Butler County implemented a central intake and common assessment process approximately 1 ½ years ago in preparation for the Coordinated Entry Process that is being mandated by HUD. As a result, anyone seeking housing and homeless services is referred to Catholic Charities, the Central Intake provider to complete a common assessment. This assessment currently being utilized is the pilot assessment that was designed by the Coordinated Entry Committee designated by the Western Region CoC. Once the assessment is completed, the central intake case managers complete the VI-SPDAT and determine which programs in our system the person qualifies for, based on both eligibility and severity of need, and makes the referrals to those programs. It is not uncommon for individuals to be placed on a waiting list, as most often our homeless programs are at capacity. In this situation, the central intake case managers and PATH

case managers will pursue emergency housing and continue to provide the individual with supports and services until a more permanent housing becomes available.

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. If no other housing option is available, a literally homeless PATH eligible person or family would be referred to Safe Harbor or the Winter Relief Center, which are two emergency shelter options in Butler County for people faced with homelessness and continue to work closely with a PATH case manager to move toward the goal of a more permanent housing situation.

### **Coordinated Entry:**

The Western Region Continuum of Care, which Butler County is a part of, began the process of developing Coordinated Entry in April 2015. The Coordinated Entry Committee has met tirelessly to develop an assessment, policies and procedures and best practices that will encompass the 20 county region that the CoC encompasses. Currently, coordinated entry is in the pilot process, where 5 counties are testing the assessment and scoring, adding to the policies and procedures and providing feedback for adjustments and improvements. Butler County Catholic Charities is one of the selected pilot agencies working closely with the Coordinated Entry Committee on this process. The Western Region CoC fully intends to have all 20 counties utilizing the Coordinated Entry by October 1, 2016. This process is monitored on multiple tiers, through Regional Housing Advisory Boards, the Western Region Continuum of Care and HUD.

### **Justice Involved:**

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 three year strategic plan is in the final stages of completion which will hopefully make 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.

Catholic Charities and the Grapevine have also worked to identify, form and foster relationships with landlords and have identified several who will accept those who 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 renter, budgeting, and 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.

It is estimated that between 65-70 % of the PATH eligible individuals to be served at Catholic Charities and the Grapevine Center will report a history with the criminal justice system.

### **Staff Information:**

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.

### **Client Information:**

Catholic Charities and The Grapevine Center serve PATH-eligible clients of all ages, ethnicities, religions, etc. A majority of program participants are Caucasian (about 92%), 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 8% of people served are Black/African American. Approximately 42% of program participants are female and 58% are male.

It is projected that Butler County will use PATH funds to contact 783 adult clients and 600 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.

### **Consumer Involvement:**

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.

### **Health Disparities Impact Statement:**

#### **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 297 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 28% of the grant total or \$27, 733.

#### **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.

**Budget Narrative – see below**

**Butler County  
Comprehensive PATH Program  
FY 2016-2017 Budget Narrative**

**Personnel (Positions and Fringe Benefits)-** PATH funds in the amount of \$92,864 will be utilized to partially fund five positions, including salaries and benefits, 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.

**Travel-** PATH funds in the amount of \$836 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.

**Occupancy-** PATH funds in the amount of \$1,000 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.

**Administrative-** PATH funds in the amount of \$3,799 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  
PATH Program  
FY 2016-2017 Budget

\*Please add additional rows as necessary

	<b>Annual Salary</b>	<b>PATH- funded FTE</b>	<b>PATH- funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing and Homeless Case Manager	\$26,323.75	0.75	\$19,742.81	\$19,742.81
Housing and Homeless Case Manager	\$26,323.75	0.49	\$12,898.64	\$12,898.64
Housing and Homeless Case Manager	\$23,023.00	0.50	\$11,511.50	\$11,511.50
Safe Harbor Project Coordinator	\$33,322.38	0.31	\$10,251.95	\$10,251.95
Housing Engagement Specialist	\$9,000.00	0.25	\$9,000.00	\$9,000.00
<b>sub-total</b>				<b>\$63,404.90</b>
<b>Fringe Benefits</b>				
Housing and Homeless Case Manager	\$16,161.50	0.75	\$12,121.13	\$12,121.13
Housing and Homeless Case Manager	\$10,655.39	0.49	\$5,221.14	\$5,221.14
Housing and Homeless Case Manager	\$9,666.74	0.50	\$4,833.37	\$4,833.37
Safe Harbor Project Coordinator	\$20,357.33	0.31	\$6,283.46	\$6,283.46
Housing Engagement Specialist	\$1,000.00	0.25	\$1,000.00	\$1,000.00
<b>sub-total</b>				<b>\$29,459.10</b>
<b>Travel</b>				<b>\$836.00</b>
<b>Equipment</b>				<b>\$0</b>
<b>Supplies</b>				<b>\$150.00</b>
<b>Other</b>				
Occupancy				<b>\$1,000.00</b>
Communications				<b>\$400.00</b>
Administration				<b>\$3,799.00</b>
<b>Total PATH Budget</b>	<b>\$99,049</b>			

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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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Source(s) of Match Dollars for State Funds:  
 For source of match dollars for state funds: Catholic Charities will receive \$86,413 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 750 Estimated Number of Persons to be Enrolled: 575

Estimated Number of Persons to be Contacted who are Literally Homeless: 563

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**BUTLER COUNTY  
CATHOLIC CHARITIES  
2016-2017 PATH INTENDED USE PLAN**

**124 New Castle Street  
Butler, PA 16001  
*PDX Name: Catholic Charities***

**Local Provider Description:**

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 Homeless and Housing Central Intake 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 \$86,413 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.

**Collaboration with HUD Continuum of Care (CoC) Program:**

Butler County Human Services holds the HUD grant that funds the Path Transition Age Project and Home Again Butler County, operated by Catholic Charities who participates directly in the HUD Continuum of Care. Butler County is one of twenty counties that make up the new Western PA COC and will remain one of seven counties in 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 rating and ranking of projects in the CoC that are applying for HUD HEARTH funding, identifying needs and gaps in the southwest region's homeless services system. There are five representatives from Butler County's Local Housing Options Team (LHOT) on this regional committee, including the PATH County Contact and the Community Action Director with Butler County Human Services. Butler County Human Services and Catholic Charities both sit on the Coordinated Entry Committee designated by the Western Region CoC and Butler County is one of the five counties identified to pilot the process. Butler County Human Services is actively involved in the Western Region COC meetings that are held quarterly at this time.

## **Collaboration with Local Community 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 Central Intake 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:

- Salvation Army, the Lighthouse Foundation, and five (5) 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 (26) different food cupboards across the county.
- 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. Eligible clients are also connected to the Social Security Administration to apply for SSI/SSD, as well as the local Veterans Administration Hospital for treatment and services when appropriate.
- 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.
- 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 who will not be entering into the housing units available through the Path Transition Age Project or Home Again Butler County (paid through alternative

funding) 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, The Grapevine Center, the Lighthouse Foundation, and Victim Outreach Intervention Center. Unfortunately, the various housing programs in Butler County are often full with waiting lists. In these instances, PATH service providers work with PATH eligible clients to identify other possible housing options, including family members, friends, housing with roommates, subsidized housing units, or independent permanent housing.

- 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.

### **Service Provision:**

#### **Outreach and Case Management:**

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. Individuals are prioritized based on need, which assures the most vulnerable adults receive housing first.

To ensure funds are used appropriately, Butler County Human Services enters into a contractual arrangement with Catholic Charities to provide street outreach and case management. Contracted providers are only permitted to provide the services dictated under the terms of their contract. A majority of the PATH funds received by Catholic Charities 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 biweekly basis. However, outreach in Butler County is done on a weekly basis, with teams from Catholic Charities and the other PATH funded provider alternating weeks. If an organization identifies a homeless individual or family while conducting outreach, they are responsible for continuing to work to engage the individual or family and provide them with initial case management services until they are connected with a longer term program.

**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, PATH services are fully integrated into our local service continuum for individuals and families who are homeless or at significant risk of becoming homeless. This is one of the major target populations for Butler County Human Services and as such, significant resources, including funds from PATH, MH Base, HAP, CSBG, PHARE, Act 137, and HUD, are combined to ensure we have a comprehensive, quality array of services available. Specific services include connection to Veterans Administration, Social Security Administration, local medical assistance office, and connection to physicians, psychiatrists and other treatment. 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 Catholic Charities, PATH funds are utilized to partially support the Central Intake Department. Case Managers in this department complete a comprehensive assessment of people who are homeless or at-risk and then 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. 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.**

Currently in Butler County's homeless service system, the primary gap is safe affordable housing. This gap has become a major priority for Butler County Human Services, the recipient of PATH funds in Butler County. The Local Housing Options Team held a Housing Summit on November 2015 where housing needs were identified in our community. Butler County Human Services has taken this information to begin building a strategic plan over the next several years and has contracted with a nonprofit agency to complete a housing plan which will assist in identifying our current gaps, foreseen gaps and priorities now and moving forward. In addition, the LHOT is working on various strategies to build public/private partnerships to increase the stock of safe, affordable housing that is available to the people we serve. A few examples include that we are currently working to re-establish a landlord association for Butler County and to work with developers to implement various housing options that mimic recovery and supportive housing. The objective of the SW RHAB and of the Butler County Local Housing Team (LHOT), both of which Catholic Charities is a partner, is to identify the gaps within our homeless service system and to work collaboratively to address these gaps.

**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. 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.**

Butler County Human Services and Catholic Charities place emphasis on ensuring that PATH-funded staff are appropriately trained and that they participate in ongoing training opportunities, including evidenced-based practices, in order to perform their jobs as effectively as possible. 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 is the SOAR (SSI/SSDI Outreach, Access, and Recovery) training in order to learn how to better assist PATH eligible clients to access social security resources to support their move to permanent housing and webinars on the LBGTO 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 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 also annually monitors Catholic Charities and the Grapevine Center for attendance at required trainings including health disparities and cultural competency.

In addition, Catholic Charities is a member 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.

Catholic Charities is trained and compliant with entering all PATH required data into HMIS. Staff at Catholic Charities are trained and newly funded PATH staff will be trained on the PA HMIS system, ClientTrack and how to enter PATH specific data.

**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.

**Data:**

Catholic Charities staff are trained and entering all PATH required data into the HMIS system. Staff 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). The PA HMIS administrators are David Weathington and Brian Miller.

**Alignment with PATH Goals:**

See Service Provision – Outreach and Case Management

**Alignment with State Mental Health Services Plan and State Plan to End Homelessness:**

Services provided using PATH funds by Catholic Charities is consistent with the State Plan to End Homelessness as 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. 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.

### **Other Designated Funds:**

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 addition, Butler County does have an Assertive Community Treatment Team (ACT) which includes a housing specialist. The ACT is designed to work intensively with individuals with serious mental illness and the housing specialist is responsible for assisting participants that are identified as being homeless or at significant risk of becoming homeless.

Catholic Charities receives additional funding (aside from the PATH funds) from Butler County Human Services through the Human Services Block Grant to support two permanent supportive housing programs that target people who are homeless and have serious mental illness.

### **SSI/SSDI Outreach, Access and Recovery (SOAR):**

Catholic Charities currently has no staff members trained in SOAR as a result of staff turnover over the past several years. To date, no consumers have been assisted through SOAR. We work with the Southwest Regional Homeless Advisory Board and the HUD Continuum of Care, to coordinate SOAR trainings on a regional basis. We acknowledge that increased emphasis is being placed on SOAR, will assign all PATH funded staff to take the online training and hope to work with the PATH state contact to arrange communication with our local social security office who is resistant to acknowledging the SOAR process.

### **Housing:**

Butler County has implemented a central intake and common assessment process and Catholic Charities has been identified as the central intake unit for housing and homeless services in Butler County. Therefore, anybody seeking housing and homeless services is referred to Catholic Charities to have a common assessment completed. The current assessment being used by central intake is a pilot assessment developed by the Coordinated Entry Committee under the Western Region CoC, in preparation for our CoC wide Coordinated Entry process.

Once the assessment is completed, the housing and homeless case managers complete the VI-SPDAT and then based on eligibility and need, determine which programs in our system the person qualifies for and makes the referrals to those programs. It is not uncommon for individuals to be placed on a waiting list, as most often our homeless programs are at capacity. In this situation, the central intake case managers continue to provide the person with supports and, in many cases, emergency housing until one of the programs has an opening. In the case of a

PATH-eligible person, they are often referred to the Path Transition Age Project, Home Again Butler County or the HOPE Project, all permanent supportive housing projects funded through the continuum of care.

As previously stated, 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, case management, vocational/educational coordination, and life skills training. If no other housing option is available, a literally homeless PATH eligible person or family would be referred to Safe Harbor or the Winter Relief Center, which are two emergency shelter options in Butler County for people faced with homelessness and continue to work closely with a case manager to move toward the goal of a more permanent housing situation.

### **Coordinated Entry:**

The Western Region Continuum of Care, which Butler County is a part of, began the process of developing Coordinated Entry in April 2015. The Coordinated Entry Committee has met tirelessly to develop an assessment, policies and procedures and best practices that will include the 20 county region that the CoC encompasses. Currently, coordinated entry is in the pilot process, where 5 counties are testing the assessment and scoring, adding to the policies and procedures and providing feedback for adjustments and improvements. Butler County Catholic Charities is one of the selected pilot agencies working closely with the Coordinated Entry Committee on this process. The Western Region CoC fully intends to have all 20 counties utilizing the Coordinated Entry by October 1, 2016. This process is monitored by each counties assigned Regional Housing Advisory Board, the Western Region Continuum of Care and HUD.

### **Justice Involved:**

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 is in the final stages of completion and which will hopefully make 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.

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.

It is estimated that approximately 70% of the PATH clients to be served by Catholic Charities will reports a criminal history.

### **Staff Information:**

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.

### **Client Information:**

Catholic Charities serves PATH eligible clients regardless of age, race ethnicity, disability, sexual orientation etc. In 2015, Catholic Charities had 1080 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. A majority of program participants are Caucasian (about 87%), 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 11% of people served are Black/African American. Approximately 48 % of PATH eligible clients were female,

with the remaining 52% male. 39% of the adults served are between the ages 18-30, 16% are 3-40, 15% are 40-55, and 5% are 55 and older.

It is projected that Catholic Charities will use PATH funds to contact 750 adult clients and 575 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.

### **Consumer Involvement:**

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 family members will be invited to sit on.

### **Health Disparities Impact Statement:**

#### **The unduplicated Number of TAY individuals who are expected to be served using PATH funds.**

It is anticipated that Catholic Charities will serve approximately 290 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 for Catholic Charities is approximately 39% of the grant total or \$33,701.

#### **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 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 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.

**Budget Narrative – see below**

**Butler County Catholic Charities  
PATH Program  
FY 2016-2017 Budget Narrative**

**Personnel (Positions and Fringe Benefits)-** PATH funds in the amount of \$82,864 will be utilized to partially fund four positions, including salaries and 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 \$236 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 \$0 will be used to purchase office supplies for the PATH workers to aid them in doing their jobs effectively.

**Other:**

**Occupancy-** PATH funds in the amount of \$0 will be used to partially pay for the office space used for the PATH workers.

**Administrative-** PATH funds in the amount of \$3,313 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 2016-2017 Budget**

\*Please add additional rows as necessary

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing and Homeless Case Manager	\$26,323.75	0.75	\$19,742.81	\$19,742.81
Housing and Homeless Case Manager	\$26,323.75	0.49	\$12,898.64	\$12,898.64
Housing and Homeless Case Manager	\$23,023.00	0.50	\$11,511.50	\$11,511.50
Safe Harbor Project Coordinator	\$33,322.38	0.31	\$10,251.95	\$10,251.95
<b>sub-total</b>				<b>\$54,404.90</b>
<b>Fringe Benefits</b>				
Housing and Homeless Case Manager	\$16,161.50	0.75	\$12,121.13	\$12,121.13
Housing and Homeless Case Manager	\$10,655.39	0.49	\$5,221.14	\$5,221.14
Housing and Homeless Case Manager	\$9,666.74	0.50	\$4,833.37	\$4,833.37
Safe Harbor Project Coordinator	\$20,357.33	0.31	\$6,283.46	\$6,283.46
<b>sub-total</b>				<b>\$28,459.10</b>
<b>Travel</b>			\$236	\$236
<b>Equipment</b>				\$0
<b>Supplies</b>				\$0
<b>Other</b>				
Administration				\$3,313
<b>Total PATH Budget</b>	<b>\$86,413.00</b>			

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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: The Grapevine Center will receive \$12,636 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 33 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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**BUTLER COUNTY  
GRAPEVINE CENTER  
2016-2017 PATH INTENDED USE PLAN**

**140 North Elm Street  
Butler, PA 16001**

**PDX Name: No current account; will contact state PATH lead to request**

**Local Provider Description:**

The Grapevine Center, Inc. is an independent, non-profit organization. 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 receive \$12,636 in PATH funds and will utilize these funds to provide outreach and case management services to hard to house individuals age 18 and older that are at risk of or experiencing homelessness and struggle with serious mental illness or co-occurring mental health and substance abuse disorders.

Historically, PATH funds have been contracted to Center for Community Resources, Inc. to support our permanent supportive housing programs but effective July 1, 2016 we intend to support the Grapevine Center with PATH funding to be more in align with PATH goals and reach a larger number of eligible individuals, not just those eligible for permanent supportive housing. Making this adjustment will provide Butler County Human Services and our funders with a clearer picture of the number of PATH eligible individuals in our community

**Collaboration with HUD Continuum of Care (CoC) Program:**

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), the Community Homelessness Assessment, Local Education, and Networking Group (CHALENG) 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 Community Homelessness Assessment, Local Education, and Networking Group (CHALENG) is led by our local VA Medical Center. It is common practice for our PATH

providers to work directly with homeless coordinators at the Veterans Administration to address the needs of homeless veterans in our community in conjunction with the Opening Doors strategy to end veteran homelessness.

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 also participates 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, Grapevine Drop-In Center, Butler Memorial Hospital, the Butler County Assistance Office, the United Way, the Salvation Army, and the Butler County Housing Authority.

### **Collaboration with Local Community Organizations:**

The Grapevine Center has been in business for many years and over that time has 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, 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. Referrals to outside programs are only made, however, with the permission of the person being served.

- In order to effectively serve PATH-eligible clients, the staff at The Grapevine Center will strive 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:
- Salvation Army, the Lighthouse Foundation, and five (5) 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 (26) different food cupboards across the county.
- The Grapevine Center 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. Eligible clients are also connected to the Social Security Administration to apply for SSI/SSD, as well as the local Veterans Administration Hospital for treatment and services when appropriate.

- 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.
- 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 assist a client in applying for housing services through providers within the homeless continuum of care, including the Housing Authority of Butler County, Catholic Charities, Center for Community Resources, the Lighthouse Foundation, and Victim Outreach Intervention Center. Unfortunately, the various housing programs in Butler County are often full with waiting lists. In these instances, PATH service providers work with PATH eligible clients to identify other possible housing options, including family members, friends, housing with roommates, subsidized housing units, or independent permanent housing.
- 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.

### **Service Provision:**

#### **Case management and Outreach**

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.

To ensure funds are used appropriately, Butler County Human Services enters into a contractual arrangement with The Grapevine Center to provide street outreach and case management. Contracted providers are only permitted to provide the services dictated under the terms of their contract. A majority of the PATH funds received by The Grapevine Center are used to pay for the salary and benefits of the permanent supportive housing program 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 biweekly basis. However, outreach in Butler County is done on a weekly basis, with teams from The Grapevine Center and the other PATH funded provider alternating weeks. If an organization identifies a homeless individual or family while conducting outreach, they are responsible for continuing to work to engage the individual or family and provide them with initial case management services until they are connected with a longer term program.

#### **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, PATH services are fully integrated into our local service continuum for individuals and families who are homeless or at significant risk of becoming homeless. This is one of the major target populations for Butler County Human Services and as such, significant resources, including funds from PATH, MH Base, HAP, CSBG, PHARE, Act 137, and HUD, are combined to ensure we have a comprehensive, quality array of services available. 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.**

Currently in Butler County's homeless service system, the primary gap is safe affordable housing. This gap has become a major priority for Butler County Human Services, the recipient of PATH funds in Butler County. The Local Housing Options Team held a Housing Summit on November 2015 where Housing needs were identified in our community. Butler County Human Services has taken this information to begin building a strategic plan over the next several years and has contracted with a nonprofit agency to complete a housing plan which will assist in identifying our current gaps, foreseen gaps and priorities now and moving forward. In addition, the LHOT is working on various strategies to build public/private partnerships to increase the stock of safe, affordable housing that is available to the people we serve. A few examples include that we are currently working to re-establish a landlord association for Butler County and to work with developers to implement various housing options that mimic recovery and supportive housing.

The objective of the SW RHAB and of the Butler County Local Housing Team (LHOT) , both of which Catholic Charities is a partner, is to identify the gaps within our homeless service system and to work collaboratively to address these gaps.

**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. 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.**

Butler County Human Services and The Grapevine Center place emphasis on ensuring that PATH-funded staff are appropriately trained and that they participate in ongoing training opportunities, including evidenced-based practices, in order to perform their jobs as effectively as possible. The Grapevine Center will support 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. 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 participated in is the SOAR (SSI/SSDI Outreach, Access, and Recovery) training in order to learn how to better assist PATH eligible clients to access social security resources to support their move to permanent housing and webinars on the LBGQTQ community.

In addition, The Grapevine Center is a member 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. The Grapevine Center will be trained prior to July 1, 2016 and is expected to be compliant with entering all PATH required data into HMIS.

**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.

**Data:**

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 so that they will be prepared to fully utilize the system. County administrators of PATH funded staff are educated in running required reports and pulling APR data for reporting purposes. The Grapevine Center, with technical assistance from Butler County Human Services as needed, is 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). The PA HMIS administrators are David Weathington and Brian Miller.

**Alignment with PATH Goals, State Mental Health Services Plan and State Plan to End Homelessness:**

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.

**Other Designated Funds:**

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 addition, Butler County does have an Assertive Community Treatment Team (ACT) which includes a housing specialist. The ACT is designed to work intensively with individuals with serious mental illness and the housing specialist is responsible for assisting participants that are identified as being homeless or at significant risk of becoming homeless.

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.

**SSI/SSDI Outreach, Access and Recovery:**

The Grapevine Center acknowledges the increased emphasis being placed on SOAR , and will assign all PATH funded staff to take the online training . Butler County Human Services also hopes to work with the PATH state contact to arrange communication with our local social security office, which is resistant to acknowledging the SOAR process.

## **Housing:**

### **Indicate what strategies are used for making suitable housing available for PATH clients.**

Butler County implemented a central intake and common assessment process approximately 1 ½ years ago in preparation for the Coordinated Entry Process that is being mandated by HUD. As a result, anyone seeking housing and homeless services is referred to Catholic Charities, the Central Intake provider to complete a common assessment. This assessment currently being utilized is the pilot assessment that was designed by the Coordinated Entry Committee designated by the Western Region CoC. Once the assessment is completed, the central intake case managers complete the VI-SPDAT and determine for which programs in our system the person qualifies, based on both eligibility and severity of need, and makes the referrals to those programs. It is not uncommon for individuals to be placed on a waiting list, as most often our homeless programs are at capacity. In this situation, the central intake case managers and PATH case managers will pursue emergency housing and continue to provide the individual with supports and services until a more permanent housing becomes available.

As previously stated, 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, case management, vocational/educational coordination, and life skills training. If no other housing option is available, a literally homeless PATH eligible person or family would be referred to Safe Harbor or the Winter Relief Center, which are two emergency shelter options in Butler County for people faced with homelessness and continue to work closely with a PATH case manager to move toward the goal of a more permanent housing situation.

## **Coordinated Entry:**

The Western Region Continuum of Care, which Butler County is a part of, began the process of developing Coordinated Entry in April 2015. The Coordinated Entry Committee has met tirelessly to develop an assessment, policies and procedures and best practices that will cover the 20 county region that the CoC encompasses. Currently, coordinated entry is in the pilot process, where 5 counties are testing the assessment and scoring, adding to the policies and procedures and providing feedback for adjustments and improvements. Butler County Catholic Charities is one of the selected pilot agencies working closely with the Coordinated Entry Committee on this

process. The Western Region CoC fully intends to have all 20 counties utilizing the Coordinated Entry by October 1, 2016. This process is monitored by each counties assigned Regional Housing Advisory Board, the Western Region Continuum of Care and HUD.

### **Justice Involved:**

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 is in the final stages of completion which will hopefully make 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.

The Grapevine Center has also worked to identify, form and foster relationships with landlords and have identified several who will accept those who 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.

It is estimated that 67% of the individuals to be served with PATH funds will report having a criminal history.

### **Staff Information:**

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.. In addition, staff attends training a minimum of annually that focuses on 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.

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. 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.

### **Client Information:**

The Grapevine Center serves PATH-eligible clients of all ages, ethnicities, religions, etc. Approximately 97% of program participants are Caucasian and 3% Black/African American. Approximately 35% of program participants are female and 65% are male. It is projected that The Grapevine Center will use PATH funds to contact 33 adult clients and 25 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.

### **Consumer Involvement:**

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.

## **Health Disparities Impact Statement:**

### **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 7 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 25 % of PATH funds will be expended on the TAY population which is approximately \$1516.00.

### **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.

## **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 2016-2017 Budget**

\*Please add additional rows as necessary

	<b>Annual Salary</b>	<b>PATH- funded FTE</b>	<b>PATH- funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing Engagement Specialist	\$9,000	0.25	\$9,000	\$9,000
<b>sub-total</b>			\$9,000	<b>\$9,000</b>
<b>Fringe Benefits</b>				
Housing Engagement Specialist	\$1,000	0.25	\$1,000	\$1,000
<b>sub-total</b>			\$1,000	<b>\$1,000</b>
<b>Travel</b>			\$600	<b>\$600</b>
<b>Equipment</b>			0	0
<b>Supplies</b>			\$150	<b>\$150</b>
<b>Other</b>				
Occupancy			\$1,000	\$1,000
Communications			\$400	\$400
Administration			\$486	\$486
<b>sub-total</b>			\$1,886	<b>\$1,886</b>
<b>Total PATH Budget</b>	<b>\$12,636</b>			

13. Cameron-Elk Behavioral and Developmental Programs

Has Sub-IUPs: No

94 Hospital St.

Provider Type: Social service agency

Ridgeway, PA 15853

PDX ID: PA-027

Contact: Karol Hill

State Provider ID: 4227

Contact Phone #: 8147728016

Geographical Area Served: Western Region

Planning Period From 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 58,431	\$ 26,724	\$ 85,155	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 58,431	\$ 26,724	\$ 85,155	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 58,431	\$ 26,724	\$ 85,155	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 58,431	\$ 26,724	\$ 85,155	

Source(s) of Match Dollars for State Funds:

Cameron-Elk-McKean MH/MR will receive \$81,155 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	149	Estimated Number of Persons to be Enrolled:	50
Estimated Number of Persons to be Contacted who are Literally Homeless:	75		
Number Staff trained in SOAR in Grant year ended in 2014:	2	Number of PATH-funded consumers assisted through SOAR:	2

**CAMERON ELK BEHAVIORAL AND DEVELOPMENTAL PROGRAMS**  
**PATH Intended Use Plan**  
**2016-2017**

**Local Provider Description**

Cameron & Elk Counties Behavioral and Developmental Programs listed as Cameron-Elk-McKean MH/MR in PDX 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. Our address is 94 Hospital Street, 4<sup>th</sup> Floor, Ridgway, PA 15853.

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 2016-2017 is \$85,155. 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**

Cameron and Elk Counties PATH Program has a representative in attendance at the following meetings to satisfy the above mentioned criterion. This helps us to plan, coordinate and access 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 of the HUD Western Continuum of Care to prepare for coordinated entry and to gain knowledge of the assessment tool the CoC will recommend using effective October 1, 2016. In the past we have attended only open meetings, but now with our new membership if it's accepted our plans are to attend all regular meetings as well.

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  
Potter County LHOT  
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  
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  
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  
Housing Expo  
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**

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 meetings and outside of meetings we continually network to provide outreach through PATH or other focused services to meet individual needs. We work with CAPSEA, DCI, and CenClear for outreach during our annual PIT counts. Other than this there are no other outreach

teams. Programs and agencies that work closely with PATH to offer services and outreach to our population are:

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  
PHBH at DCI  
Mobile Psych Rehab  
NAMI  
COPE Drop-In Center  
The Cove Drop-In Center  
School Districts and Intermediate Units 6, 9, and 10  
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  
Oxford Houses where available  
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 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 are staying on top of new housing initiatives, trainings, webinars, as well as, keeping current with housing regulation changes, like new definitions, coordinated entry, and Housing First.

Building relationships with shelter staff, church groups, police, hospitals, and County Assistance offices. PATH in collaboration with CAPSEA's Housing Coordinator will be conducting an Unsheltered Count in 2016(date TBA) 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. When an individual presents as eligible for other services (VA, BCM, CPS, etc.) through other funding sources, PATH caseworkers refer on as deemed appropriate. This allows us the opportunity to maximize the efficiency of PATH funding. In addition, 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 interfering with 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.
- Loss of General Assistance making it difficult to pay rent and afford fees for needed documentation such as Birth Certificate replacements which now have an increased cost.
- 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. Cen-Clears new TASS Program may be a benefit here. 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.
- 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 a natural support system. 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.
  - Missed appointments results in being closed from services.
  - 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.
  - Oxford houses are closing and causing displacement.
  - 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 (we are anticipating a growth)  
 Alcohol and Drug Abuse Services Cameron, Elk, McKean and Potter Counties  
 Erie City Missions  
 Two Roads Counseling Services  
 Community Guidance  
 Clearfield Jefferson Drug and Alcohol Program  
 Pyramid Healthcare  
 Penn Highlands DuBois Behavioral Health  
 DCI  
 Cen-Clear Services  
 The Guidance Center  
 Blue Dog Counseling  
 Beacon Light Behavioral Health  
 Psychiatry in the county prison

- **Training of EBPs and HMIS**

PATH staff attend trainings as applicable. C/E Behavioral and Developmental Programs attended trainings on HMIS TA in April 2016. We continue to participate in Webinars as well to stay current.

- **Please provide information on whether or not your agency is required to follow the 42 CFR Part 2 regulations**

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.

## **Data**

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 from July 1, 2015 and after. Our plan is to be entering full data into the HMIS system by July 1, 2016. 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**

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 services. We will comply with coordinated entry as per our CoC once it rolls out in October 2016 but have always focused on our vulnerable populations.

## **Alignment with State Mental Health Services Plan**

Our PATH program follows the Housing First model to stay with the states plan to end homelessness. Our agency has CoC funded HUD money to administer a chronic housing program and we make chronic a priority in all of the housing programs to reduce/eliminate chronic homelessness.

Our 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.

## **Alignment with State Plan to End Homelessness**

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.

### **Other Designated Funds**

CE Behavioral and Developmental Programs do not utilize Block Grant Funding from any source for PATH Services.

### **SSI/SSDI Outreach, Access, Recovery (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 Mental Health Agencies. There are 2 PATH workers so we have no plans for trainings in the 2016 grant year but we will continue with SOAR when needed. To date we have had 2 SOAR eligible consumers that have been approved.

### **Housing**

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  
CLIP-C/J Community Connections  
Potter County Transition Housing-Potter County Housing Authority  
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

## **Coordinated Entry**

We plan to follow the Western CoC coordinated entry plan once it is implemented in October 2016.

## **Justice Involved**

PATH counties currently do not have access to specialized courts (i.e. veterans' courts, drug courts). Our county MH program has funding for services to decrease recidivism in our forensic population. With the use of county MH dollars the following services are provided in the jail. Outpatient, medication management, BCM, Psychiatrist, and peer support. PATH Liaisons work to connect consumers to these services. PATH workers are also kept abreast of CJAB meetings and planning. We serve about 75% who are justice involved.

## **Staff Information**

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 – Office of Aging Adult Protective Service case manager, Rep-payee for Helpmates, TSS, Ridgway Home Care Medical Social worker assistant, Partial Hospitalization Program staff, inpatient D&A treatment counselor, inpatient mental health treatment counselor, face to face evaluator in an ER and domestic violence volunteer. 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 RHC. We also have contacts in the Fair Housing Realm.

Staff of the PATH Program attends training in Cultural Competency 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 serve our population. As well as a conference in the Western Regions biennially that focuses on hard to house, targeted populations, etc.

## **Client Information**

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 served were diagnosed with Major Depression, Anxiety, or Bipolar Disorder. The population served last fiscal year was 49% male and 51% female and the majority was Caucasian. At the time of referral 60% had graduated from High School or received their GED. Of that 51%; 4 had some post-secondary education. Our youth usually have little or no income upon referral and 9 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 72% 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 70 new individuals during fiscal year 15-16 and that we will probably continue to serve at least 79 individuals who are already in the program for a total of 149 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 50 individuals will be enrolled into the PATH Program.

The PATH Liaisons estimate that about 25 (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**

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 but 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 to our Local Housing Options Team (LHOT). She has been a member for over 2 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**

- The unduplicated number of TAY individuals who are expected to be served using PATH funds

We expect to serve 149 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 monies 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

Because PATH serves 6 counties of TAY in this rural area of Pennsylvania we are not able to fund services. We fund PATH Liaisons to make referrals or assist individuals to connect within the community. If services are not covered by insurance we request county mental health dollars or program funding that is set up to cover such services. For example AHEAD, Home Again, County Mental Health Dollars, ect.

- 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 terms of services that because of their regulations are 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 office. This is nearly impossible for some of our consumer's schedules if they do have employment, or transportation issues, then they are unable to have services. We continue to reach out to these providers and advocate for our TAY in these circumstances.

### **Cameron/Elk Counties PATH 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 2016/2017 will be \$85,155 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 80% of her time on the program and will be paid 80% 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 \$2,677 for the year. Aside from this expense which will cover gas and a \$0.40 per mile reimbursement when necessary, another \$487 has been added for incidental vehicle maintenance according to our cost allocation plan.

Supplies - Projected expenditures for this category total \$407. Included are expenses for office supplies, \$318, 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 \$2,893 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 \$2,232 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 \$1,030. 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 correspondence.

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, Sarah Grunthner, Karol Hill

PATH Program

Cameron & Elk Behavioral and Developmental Programs

94 Hospital Street, 4<sup>th</sup> Floor

Ridgway, PA 15853

814-772-8016

Cameron Elk County Behavioral and Developmental Programs  
PATH Program FY 2016-2017 Budget

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
<b>Position</b>				
Case Manager	\$ 35,812	.8	\$ 27,684	\$ 27,684
Case Manager	\$ 37,854	.75	\$ 25,605	\$ 25,605
<b>sub-total</b>	<b>\$ 73,666</b>		<b>\$ 53,289</b>	<b>\$ 53,289</b>
<b>Fringe Benefits</b>				
FICA Tax	\$ 5,599		\$ 3,914	\$ 3,914
Health Insurance	\$ 16,913		\$ 12,257	\$ 12,257
Retirement	\$ 5,378		\$ 3,759	\$ 3,759
PA Unemployment	\$ 1,325		\$ 992	\$ 992
Worker's Compensation	\$ 483		\$ 373	\$ 373
Life Insurance	\$ 702		\$ 543	\$ 543
<b>sub-total</b>	<b>\$30,400</b>		<b>\$21,838</b>	<b>\$21,838</b>
<b>Travel</b>				
Clients/Outreach	\$ 2,677		\$ 2,677	\$ 2,677
Vehicle Exp	\$ 487		\$ 487	\$ 487
<b>sub-total</b>	<b>\$ 3,164</b>		<b>\$ 3,164</b>	<b>\$ 3,164</b>
<b>Supplies</b>				
Office Supplies	\$ 318		\$ 318	\$ 318
Copies	\$ 89		\$ 89	\$ 89
<b>sub-total</b>	<b>\$ 407</b>		<b>\$ 407</b>	<b>\$ 407</b>
<b>Other</b>				
Occupancy	\$ 2,893		\$ 2,893	\$ 2,893
Insurance	\$ 2,232		\$ 2,232	\$ 2,232
Telephone	\$ 1,030		\$ 1,030	\$ 1,030
Postage	\$ 60		\$ 60	\$ 60
Staff training	\$ 145		\$ 145	\$ 145
Computer Exp	\$ 97		\$ 97	\$ 97
<b>sub-total</b>	<b>\$ 6,457</b>		<b>\$ 6,457</b>	<b>\$ 6,457</b>
<b>Total PATH Budget</b>			<b>\$ 85,155</b>	

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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 31,577	\$ 14,442	\$ 46,019	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 31,577	\$ 14,442	\$ 46,019	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 31,577	\$ 14,442	\$ 46,019	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 31,577	\$ 14,442	\$ 46,019	

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Center for Community Resources will receive \$47,377 in federal and state PATH funds.

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 ended in 2014:	0	Number of PATH-funded consumers assisted through SOAR:	0

# 2016-2017 PATH IUP

**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. 7<sup>th</sup> Ave., Clarion Pa 16214. The services they provide in Clarion include the base service unit functions, crisis services, the mental health Drop In Center and transitional/supported housing services. 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. 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.

**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 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.

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 CareerLink office located in Clarion 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 newly developed Drop-In Center and provides regular budgeting classes to the adult mental health population. 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** – The Mental Health Housing Coordinator (HC) contacts the owners of businesses and requests permission to leave information at their sites and to contact her 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, rental community, public housing, churches, food banks, etc.

The HC will continue to visit the Drop-In Center and other places such as 24 hour convenience stores and Laundromats, where 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, e.g. those waiting for their social security income (SSI) to begin or those who are unemployed/underemployed. The MH Administration and CCR are working on developing 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 will be ready for residents in May 2016.
- 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 currently fills some of this gap, however waiting lists make it difficult to access and funding for these programs
- Assistance with rent and utilities- available on a limited basis through the Housing Assistance Program (HAP) 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. 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. They also operate a women's Oxford House and men's Oxford House in Clarion, which provides support and housing to individuals in recovery. Outpatient counseling, intensive outpatient counseling and referral for inpatient treatment is provided by ARC Manor, a subcontractor located in the FQHC building. Additional drug and alcohol treatment programs are available through a second subcontractor, Cen-Clear, new to Clarion County 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.

Training: 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 15/16. 100% of the annual report will be generated from HMIS in year 16/17. Currently PATH liaison utilizes the IT representative for HMIS to troubleshoot any problems she may encounter with HMIS and participates in on-going training provided for HMIS users.

**Alignment with PATH goals** – The PATH Liaison will continue 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 the Chair 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 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 Depute Administrator and the Hospital Liaison collaborate with the Mental Health facility to create a "home plan" for the discharge of the client. CCR currently provide transition housing for clients for up to one year after discharge. 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 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 share as the Chair of 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.

**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.

**SSI/SSDI Outreach, Access, Recovery (SOAR)** – SOAR trainings have not been recently available in Clarion County at this time. The Housing Coordinator and other identified staff will attend when this becomes available. The Housing Coordinator refers to case managers to assist people with the SSI/SSDI application process, and is available to assist consumers as needed.

**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.
- HAP provides rental assistance and payment of security and utility deposits.
- Community Action has a four person men's shelter located in Clarion. Availability is limited.

- The MH Administration and CCR are working on developing 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 will be ready for residents in May 2016.

**Coordinated Entry** – The Housing Coordinator at Center for Community Resources, serves as the Coordinator Entry for Clarion County. She screens all clients to see if they meet the criteria PATH and if 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 2016/2017 is to create a coordinated entry plan.

**Justice Involved** – The Mental Health Deputy Administrator attends the Criminal Justice Advisory Board (CJAB) in Clarion County on a monthly basis to inform local authorities of the homelessness needs of the County. The PATH Liaison works closely with the Forensics Liaison and will assist consumers as they transition back into the community from local jails. CCR also provides transitional housing to clients being released from jail with no home to return to. The Housing Coordinator provides supports and helps find permanent housing for the client. Clients can live in transitional housing for up to one year. The PATH Liaison reports that 50-75% of clients enrolled in PATH have some criminal history.

**Staff Information** – There is one staff person, 60% funded by the PATH program. She 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 4 years. Her office is located at 214 S. 7<sup>th</sup> 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).

**Client Information** – The previous reporting period showed that there were 27 individuals enrolled in PATH, 17 female and 10 male. The majority of both of these genres were between the ages of 31-50. The dominate race in Clarion County that was contacted or enrolled in PATH is white and non-Hispanic. There are a very low number of veterans that are enrolled in PATH. The majority of consumers that are enrolled in PATH are staying with a friend the night prior to enrollment and are at risk of homelessness. The percentage of people enrolled that are literally homeless is 11% (3/27). The PATH liaison projects that enrollment for PATH in the year 16/17 will be larger based on a greater emphasis on outreach as well as provider guidelines on intake and enrollment strategies. Our goal for PATH enrollment in 16/17 is 30 individuals. For outreach, veterans and TAY will be targeted and we would like to to see at least a 1-2% increase in these areas.

**Consumer Involvement** – The PATH Program is an integral part of the County’s Mental Health Program. Consumers and their families are involved in determining the program’s mission; program planning; program administration, governance and policy determination, and program evaluation through representation on the Mental Health Advisory Board and local Consumer Support Program, CCR’s Advisory Board, and by being involved in the county planning as described below. Input and feedback is also gained through the Consumer/Family Satisfaction Team’s surveys and evaluation of services.

As outlined in the state information: The MH/MR Act of 1966, which governs the provision of MH services in the Commonwealth requires that the County MH/DD Program 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. All County MH/DD 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 County, and always have sufficient notice and opportunity to comment.

**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 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 that is currently being observed is 18-23 year olds. Last year’s report projected 6-10

people enrolled. There were 2, 18-23 year olds enrolled in the year 14/15. This current year should project somewhere between 6-10 persons enrolled in that age group.

\$2,099 has been of PATH Funds has been expended on services for the TAY population.

Services that are available for the TAY population include planning for housing (emergency or long-term), finding and securing housing, assistance with housing (rent, utilities, furniture, assistance moving, assistance acquiring an income, housing case management, budgeting and referrals to community based human service and MH programs.

To decrease the disparities in access to the TAY population, the plan is to create a collaboration with agencies that serve this population within the community.

- Collaborate with agencies such as Early Head Start, Head Start, Family Literacy, Community Action, etc. by attending staff meetings, to educate staff about PATH services and how they can make a referral.
- Collaborate with local hospitals and physicians offices to educate staff on how to make a referral if they have concerns with homelessness.

**Budget Narrative**

Clarion County  
Center for Community Resources  
PATH Program  
FY 2016-2017 Budget

**Federal allocation \$31,577**

**State match \$14, 442**

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
<b>Housing Coordinator</b>	\$29, 405.00	.6	\$17,343.00	\$17,643.00
<b>Fringe Benefits</b>				\$12,389.00
<b>Travel</b>				\$720.00
<b>Equipment</b>				\$750.00
<b>Supplies</b>				\$360.00
<b>Communications</b>				\$720.00
<b>Rental Assistance</b>				\$7,000.00
<b>Security Deposits</b>				\$2,095.00

<b>Consumer Supplies</b>				\$500.00
<b>Other</b>				\$1,200.00
<b>Admin Fees</b>				\$4,000.00
<b>Total</b>				\$47,377.00

\*Please enter additional rows as necessary

Budget Matrix:

Your matrix totals \$47,377. Your indicated PATH federal and state match total \$46,019. Please explain the variance and note in your budget narrative.

Budget Narrative

*Personnel:*

*Funding of \$17,643 is being requested to provide for the full-time salary, 60% 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 \$17,643.*

*Fringe Benefits:*

*Funding of \$12,389 is being requested to provide for the full-time fringe benefits of a MH Housing Coordinator. Fringe benefits include the following costs: FICA at \$1349 health insurance at \$10,043, retirement at \$526 life insurance at \$133 and state unemployment at \$338. Total request for fringe benefits is \$12,389.*

*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 \$0, lodging at \$0, gas & maintenance of county vehicles at \$ and estimated registration fees of \$. 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 \$720. Total travel request: \$720.*

*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 \$200 and safety/emergency/hygiene/habilitation supplies at \$160 for a total of \$360 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 25-35 individuals experiencing homelessness or at imminent risk at approximately \$308 each, not to exceed \$10,795. Internet/computer service for a year at \$1270, postage costs at \$200; administrative costs are computed at 8.4% 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 8.4% \$4000, include the costs of space and utilities to house the PATH staff at \$ 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 \$16,295.00:*

<i>MH Dept. Supv. of MH Housing Program Coordinator @ 1%</i>	<i>\$571.00</i>
<i>MH Dept. Fiscal Officer Time @ 1%</i>	<i>\$505.00</i>
<i>BSU Housing Coordinator @ 40%</i>	<i>\$12,062.00</i>
<i>County Match (on State allocation)</i>	<i>\$3,157.70</i>

*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 over \$172,564.00 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:*

<i>NW9 (As Reinvestment funds are available)</i>	<i>\$20,000.00</i>
<i>Hope Homes</i>	<i>\$127,534.00</i>
<i>Emergency Housing Apartment</i>	<i>\$25,030.00</i>

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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 42,708	\$ 14,236	\$ 56,944	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 42,708	\$ 14,236	\$ 56,944	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 42,708	\$ 14,236	\$ 56,944	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 42,708	\$ 14,236	\$ 56,944	

Source(s) of Match Dollars for State Funds:

Crawford County MH/MR will receive \$56,944 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 90 Estimated Number of Persons to be Enrolled: 58

Estimated Number of Persons to be Contacted who are Literally Homeless: 68

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 1

**Crawford County Mental Health Awareness Program (CHAPS)  
PATH Grant Intended Use Plan 2016 - 2017  
944 Liberty Street ~ Meadville, PA 16335 ~ (814)333-2924**

**Local Provider Description**

**Provider name as it appears in PDX:** Crawford County MH/MR, CHAPS

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* - Open 365 days per year, this consumer-run center provides an atmosphere of peer support, empowerment, education, advocacy and enrichment for adults with mental illness.
- *Community Education and Outreach* - Offers information and connections to resources on mental illness, self-advocacy, and other pertinent mental health topics.
- *Representative Payee / Money Management* - Offers financial management and counseling. The level of support provided is based on individual needs.
- *Mobile Psychiatric Rehabilitation (Supported Living)*- Offers supports to consumers who wish to live in the community. Flexible supports are offered to consumers in their homes which are designed to meet each person's needs. Case workers assist consumers build skills to maintain good mental health and physical health.
- *Transitional Housing* - Maintains an apartment for temporary access by consumers that need housing and support during transitional times.
- *McKinney Housing Advocacy* - Provides intensive case management and support to homeless individuals and families. Assistance is provided in finding appropriate housing and building skills to maintain stable housing.
- *Clubhouse and Vocational Counseling (Journey Center)* - Offers the opportunity to consumers to build on their strengths and capabilities while working towards independence and productivity. Members and staff are treated as equals and work side-by-side. Typical activities include: Work Order Day, Transitional Employment, and Educational Sessions. Vocational Counseling assists members in attaining vocational goals. Assistance is offered in helping persons obtain work opportunities which may include volunteer, paid, part-time, and full-time options.
- *Fairweather Lodge* - Offers a supportive housing option which guarantees access to employment, decent affordable housing and an opportunity to be a stockholder in all functions of the lodge. .

- *Warmline* – Offers a non-emergency telephone support line to persons with mental illness, Monday through Fridays from 5:00 PM to 8:00 PM.
- *Shelter Plus Care* – Twenty-six housing subsidy vouchers available for persons with serious mental illness who meet HUD’s definition of homelessness.
- *Housing Now* – Eight housing subsidy vouchers available for persons with serious mental illness who meet HUD’s definition of chronic homelessness.
- *Certified Peer Specialist*- Offers one-on-one peer to peer service for persons with mental illness. Service is mobile and focuses on individual goals and recovery.
- *Family Housing Voucher Program*- Five housing subsidy vouchers available for families with a parent who has a serious mental illness and who meets HUD’s definition of homelessness.
- *Emergency Solutions Program* – Offers expedited services to individuals and families that are literally homeless, on the street or in temporary shelter, providing assistance to establish appropriate housing and building skills to maintain housing.
- *CHIPP Diversionary Shared Housing Program*-provides individuals who experience chronic mental illness a safe and affordable housing opportunity along with a comprehensive level of support to promote recovery, independent living skills, and healthy lifestyles in order to avoid re-hospitalization.

Crawford County Mental Health Awareness Program, Inc. (CHAPS) will receive \$56,944 in federal PATH allocation and state cash match with an additional county cash match of \$1,741 for a total of \$58,685 for this PATH Project. These funds will be utilized to provide a PATH Outreach Worker/Case Manager for the target population. A PATH Outreach Worker/Case Manager will be employed through PATH funding.

### **Collaboration with HUD Continuum of Care (CoC) Program**

Crawford Co is part of the Western PA CoC, which is comprised of 2 subareas for planning purposes. Each subarea is managed by a Regional Homeless Advisory Board, or RHAB.

Crawford Co falls into the Northwest PA HRAB. Representatives from CHAPS serve as Board Members for the Northwest Regional Homeless Advisory Board (RHAB) and also the Western Region CoC. In addition, CHAPS staff presently serve on the Transition Age Youth and Membership subcommittees.

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. Through the Coalition’s efforts, 22 affordable housing units have been

developed, a Furniture Closet and Emergency Shelter Program are available, positive networking has been established, and advocacy and community education takes place on a regular basis.

In addition, various non-profit agencies have established programs including Shelter Plus Care, Emergency Solutions Program, Housing Advocacy, Transitional Housing, Mortgage and Homebuyer Assistance Programs, and Section 811 Housing for Persons with Disabilities. These programs were developed in response to needs identified at the Housing Coalition meetings.

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 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**

A variety 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 for persons in Crawford County with Medical Assistance Cards or those with no ability to pay. Meadville Dental and Conneaut Valley Dental also serve patients with Medical Assistance cards. 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:* For persons without medical coverage, 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 Mental Health, 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, Meadville Behavioral Health, Crawford County Drug and Alcohol Program Executive Commission, CHAPS, and the Titusville YWCA.

*Substance Abuse:* Substance Abuse services are readily available to consumers with both private and public health insurance and are primarily coordinated through Crawford County Drug and Alcohol Executive Commission. Services available include: Intensive Case Management, Prevention Programs, Resource Coordination, Outpatient, Intensive Outpatient (individual and group therapy), Dual-Diagnosis Support Groups, access to Detox programs, Halfway Houses, and Residential Treatment Programs. They also employ a Certified Recovery Specialist who works closely with case management to provide outreach, education, motivation, mentoring to adults with substance abuse issues. 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. There is a weekly support group held at Meadville Medical Center. With the rise in overdoses related to Opiate abuse, CCDAEC has been providing education to consumers, families, and professionals in regard to the use of Narcan.

*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. There are many subsidized housing options for individuals and families within Crawford County. They include: The Housing Authority of the City of Meadville, Snodgrass Apartments, Fairview Fairmont Apartments, Forest Green Apartments, Housing and Neighborhood Development Service (HANDS), and Bartlett Gardens in Cambridge Springs.

## **Service Provision**

- Provide specific examples of how the agency maximizes the 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.

- Describe any 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.

- Provide a brief description of the 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:

- a. Understanding Dual Illness and Recovery
- b. How to Benefit from Services in Your Dual Recovery
- c. The Role of Medication in Recovery
- d. Dual Illness and the Family
- e. Developing a Dual Recovery / Relapse Prevention Plan
- f. Using Support Systems in Dual Recovery
- g. 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 their 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.

CCDAEC has also been providing educational outreach to individuals, families, and professionals to address the new heroine epidemic. They have been providing information about the use of Narcan to help prevent opiate-related overdoses.

- 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

All CHAPS' staff receives at least 18 hours of training per year. CHAPS strives to offer staff an array of job relevant trainings which include evidence-based practices. Some recent trainings attended by Housing staff include: Ethics, Compassion Fatigue, Cultural Competence, Trauma Informed Care, Fair Housing, Serving Transitional Aged Youth, Poverty and Mental Health, Housing First, SOAR, PA PATH Program Participation in HMIS, and other homeless related programs. CHAPS ensures that all involved employees are properly trained to utilize the HMIS system. Trainings are paid for through the General Agency Budget. PA HMIS Trainings are free and the recent HMIS Technical Assistance Conference in State College was also free as well (minus transportation costs).

- Please provide information on whether or not your agency is required to follow 42 CFR Part 2 regulations

Our agency is not required to follow 42 CFR Part 2 regulations.

## **Data**

CHAPS's currently enters all PATH clients and data into the PA HMIS system. CHAPS' staff participates in regularly scheduled HMIS trainings, webinars, and conference calls. New staff would be fully trained on PA 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 PA HMIS. Brian Miller is the HMIS Director.

## **Alignment with PATH goals**

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 Mental Health Services Plan**

CHAPS collaborates with The Red Cross in the event of housing disasters. CHAPS has formed a working relationship with the Meadville City Fire Dept., who visits our building for inspections and suggests areas of improvement in relation to disaster planning. CHAPS has regular fire drills at the main building and in off-site buildings, such as Fairweather Lodges and CHIPP Diversionary Shared Housing House and Apartment.

The Path Outreach Worker/Case Manager provides street outreach on a weekly basis in an attempt to find and engage homeless individuals and connect them to permanent housing. When utilizing CHAPS' housing vouchers, priority is given to individuals with significant

mental illness who are experiencing chronic homelessness. When CHAPS has an available housing voucher in Shelter + Care, Housing Now, or Family Housing Program, the Executive Director sends an email to the members of our region's CoC informing them of the opening. If a CoC member has a candidate who is chronically homeless and meets all other HUD criteria for the programs, they are asked to respond with more information within 7 days so housing can be coordinated for the individual experiencing chronic homelessness.

### **Alignment with State Plan to End Homelessness**

Our region's CoC is piloting a coordinated entry program targeting chronically homeless individuals and families. The plan that is being developed ranks and targets vulnerable populations (i.e. chronically homeless, transition-age youth, veteran's, domestic violence victims, etc.). The PATH Outreach Worker/Case Manager provides street outreach on a weekly basis visiting previously identified areas where homeless individuals gather as well as hanging outreach fliers throughout the county. The PATH Outreach Worker/Case Manager will attempt to engage homeless individuals both on the street and in shelter to connect them to permanent housing and other critical services. The worker also targets homeless veterans and attempts to engage them in services with the VA and connect to local veteran's resources as well as help them obtain a VASH Voucher, if eligible.

### **Other Designated Funds**

The Mental Health Block Grant funds various support services including an emergency apartment, housing advocates at CHAPS, Drop In Center, and Representative Payee/Money Management Services. PATH Federal Funds total \$42,708. State Block Grant Funds total \$14,236, and the County Match is \$1,174.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

CHAPS recognizes the value of SOAR in assisting consumers with 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. Updates to SOAR training have been provided through webinars, which 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. Staff recently participated in a SOAR webinar that targeted Transitional Age Youth. CHAPS continues to build a partnership with the local Social Security Administration. CHAPS completed one SOAR referral in 2015-2016, but the consumer received a denial of SSI Benefits.

## Housing

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**

Our CoC Region is in the process of developing a coordinated entry program. The program is being piloted in a few counties (not Crawford County).

## **Justice Involved**

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 2015-2016 service year, 44 % of our PATH clients had a criminal history.

## **Staff Information**

CHAPS has a solid history of hiring qualified consumers for professional positions and will continue to value this practice. There are presently 46 CHAPS employees, and 23 individuals or 50% of them have shared that they have a mental illness and have received treatment. Of the 46 staff at CHAPS, 7 CHAPS staff have been trained as Certified Peer Specialists. Of the 46 staff at CHAPS, 4 are trained PATH Outreach Workers/Case Managers. 75% of PATH Outreach Workers/Case Managers are male and 25% female. 100% are white. 25% are lesbian and 75% heterosexual.

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.

Appropriate staff will participate in training provided utilizing the National CLAS Standards: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. In addition, staff will have training and understanding of both persons with mental illness and co-occurring substance abuse disorders (MISA).

Efforts will be made to identify and assist individuals in underserved populations 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.

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**

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 current year, the Crawford County PATH project has served the following demographics: Y range, 9% were Black, 1% were Native American, 3% Hispanic and 87% were White, 100% of participants were below poverty level, 65% of PATH participants were male and 35% were female. Also one hundred percent of those served had mental illness and 40% had co-occurring disorder (mental illness and substance abuse).

During the 2016-2017 fiscal year it is projected that 90 clients will be contacted using PATH funds. It is projected that 58 individuals will be enrolled utilizing PATH funds. It is also projected that 76% of consumers enrolled in the PATH Program will be literally homeless.

### **Consumer Involvement**

Homeless consumers and their family members will be encouraged to participate in the planning, implementation and evaluation of the PATH program. 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 23 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**

- The unduplicated number of TAY individuals who are expected to be served using PATH funds

During the past program year 12 TAY individuals (25%) were served with PATH funds. We anticipate that 15 to 20 TAY individuals will be served in the 2016-17 program year.

- The total amount of PATH funds expected to be expended on services for the TAY population

During fiscal year 2016-2017 we anticipate expending 14,671 dollars of PATH funding on the TAY population.

- The types of services funded by PATH that are available to TAY individuals

The Housing First Model will be used to assist TAY individuals in searching for housing, completing affordable housing applications and applications for private apartments, searching for employment, applying for benefits, securing housing and providing support to develop independent living skills. Appropriate referrals will be made to other service providers to assist with physical and mental health issues, effects of trauma, education, employment, substance abuse and other needs of the TAY individuals on a case by case basis. Staff will make connections to other appropriate supports including the Drop in Center, Representative Payee, Mobile Psychiatric Rehabilitation, Site-Based Psychiatric Rehabilitation (Clubhouse), outpatient Drug and Alcohol treatment, and many other community programs ( YMCA, YWCA, READ etc.) in which they would benefit.

- 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

CHAPS will provide outreach services to TAY individuals by visiting common sites where youth gather. CHAPS will also further establish and foster relationships with community agencies that traditionally serve the TAY population (schools, guidance counselors, Children and Youth Services, probation, etc.). CHAPS staff will visit schools, training centers and other locations as needed to connect with TAY individuals in need of services. CHAPS staff will facilitate transportation for TAY individuals as well as assisting them with obtaining government sponsored low cost telephones to enable them to communicate with providers. Referrals will be made to appropriate agencies to ensure youth have access to services. Further education will be

provided for CHAPS staff regarding the special needs of this population and the most effective ways to provide outreach and support services. Outcomes will be tracked using HMIS.

**Budget Narrative** – *see below*

Crawford County Mental Health Awareness Program, Inc.  
 Budget Narrative  
 PATH 2016-2017

Personnel:

CHAPS full time work week = 40

The PATH Case manager/ Outreach worker provides 35 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 5% of annual salary to a 401K on the employees' behalf. All PATH employees are eligible for retirement benefits.

Admin:

Executive Director 3 hr per month @ 36.75	1,323.00
Financial Director 2 hr per month @ 30.63	735.12
Fiscal Assistant 2 hr per month @17.78	426.72
Payroll Taxes	442.44
Benefits	311.30
Audit expense – additional for Single audit	650.00
<b>Total</b>	<b>\$3,888.58</b>

In-Kinds Supports:

1. CHAPS Administrative costs not included on budget page \$ 1,303
2. HUD Grant for Housing Now \$92,231
3. County MH base service dollars CHAPS Drop in Center, Clubhouse, \$32,216
4. Mobile Psych Rehabilitation, Representative Payee program will be available to PATH Consumers
5. 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.

Crawford County  
Crawford County Mental Health Awareness Program, Inc.  
PATH Program  
FY 2016-2017 Budget

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded Salary</b>	<b>Match-funded Salary</b>	<b>TOTAL</b>
	<b>Position</b>				
PATHCaseMan/Outreac	33,598	0.875	21,395	8,003	29,398
Housing Services Coor.	43,860	0.125	3,990	1,493	5,483
Housing Admin Assist.	33,775	0.160	3,933	1,471	5,404
<b>sub-total</b>	<b>\$144,590</b>	<b>1.160</b>	<b>\$29,318</b>	<b>\$10,967</b>	<b>\$40,285</b>
	<b>Fringe Benefits</b>				
FICA Tax/WC/UI			3,592	1,344	4,936
Health Insurance			6,451	2,414	8,865
Retirement			1,466	548	2,014
<b>sub-total</b>			<b>\$11,509</b>	<b>\$4,306</b>	<b>\$15,815</b>
	<b>Other</b>				
Admin			1,881	704	2,585
<b>sub-total</b>			<b>\$1,882</b>	<b>\$704</b>	<b>\$2,585</b>
<b>Total Budget</b>			<b>\$42,708</b>	<b>\$15,977</b>	<b>\$58,685</b>
<b>Total PATH Budget</b>			<b>\$42,708</b>		
<b>State cash Match</b>				<b>\$14,236</b>	
<b>County Cash Match</b>				<b>\$1,741</b>	
<b>Total Allocation</b>			<b>\$42,708</b>	<b>\$15,977</b>	<b>\$58,685</b>

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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 76,021	\$ 25,340	\$ 101,361	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 76,021	\$ 25,340	\$ 101,361	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 76,021	\$ 25,340	\$ 101,361	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 76,021	\$ 25,340	\$ 101,361	

Source(s) of Match Dollars for State Funds:

The total for Dauphin County overall is \$101,361 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 ended in 2014:	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 2016-2017**

**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](mailto:rschultz@dauphinc.org)

Frank Magel                                      MH Program Specialist 2      717/780-7045  
[fmagel@dauphinc.org](mailto:fmagel@dauphinc.org)

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 the main 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 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 recently opened a drop in center in September 2015. They offer a safe warm and dry place to be during the day. Individuals have access to computers and information regarding resources

available in the community. The center is staffed by activity aides and volunteers to assist individuals in accessing needed services and supports. There are some social activities also available. Since opening DDB has provided services to 147 individuals self-identified as homeless.

Dauphin County MH/ID Program also contracts with an additional agency, Central Pennsylvania Supportive Services (CPSS) for services to adults who are PATH eligible offering life skills and housing supports to end homelessness and reduce risk of imminent homelessness.

Dauphin County is located in the South Central Pennsylvania and it is comprised of 40 municipalities and is a mix of rural, small urban and suburban areas. There are 525 square miles, and the Susquehanna River is one of its borders. Dauphin County includes the City of Harrisburg, which is also the State Capitol of the Commonwealth of Pennsylvania.

According to the US census data Dauphin County has an estimated population at 272,983 individuals in 2015. 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 FY2016-17 is \$101,361 of which \$25,340 consists of State Funds and \$76,021 are Federal Funds.

Based on data collected in the PATH Annual Report for 2014-15, it is projected that outreach efforts will be made to approximately 380 individuals and approximately 300 individuals will be enrolled in PATH services for FY 2016-17. It is estimated that 180 individuals will be literally homeless or in short-term shelter at the time of enrollment and the remaining will be at imminent risk of homelessness. The Crisis Intervention Program of Dauphin County MH/ID will identify 240 individuals through outreach efforts and enroll 200 in PATH services. Downtown Daily Bread will identify 140 individuals through outreach efforts and enroll 100 individuals in PATH services during FY 2016-17. Among the 300 individuals enrolled in PATH, eight (8)-individuals will also receive services from CPSS.

**Table 1 – Projected PATH Services FY16-17**

<b>Provider</b>	<b>MH/ID Crisis Intervention Program</b>	<b>Downtown Daily Bread</b>	<b>Central PA Supportive Services</b>	<b>TOTAL</b>
<b>Estimated Number Outreach</b>	240	140	Doesn't conduct outreach	380
<b>Estimated Number enrollment</b>	200	100	Accepts persons enrolled; est. eight (8) to be served	300
<b>Estimated Number &amp; % Literally Homeless</b>	120/60%	60/60%	Eight (8) persons should be literally homeless	180/60%

## **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 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.

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 be 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. D & A Recovery Specialist positions were added to the array of services with Medicaid funds and have demonstrated a positive impact on engaging individuals in Drug & Alcohol treatment and supports. 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 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 and Recovery (SOAR) Coordinator position in Dauphin County. SOAR offers quicker access and approval of Social Security benefits for persons who are homeless. SOAR is not funded with PATH dollars. No PATH funded staff were trained in SOAR in FY 2011-12. 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. The total number of employed Certified Peer Specialists in Dauphin County was surveyed at 24 in Fall 2015 and includes both full and part-time employees. Fifteen (15) are employed in Medicaid funded CPS programs.

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.

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.

Hamilton Health Center is a federally qualified health center and offers comprehensive medical services, including dental services. Hamilton Health Center is approved to provide MH counseling with LCSW staff. Recruitment has been underway for a staff psychiatrist. Approximately 33% of the individuals served at Hamilton Health Center are uninsured. 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.

The following chart best illustrates the range of unique specializations and evidenced based interventions available for a diverse population at the outpatient level of care:

**Table 2 – Licensed Psychiatric Outpatient Service Providers 2016-2017**

<b>Provider</b>	<b>Unique characteristics</b>
Adler Health Services	Integrated physical & behavioral health. Serves LGBTQI population. City location. Medicaid & Medicare.
Catholic Charities of the Capital Region	Homeless Clinic and works with Mission of Mercy. Medicaid and County funded.
Community Services Group	Children and families. Groups for adolescents. PCIT certified provider. Medicaid and County funded. Adding DBT Teen in 2016.
Commonwealth Clinical Group	Specialized offender and at-risk offender services to adults and teens. City location. Medicaid and County funded.
NHS of PA Capital Region	Primary clinic co-located with CMU, PA model, tele-psychiatry, DBT and PCIT, open access clinic. Adults, older adults, children. City location & rural Northern Dauphin. Medicaid, Medicare and County funded. Adding DBT Teen in 2016.
Pennsylvania Psychiatric Institute (PPI)	Culture specific –Hispanic and geriatric clinics, Clozaril and dual diagnosis (MH/ID) clinics. Adults and children. CBT & DBT trained. City location. Medicaid, Medicare and County funded.
Pennsylvania Counseling Services	Also a D&A outpatient provider. COD Integrated treatment. City & suburban sites, including school-based sites. Medicaid, Medicare and County funded.
Philhaven	Tele-psychiatry, Trauma-informed care, community based location. Medicaid and Medicare.
Pressley Ridge	Staff trained Play Therapists, The Incredible Years used in school based clinics. Medicaid, Medicare and County funded. School, city & suburban sites. Also in rural Northern Dauphin.
TeamCare	Suburban site. Medicaid and Medicare.
TW Ponessa and Associates	Also a D&A outpatient provider. Trauma-informed care; CBT trained. City location. Medicaid, Medicare and County funded.
Youth Advocate Programs	Certified Registered Nurse Practitioner/Art Therapist Community and school-based site. Medicaid, Medicare and County funded.

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 facility based Psychiatric Rehabilitation Program that is funded with County dollars and opened in 2014. Mobile Psychiatric Rehab services are planned.

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 Elwyn, (KMHS) Keystone Mental Health Services, NHS of PA and Gaudenzia. KMHS opened in 2015 a licensed full-care CRR program for transition age population, ages 18-24 with a capacity to serve three individuals. NHS –PA opened a DBT full-care residential program using CHIPP funds in 2016. Supportive living services are provided by Volunteers of America (VOA), Keystone and Central Pennsylvania Supportive Services (CPSS). CPSS is a small provider of supportive services funded with PATH.

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 contracts with NHS PA and Keystone Service Systems for Specialized Care Residences (SCRs) licensed as Personal Care Homes (PCHs), but are exclusively for adults and older adults with serious mental illnesses. Staff has extensive mental health training, clinical support skills, which meet the unique characteristics of residents who also require PCH level of care. Personal care services include: assistance in completing tasks of daily living, social activities, assistance to use community services, and individualized assistance to enhance daily goals and life quality. Dauphin County also contracts with Paxton Ministries to provide personal care home services.

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 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 HACD to serve approximately 6 individuals who have a serious mental illness beginning in FY15-16. Through ongoing collaboration and support the landlord/tenant relationships have been strengthened, and there is stability in permanent housing options. Dauphin County has a Local Housing Options Team (LHOT) that meets periodically to improve working relationships with landlords around problem-solving to prevent homelessness.

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.

One Safe Haven project is located in Dauphin County. The men's program is operated by Christian Churches United and offers transitional and "housing first" living for up to 25 men. The women's safe haven program had a capacity for 8 women and was operated by the YWCA of Greater Harrisburg. The YWCA transitioned the 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. With the support of the US Department of Housing and Urban Development through the Continuum of Care Grant program, this new housing effort will become an established long-term resource in our community.

The 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 new HUD 811 project-based vouchers are a demonstration project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) make 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 has leased up individuals in 2016. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH). 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. Dauphin County is one of five Counties statewide first selected for this opportunity in permanent supportive housing.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals based upon the Fairweather Lodge model. This program has an employment component called Paxton Cleaning Solutions and has competitive contracts with local companies 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, supportive living (CPSS) 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, in which a portion of these funds are in Dauphin County's existing PATH budget.

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 2016-17 include:

1. Outreach services (partially funded)
2. Screening and assessment for treatment services (partially funded)
3. Habilitation and rehabilitation (partially funded)
4. Staff training (partially funded)
5. Case management (partially funded)
6. 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.

CMU (Case Management Unit) provides homeless outreach to PATH eligible individuals to assist in registering those with a serious mental illness and those with co-occurring disorders into the community mental health system through intake at CMU. A homeless case worker position is not PATH funded, and staff is SOAR trained and processes all Dauphin County SOAR applications for SSI/SSDI.

#### Screening for diagnostic 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.

#### Habilitation and Rehabilitation

The Independent Living Resource (ILR) for PATH eligible individuals assists by developing and enhancing life skills based on the individual's needs. The skill sets that are offered include budgeting, homemaking, self-care, interpersonal skills, pre-vocational guidance, housing assistance as well as mobility training. ILR services are provided by the Central Pennsylvania Supportive Services (CPSS) on a fee-for-service basis in small group or individual settings.

## 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 topics may also be proposed by the Capital Area Coalition for Homelessness (CACH)'s Service Delivery Committee where there is cross-representation among homeless, basic needs, mental health and drug & alcohol programs. The training reflects a commitment to the fundamentals of recovery and resiliency in the mental health system. Training in 2016 is scheduled on Gender and Trauma: How Men and Women Differ in their Experiences and will be 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 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 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.
- 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. Dauphin County, including the Crisis Intervention Program, Downtown Daily Bread, and other mental health agencies continue to participate in Project CONNECT events.
- 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. The Dauphin County Local Housing Options Team (LHOT) has been instrumental in developing a master list of landlords in conjunction with the local housing authorities and has revised the landlord –tenant protocol. The protocol found at [www.parecovery.org](http://www.parecovery.org) was developed to address landlord-tenant issues before legal problems or eviction occurs. 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. CACH reviews applications for completeness and eligibility criteria and forwards applications to building managers/owners for their consideration as potential new tenants.

- Security Deposits: Dauphin County can assist PATH eligible individuals with funds for security deposits or first/last month rents. CIP and case management entities provide this assistance. This service can provide quicker access to more permanent housing options for individuals, rather than relying on limited shelter space.
- 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. CIP and all case management entities have access to limited 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. CIP and all case management entities have access to limited funds for preventing eviction on a one-time basis.

### 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

- Limited existing resources and long waiting lists for transitional, as well as, permanent housing resources
- Programs continue to be challenged with complex mental health needs
- The loss of General Assistance funds in Pennsylvania has exacerbated housing challenges for many PATH eligible persons
- 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. State-level factors are prohibiting the system in moving in the right direction. Two different administrative entities, including licensing bureaus, add to the lack of common philosophies and views on how treatment is provided. Unfortunately, most co-occurring services are delivered in a parallel or sequential method between mental health and drug and alcohol agencies. Co-occurring training for professionals is essential for staff.

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: 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. Dauphin County in collaboration with PerformCare have implemented two (2) COD clinics using the Hazelden model of integrated treatment in licensed Drug & alcohol clinics. Integrated treatment was disallowed in a licensed MH clinic. The start-up was funded with HealthChoices re-investment funds.

The YWCA received a grant to work specifically with individuals with Co-occurring D&A and MH disorders. The grant provides evidence based interventions, such as Illness Management & Recovery (IMR) and Supported Employment to the homeless population. The program serves veterans and non- veterans.

Peer-run Double Trouble meetings similar to the 12 step AA/NA meetings are available throughout the week in Dauphin County for individuals experiencing co-occurring MH & D&A

issues that need additional ongoing support. There is a Double Trouble Steering Committee composed of providers and peers that meets on a quarterly basis to assure there are adequate meetings and activities available to engage individuals to participate in throughout the County.

### 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. The following are evidence based and promising practices that are available in Dauphin County currently:

ACT (Assertive Community Treatment) – There are limited County-funds available for persons to receive these services until other benefits and entitlements are secured. ACT is Medicaid funded under HealthChoices, not MA Fee-for-Service.

Supported Employment –Dauphin County contracts with the YWCA of Greater Harrisburg to provide evidence-based Supported Employment program after a SAMHSA grant funding ended in September 2014. Dauphin County suspended its policy requiring first going through OVR (State Office of Vocational Rehabilitation) to access employment resources and supports. The process was too lengthy and yielded few positive results of eligibility for OVR services. Since these factors were not consistent with SAMHSA’s supported employment principles, rapid access to competitive employment resources at the YWCA will reduce barriers to employment services.

Family Psycho-Education – NAMI Dauphin County offers several classes per year for family members in the Family-to-Family Program. NAMI has also introduced Peer to Peer training for individuals as well. This resource is valuable for peers and family members to better understand their relative, spouse, parent or child.

Integrated Treatment for Co-occurring Disorders (COD) – PATH funds continue to support the co-occurring training needs of the homeless network in Dauphin County. Two outpatient psychiatric clinics have D&A outpatient clinic licenses. Two (2) COD clinics integrated treatment clinic are operational and Medicaid HealthChoices and County funded. Dauphin County has one (1) residential program based upon a therapeutic community model and persons referred must also be forensically involved; many individuals are also COD.

Illness Management and Recovery (IMR) – Several agencies use this program in small groups and individually in social rehabilitation, psychiatric rehabilitation, and residential services in Dauphin County.

Wellness Recovery Action Plans (WRAP) – Many individuals have been trained in WRAP and, as WRAP facilitators, are able to run groups. Certified Peer Support Programs have individuals who can assist in facilitating an individual's WRAP plan or can conduct WRAP training in a group setting. Ongoing training efforts continue with providers in further understanding how WRAP can be used to assist individuals in successfully moving forward in their recovery journey.

Additional recovery-oriented and promising practices such as Advanced Directives, Certified Peer Specialists, Double Trouble Groups, and Fairweather Lodges have been described in other sections of the PATH Intended Use Plan. Forensic Blended Case Management, Mental Health Court (currently suspended) and Drug Courts are also available to individuals that qualify for alternative sentencing and treatment options instead of incarceration. Two of Dauphin County's mental health outpatient clinics and the NHS PA ACT team have been trained in the Seeking Safety model. Additional training and certification of therapist in three (3) MH outpatient clinics in Cognitive Behavioral Therapy and Dialectical Behavioral Therapy have been completed. NHS PA provides OP DBT groups and individual therapy and has recently developed an open access walk in OP clinic that started in 2015. Training in DBT Teen will be completed in Spring 2016 with several agencies.

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.

A program developed by Volunteers of America (VOA) and funded by a grant from US Department of Veterans Affairs provides supportive services for low-income veterans and their families aimed at preventing homelessness and improving stability. These services include case management, transportation assistance, housing counseling, financial planning, legal services, employment search assistance, temporary financial assistance as well as assistance with obtaining VA and other public benefits. Capital Area Coalition on Homelessness (CACH) was actively involved in the planning process with the Veterans Affairs in order to eliminate homelessness for veterans.

As indicated throughout the Intended Use Plan, 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. The CSP leadership provides an ongoing monthly calendar of recovery events that provides an opportunity for individuals to participate in moving toward their own recovery. As a Block Grant County, Dauphin MH/ID Program documents their recovery and resilience priorities and activities.

CACH is the local lead agency that leverages HUD funding through the Continuum of Care in Dauphin County that provides and support and assistance in identifying the local needs of the homeless population and prioritizes funding for EBP and trainings for local PATH-Funded staff training activities to support the collection of PATH data in HMIS.

Dauphin County MH/ID Program uses a mix of County Base funds and HealthChoices funding through PerformCare, a Behavioral Health MCO, to fund EBPs that meet the needs of the MH population in Dauphin County.

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.

## **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 and various agencies in the homeless provider network are 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 in Dauphin County to develop a work plan for implementation of HMIS for all PATH data entry and reporting as required by June 30, 2016.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH agency staff will be supported on a day-to-day basis by Dauphin County MH administrative staff.

## **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. 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.

## **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.

Capital Area Coalition on Homelessness (CACH) as mentioned throughout the IUP is the designated local lead agency to implement the "Home Run", which is the Capital areas 10 year plan to end homelessness in the County of Dauphin and Harrisburg. CACH oversees the submission of the annual HUD Continuum of Care. The revised goals of the "Home Run" are as follows:

- To maintain and strengthen the Capital Area Coalition on Homelessness as the lead agency and facilitate and coordinate the organizational structure and planning for homelessness in Dauphin County.
- To develop HMIS to its full potential to make service providers jobs easier, while significantly improving the use of consumer information in screening, planning and coordination of services for homeless. Consumer information will also be utilized to evaluate the effectiveness of the service delivery system and the need for new and revised services/programs.
- To preserve existing resources and ensure the development of new, safe, decent, affordable housing opportunities for all homeless individuals and families.
- To ensure access to timely, appropriate, affordable and easily accessible services to end homelessness and prevent its recurrence.
- To educate the community to raise awareness and public support for more resource partners in order to open up new doors to end homelessness in Dauphin County.
- To develop short and long term strategies to significantly prevent the occurrence of homelessness in our community.

## **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. Dauphin County’s HAP staff and providers collaborate with the Capital Area Coalition on Homelessness (CACH), the lead agency for the Harrisburg City/Dauphin County Continuum of Care to coordinate services, leverage funding from HUD, Emergency Solutions Grant, and local funding. The use of data through HMIS continues to be refined. HAP providers also collaborate with CACH for the annual CACH Project Homeless Connect. The table below identifies the anticipated number of individual served in the HAP as reported in the Dauphin County Humans Services Block Grant FY 2105-16.

**Table 3 – HAP Services in FY15-16**

<b><i>HOMELESS ASSISTANCE SERVICES</i></b>	
Bridge Housing	100
Case Management	1,350
Rental Assistance	530
Emergency Shelter	910
Other Housing Supports	0
<b><i>TOTAL HAP SERVICES</i></b>	<b>2,890</b>

**Bridge Housing:**

Bridge Housing is a transitional housing program that allows clients who are in temporary housing to move to supportive long-term living arrangements while preparing to live independently. Clients must receive case management, supportive services and have a service plan that describes how the program will assist them for up to 18 months with the goal of returning client to the most independent life situation possible. This component is designed to “bridge” the gap between Emergency Shelter and stable long – term housing. Clients are generally eligible for 12 months of program participation. With county permission, a service provider can extend a client’s stay from 12 to 18 months. The YWCA and Brethren Housing Associates provide Bridge Housing. Dauphin County evaluates the efficacy of the program by measuring the change in accessing mainstream benefits as a result of program participation and housing status at exit as reported in Dauphin County’s FY 2015-16 Block Grant Plan.

**Case Management:**

Case management services assist clients in overcoming barriers in order to move from homelessness (out of shelter, off the street or out of danger of eviction) to a more stable situation and obtaining self-sufficiency. Case managers make referral and linkages to mainstream resources, other social service agencies and medical and treatment providers. Case managers work with HAP clients to establish realistic goals in the areas of basic life skills, financial management, parenting, home maintenance, employment preparation or employment skills. HAP

clients benefit from the advocacy role case managers provide and their assistance in navigating social services and educational systems and obtaining funding for other services, finding health care, meeting basic needs, and obtaining assistance in their search for permanent housing. Case management services are available to any client receiving HAP services. Gaudenzia and Christian Churches United are funded to provide case management services. Dauphin County evaluates the efficacy of the program by measuring the change in accessing mainstream benefits as a result of program participation and housing status change and/or the number of evictions successfully resolved as reported in Dauphin County's FY 2015-16 Block Grant Plan.

#### **Rental Assistance:**

The Rental Assistance program provides payment for delinquent rent for both apartment and mobile home lots; and security deposits and/or first month's rent for families and/or single individuals who are facing eviction or who are homeless. An individual or family is facing eviction if they have received either written or verbal notification from the landlord that they will lose their housing unless some type of payment is received. Clients have the opportunity to participate in budgeting; money management and landlord tenant information workshops to further assist clients in overcoming barriers and obtain assistance in gaining stability and becoming self-sufficient. Christian Churches United provides the Rental Assistance Program Service. Dauphin County evaluates the efficacy of the program by measuring the housing status change and/or the number of evictions successfully resolved as reported in Dauphin County's FY 2015-16 Block Grant Plan.

#### **SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)**

In FY 2011-12 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 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. The process is very time-consuming, detail oriented and comprehensive. In FY 12-13 4 SOAR applications were granted; FY 2013-14 5 SOAR applications were completed and approved; in FY14-15 seven (7) were approved and in FY15-16 twelve have been completed and approved as of April 2016.

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. No PATH funded positions in Dauphin County complete the SOAR process. This individual also maintains a small case load of homeless individuals in addition to the SOAR responsibilities. The SOAR process has proved to be very effective in Dauphin County in assisting individuals in obtaining the income and benefits needed to manage their basis needs as well as securing housing and moving on toward their recovery.

## 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 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. Dauphin County Local Housing Options Team (LHOT) has an active membership.

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.

The YWCA's Supportive Housing program recently received an award by the State for their housing program that supports veterans by using a housing first model in which they have successfully maintained 80% of the participants in permanent housing.

Paxton Ministries developed two (2) Fairweather-type Community Lodges in the Penbrook area for up to five individuals and in the Colonial Park area for up to three individuals. The Paxton Lodges are run and 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. The business model the Lodges developed is a cleaning company named Paxton Cleaning Solutions and has developed contracts with several area businesses to clean offices.

## **COORDINATED ENTRY**

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.

### 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.

Among this service population requesting emergency shelter:

- The HELP Office will first divert those who are about to become unsheltered within 14 days but can through short term rental assistance be rapidly rehoused or prevented from being homeless through housing prevention through Rapid Rehousing Program (RRH) or Homeless Prevention (HP). The HELP Office may have to place RRH candidates into shelter initially if more time is needed to process them into RRH units.
- Those who cannot be helped by rental assistance or rapid rehousing because of lack of funds or other reasons and likely require 1 to 3 months of emergency housing, as determined by intake assessment, will be referred to available emergency shelter.
- Those who are likely to need more than 3 months will be targeted for State HAP funded Transitional housing (TH) referrals (YWCA Bridge and BHA Transitions programs). The

HELP Office may have to refer candidates to ES in the event that TH is unavailable or requires more time.

Unsheltered Homeless Persons (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.

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).

Rural 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.

Homeless Veterans:

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 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's Mental Health Court has gone through a transition and has not been operating for quite some time. Ongoing negotiation and planning continues with plans to eventually reinstate this program in the future.

Dauphin County has a strong 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.

The Dauphin County SCA is also involved in a myriad of programs to assist those with substance use disorders in the criminal justice system. D&A has a staff person available to screen and assess individuals at the Judicial Center for diversion from incarceration.

At this point in time we are not required to and 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 we could predict it could 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.

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 enacted to replace the State Civil Service system and County Human Resources Department who reviews and monitors staff composition and equal employment opportunity criteria. We will continue to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

## **CONSUMER INFORMATION**

Dauphin County is a third class county located in south central Pennsylvania with a population of 272,983 individuals in 2015. It is estimated that 13.4% of the individuals that reside in Dauphin County live at or below the poverty level.

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 2016-17 to be similar to the previous year's annual data on hand. 100% of the individuals served in 2014-15 were between ages 18-61. 35% were males and 64% were female. Percentages of males and females was the greatest change over time. Among individuals reporting race/ethnicity 41% were African American; 55% were Caucasian; less than 1% were Asian and less than 1% were Hispanic/Latino. 54% of the individuals served reported having a Co-occurring MH and Substance Abuse Disorder and 37% reported they only had a MH disorder. 93% of individuals served indicated they were not a veteran. Less than 4% indicated they were a veteran. The remaining 3% did not report a veteran status. 35% of the individuals served indicated they lived outdoors (e.g. street, abandoned or public building or automobile) and 16% of those served indicated they were residing in an emergency shelter or transitional housing. Other living arrangements are not reported.

The Capital Area Coalition on Homelessness conducted a 2016 Point-In-Time Survey (PIT) of individuals and families who experience homelessness and the services they request. This point in time survey tracked all participants through anonymous identifiers enabling an unduplicated count of homeless census participants at multiple locations. There were a total of 433 surveys completed. There were 433 persons of which 132 were children. A total of 248 or 57% of those surveyed were either unsheltered or in emergency shelters. Of the unsheltered and emergency shelter respondents ( n=248) , 43 or 17% were unsheltered, 205 or 82% were in

emergency shelter .Of those in transitional housing and Safe Haven, 170 or 68% were in transitional housing and 15 or 16.53 % were in safe havens. The majority of the homeless adult responses were male 71% with female responses at 28%. 230 or 53% of the responses were from persons self-identified as African American followed by Caucasian at 175 or 40%. Persons self-reporting as ethnically Hispanic were 125 or 28%. 8 individuals or .03% identified themselves as veterans. The highest percentage of participants 54% indicated they were single adults followed by 45% from households with children.

The CACH Service Delivery Committee held its sixth Project Homeless Connect (PHC) in November 2015. The 2015 PHC served 344 guests plus 31 children seeking various forms of assistance; with a total of 375 people, including three unaccompanied youth. There were more than 82 hours of case management services following the event through December 2015. The Project was supported by more than 460 volunteers and had 72 different service providers and agencies available to offer assistance. The Project used a new format this year that concentrated services on unsheltered individuals and those persons living in emergency shelters. This approach led to improved service accessibility for the most vulnerable members of our community. The effort was fully funded by more than \$25,500 in private donations.

## **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. Dauphin County recruits and trains volunteers on an ongoing basis and provides a stipend to conduct the satisfaction surveys, conduct focus groups. Volunteers are supported by County staff in their roles. 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 has handled complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns. Person experiencing homelessness, including chronic homelessness have been involved in these activities as leaders/volunteers.

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 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.

## **BEHAVIORAL HEALTH DISPARITIES**

Behavioral health and 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. We continue to evaluate how this engagement strategy has impacted the number of persons in the PATH eligible target group accessing mental health services. 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. Dauphin County will continue to track and monitor as well as create strategies with the provider organization.

The previous section on service provision illustrates the relationship we have on access not only to mental health services but health care as well. 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. Dauphin County maintains a contract with the International Service Center for ethnic-specific services to persons, typically recent immigrants, who are of Asian descent. Dauphin County agencies have contractual agreements with interpreter services based on the needs of the individuals they serve. Providers continue to tailor services based on individual needs as well as accommodating individuals with 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. Unfortunately agencies continue to struggle with recruiting qualified employees.

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 supported 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.

The Lesbian, Gay, Bi-sexual, Transgendered, Questioning and Intersex (LGBTQI) population has been an on-going subpopulation of concern. Training was conducted in Dauphin County in FY2012-13 for PATH, homeless providers and mental health agencies. Alder Health Care is an established a licensed mental health outpatient psychiatric clinic co-located and integrated with their physical health services to serve individuals within the LGBTQI community.

Efforts to improve access to outpatient clinics have varied success and will continue to be prioritized. State-wide provider action to reduce psychiatrist's administrative burden in clinics through regulatory relief is still pending in State government. Provider-driven efforts to improve scheduling changes for medication clinic and evaluations are random and require psychiatric and

management cooperation. One agency, NHS of PA has been successful in establishing an open clinic two days per week. Strengthening the clinical skills of therapists has been and will continue to be a concern. Tele-psychiatry has been expanded in Dauphin County to address the shortage of qualified psychiatrists available at clinic locations to expand capacity and reduce waiting time for access to treatment.

Issues of aging are complex in Dauphin County. Because we serve persons with a serious mental illness, we are a primary support system to person who stay in the county and receive MH services as they age. Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served. Trainings will be planned to assist case managers in understanding nursing home assessment criteria, alternative to nursing homes, and information on guardianships in FY 2016-2017.

Dauphin County has been instrumental in working with county-funded agencies and the Medicaid BH-MCO in designing and carrying out their own wellness initiatives. Some activities that have been successful include:

- Wellness events on health topics open to individuals using mental health services and professionals.
- Toolkits and training for persons in services have assisted with communication with physicians, psychiatrists, and pharmacists.
- Health oriented activities in partial hospitalization programs, drop-in centers, and social rehabilitation, psychiatric rehabilitation, residential programs and at a 1:1 level with Certified Peer Specialist.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. There has been some confusion as to the exact age group TAY encompasses. Some OMHSAS information suggests persons age 16-24 years, SSA has referenced 18-24 year olds and SAMHSA PATH includes person ranging in ages from 18-30 years.

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 2014-15 28% of the individuals served were between the ages of 18-30 years.

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.

Local efforts began in the late 1990's to identify a set of needed supports and skills specific to person transitioning to adulthood. Based upon the work of Dr. Hewitt Clark at South Florida University and his TIP program, Dauphin County launched The JEREMY Project. JEREMY (Joint Efforts Reach and Energize More Youth) 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 JEREMY Project is in its 11<sup>th</sup> year of operation.

The area of employment is a major focus of individual sessions. The Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews. Additionally, in the large groups, employment soft skills are addressed and participants are connected to community resources to aid them in their employment goals. Participants have met with several employment agencies in order to access more resources and assistance with finding employment. Those individuals who meet criteria are also referred to the Office of Vocational Rehabilitation (OVR) to gain supports to meet their employment goals. The Transition Coordinator also collaborates with OVR and the school transition coordinators in order to set up gainful employment for the JEREMY Project participant.

Dauphin County MH/ID developed a Community Residential Rehabilitation (CRR) program was opened in 2015 for three (3) transition age young adults (18-24) with a specific design to allow for more structured support to transitional age persons navigating their adult lifestyle and supporting their mental health needs. Recovery measures had suggested that transition –age adults need additional support and programming to achieve successful independent living specific to their emotional, social and developmental issues.

**COMPREHENSIVE BUDGET NARRATIVE:**

**Personnel (\$ 55,613):** \$20,399 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. \$35,214 is the full-time salary of the Downtown Daily Bread Outreach Specialist position.

**Fringe Benefits (\$25,855):** \$9,708 or 47.59% references the benefits for one position within the Crisis Intervention Program. \$16,147 or 45.8 % 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 (\$1,800):** 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 (\$12,039):** **Staff Training (\$2,346):** 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. **Independent Living Resource (\$5,000):** This budget line represents the purchased services for life skills, pre-employment service and housing supports for PATH eligible consumers in transition from homelessness or at risk status to more stable independent living. **One-time Rental Assistance (\$2,347):** 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 (\$2,346):** 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% @ \$4,054):** Four (4) percent of the PATH grant is allocated to cover administrative expenses at MH/ID and Downtown Daily Bread

**Total PATH Request.....\$ 101,361**

**Dauphin County MH/ID Program  
FY 2016-17 PATH Comprehensive IUP Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Personnel Position</b>				
Crisis Caseworker	40,798	50%	20,399	20,399
DDB Outreach Specialist	35,214	100%	35,214	35,214
<b>Salary sub-total</b>			<b>55,613</b>	<b>55,613</b>
<b>Fringe Benefits (47.59% &amp; 45.8%)</b>				
Crisis (47.59%)				
FICA, Health, Ret, Life			9,708	9,708
DDB Outreach Spec (45.8%)				
FICA, Health, Ret			16,147	16,147
<b>Fringe sub-total</b>			<b>25,855</b>	<b>25,855</b>
<b>Travel</b>				
DDB Local Travel & parking			2,000	2,000
<b>Travel sub-total</b>			<b>2,000</b>	<b>2,000</b>
<b>Equipment</b>				
(list individually)			0	0
<b>sub-total</b>			<b>0</b>	<b>0</b>
<b>Supplies</b>				
Consumer-related items			1,800	1,800
<b>Supplies sub-total</b>			<b>1,800</b>	<b>1,800</b>
<b>Other</b>				
Staff training			2,346	2,346
One-time rental assistance			2,347	2,347
Security deposits			2,346	2,346
Independent Living Resource			5,000	5,000
<b>Other sub-total</b>			<b>12,039</b>	<b>12,039</b>
<b>Indirect Administration @ 4%</b>				<b>\$ 4,054</b>
<b>Total PATH Budget (Federal \$76,021 /State \$25,340)</b>				<b>\$ 101,361</b>

17. Dauphin County - Central Pennsylvania Supportive Services

3612 Centerfield Road

Harrisburg, PA 17106

Contact: Leta Detrick

Contact Phone #: 7179015099

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID:

State Provider ID:

Geographical Area Served: Central Region

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:  
 For source of match dollars for state funds: Central PA Supportive Services will receive \$5,000 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 0 Estimated Number of Persons to be Enrolled: 8  
 Estimated Number of Persons to be Contacted who are Literally Homeless: 8  
 Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Dauphin County MH/ID Program  
PATH Intended Use Plan with Central Pennsylvania Supportive Services  
FY 2016-17**

**LOCAL PROVIDER DESCRIPTION**

Central Pennsylvania Supportive Services, Inc. (CPSS) is a private, not-for-profit organization that adheres to a recovery philosophy which enhances and will continue to improve the Rehabilitation Programs at CPSS. The ways in which the Recovery Model is implemented, and how the outcomes are measured in each program, are stated in the Promoting Recovery document. A planned program of goal setting, functional assessment, identification of individuals strengths, their needs and preferred skills and supports, skill teaching and incorporating supports and resources are used to produce the desired outcomes consistent with a person's cultural environment.

Recovery is implemented by (1) the consumer taking an active role in goal setting and (2) taking more personal responsibility in the recovery process. CPSS provides the needed tools of formal and informal structure assisting the consumer in identifying their individual strengths, and how to build on them, which empowered the consumer. Empowerment enables them to better utilize their strengths and have the hope needed as they move toward recovery and independence.

CPSS is located at 3612 Centerfield Road, P.O. Box 62126, Harrisburg, PA 17106. While the Program has an office site, most services are provided on location wherever the person may be or in public facilities such as libraries, mental health programs or other settings where persons with homelessness frequent. Hours of service are arranged at the individual's convenience.

Dauphin County MH/ID Program will contract with Central Pennsylvania Supportive Services using \$5,000 in PATH funds. Dauphin County MH/MR Program and Central Pennsylvania Supportive Services will focus on the needs of literally homeless and imminently homeless individuals per the PATH definition. The service is called Independent Living resources (ILR). CPSS is expected to serve 8 persons in FY 2016-17.

**COLLABORATION WITH HUD CONTINUUM OF CARE**

Central Pennsylvania Supportive Services is a small organization and has not been involved with CACH activities except to participate in Project CONNECT and with mental health agencies that work with homeless persons with mental illness. Their referral source is usually the mental health case management base service unit which is the gateway to county-funded MH services which tend to be supportive and rehabilitative in nature.

## **COLLABORATION WITH LOCAL COMMUNITY 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 be 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. D & A Recovery Specialist positions were added to the array of services with Medicaid funds and have demonstrated a positive impact on engaging individuals in Drug & Alcohol treatment and supports. 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. The total number of employed Certified Peer Specialists in Dauphin County was surveyed at 24 in the fall 2015 and includes both full and part-time employees.

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. 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 BH-MCO contracts but not a county contracts. 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 providing integrated MH and D&A treatment.

The following chart best illustrates the range of unique specializations and evidenced based interventions available for a diverse population at the outpatient level of care.

**Table 8 – Licensed Psychiatric Outpatient Service Providers 2015-2016**

<b>Provider</b>	<b>Unique characteristics</b>
Adler Health Services	Integrated physical & behavioral health. Serves LGBTQI population. City location. Medicaid & Medicare.
Catholic Charities of the Capital Region	Homeless Clinic and works with Mission of Mercy. Medicaid and County funded.
Community Services Group	Children and families. Groups for adolescents. PCIT certified provider. Medicaid and County funded. DBT teen in 2016.
Commonwealth Clinical Group	Specialized offender and at-risk offender services to adults and teens. City location. Medicaid and County funded.
NHS of PA Capital Region	Primary clinic co-located with CMU, PA model; telepsychiatry, DBT and PCIT. Adults, older adults, children. City location & rural Northern Dauphin. Medicaid, Medicare and County funded. Open access clinic 2 days/week DBT Teen in 2016.
Pennsylvania Psychiatric Institute (PPI)	Culture specific –Hispanic and geriatric clinics, Clozaril and dual diagnosis (MH/ID) clinics. Adults and children. CBT & DBT Trained. City location. Medicaid, Medicare and County funded.
Pennsylvania Counseling Services	Also a D&A outpatient provider. COD Integrated treatment. City & suburban sites, including school-based sites. Medicaid, Medicare and County funded.
Philhaven	Telepsychiatry, Trauma-informed care, community based location. Medicaid and Medicare.
Pressley Ridge	Staff trained Play Therapists, The Incredible Years used in school based clinics. Medicaid, Medicare and County funded. School, city & suburban sites. Also in rural Northern Dauphin.
TeamCare	Suburban site. Medicaid and Medicare.
TW Ponessa and Associates	Also a D&A outpatient provider. Trauma-informed care; CBT trained. City location. Medicaid, Medicare

	and County funded.
Youth Advocate Programs	Certified Registered Nurse Practitioner/Art Therapist Community and school-based site. Medicaid, Medicare and County funded.

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 opened in 2014 a licensed facility based Psychiatric Rehabilitation Program that is funded with County dollars. 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 Elwyn, (KMHS) Keystone Mental Health Services, NHS of PA and Gaudenzia. KMHS opened in 2015 a licensed full-care CRR program for transition age population, ages 18-24 with a capacity to serve three individuals. NHS of PA using CHIPP funds established a DBT full-care CRR program in 2016. Supportive living services are provided by Volunteers of America (VOA), Keystone and Central Pennsylvania Supportive Services (CPSS) CPSS is a small provider of supportive services funded with PATH.

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 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. One short term residential bed was added in each program to specifically serve individuals with intellectual disabilities (ID) and mental illness (MH).

Dauphin County contracts with NHS PA and Keystone Service Systems for Specialized Care Residences (SCRs) licensed as Personal Care Homes (PCHs), but are exclusively for adults and older adults with serious mental illnesses. Staff has extensive mental health training, clinical support skills, which meet the unique characteristics of residents who also require PCH level of care. Personal care services include: assistance in completing tasks of daily living, social activities, assistance to use community services, and individualized assistance to enhance daily goals and life quality. Dauphin County also contracts with Paxton Ministries to provide personal care home services.

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 Systems Supportive Living Program has a designated staff that acts as a housing locator for individuals that secure HUD vouchers. Dauphin County MH/ID is implementing a Bridge Rental Subsidy program with HACD to serve approximately 6 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. Dauphin County has a Local Housing Options Team (LHOT) that meets regularly to improve working relationships with landlords around problem-solving to prevent homelessness.

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 now funded through Dauphin County. Most programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

A Safe Haven project is located in Dauphin County. The men's program is operated by Christian Churches United and offers transitional and "housing first" living for up to 25 men. The women's safe haven program had a capacity for 8 women and was operated by the YWCA of Greater Harrisburg. The YWCA transitioned the program to a Permanent Supportive Housing Program. The transition significantly improves 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. With the support of the US Department of Housing and Urban Development through the Continuum of Care Grant program, this new housing effort has become an established long-term resource in our community.

The 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 new HUD 811 project-based vouchers is a demonstration project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) make available safe and affordable permanent housing for individuals with disabilities. Dauphin County has two 2-bedroom vouchers. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH). The vouchers are serving 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.

Dauphin County is one of five Counties statewide selected for this opportunity in permanent supportive housing.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals based upon the Fairweather Lodge model. This program has an employment component called Paxton Cleaning Solutions and has competitive contracts with local companies in the surrounding area.

Hamilton Health Center is a federally qualified health center and offers comprehensive medical services, including dental services. Clinical supervision and psychiatric services are provided by Philhaven, a licensed mental health agency on-site. Approximately 33% of the individuals served at Hamilton Health Center are uninsured.

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, supportive living (CPSS) 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, in which a portion of these funds are in Dauphin County's existing PATH budget.

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 Central Pennsylvania Supportive Services PATH Services

Habilitation and rehabilitation services with individuals referred by the Dauphin County MH system who meet PATH eligibility criteria. A goal of the PATH Independent Living Resource (ILR) is that consumers with mental illness who are literally homeless, chronically homeless, or at imminent risk of homeless move toward life-style decisions that promote personal safety, recovery, independence and satisfying lives. The Independent Living Resource is intended to provide a range of rehabilitation supports and personalizing services based on the individual

needs in order to strengthen specific skill sets that will assist individuals in maintaining independent living arrangements in the community.

In addition to life skills training, Central Pennsylvania Supportive Services (CPSS) is dedicated to the employment of people who are displaced due to homelessness and experiencing mental illness. CPSS has a desire is to increase the level of independence and to improve the quality of life for individuals in the community. The goal is to instruct and support by providing job coaching and guidance through the development of employment related independent living skills. Each individuals is treated with respect and dignity and are seen as a unique with special needs and considerations.

A goal of service through CPSS is that individuals pursue employment in a field that makes use of their skills, interests and abilities. Life skills education and assistance with daily life activities also may be pursued outside the framework of promoting vocational readiness. The experience in service is geared to promoting recovery and assisting in the re-establishment of normal roles in the community. CPSS's particular contribution to the PATH initiative is in Life Skills Education, which may or may not have a vocational focus for PATH eligible consumers who may not be ready for or embrace work.

Services are intended for consumers with unconventional lifestyles and fragile tolerance for traditional and site-based mental health services. High premium will be placed on the staff spending time in the community working person to person with identified consumers, moving step by step to strengthen or acquire need skills in living and successfully housing.

Communication occurs regularly among the PATH-eligible consumer, CPSS and the involved case management or crisis intervention team. Meetings for review of progress will occur at intervals, with changes in the service plan proposed and made, if indicated. Family support is encouraged as much as possible.

Operationally, an initial intake is completed for the person, during which a needs assessment is completed. Documentation of PATH eligibility is required prior to service delivery. Services commence once needs are determined and a specific plan is developed for the consumer. Evaluations are completed within the first 30 days of service and every 60 days thereafter. The Case management entity is informed if progress is determined to be unsatisfactory. The service plan is reviewed and revised if necessary.

The consumer who becomes a candidate for job coaching will meet with a job coach to complete a skills and values assessment. The job coach and consumer discuss job opportunities that would support the consumer's values and skills. Competitive employment is sought with support. Once employment is in place, coaching is provided to ensure supports necessary to increase independence and self-sufficiency. Follow-along services occur at the pace of no less than two visits monthly. The follow—along phase is succeeded by one of monitoring, at a frequency of one monthly visit for an indefinite period, as agreed upon by the consumer, the agency, and the case management entity.

Life Skills introduced or reinforced through CPSS for PATH consumers will include those applicable to several life domains:

- ✓ Personal finances
- ✓ Housing
- ✓ Transportation
- ✓ Self-esteem
- ✓ Discrete job readiness
- ✓ Self-assessment
- ✓ Health care
- ✓ Academic activity
- ✓ Life training
- ✓ And Communication.

After initial support sessions, follow-along and monitoring are provided as deemed necessary by the person, the referring case management or crisis team, and the CPSS staff person. Community contacts are made for the purpose of continued education and support.

Transportation is a goal of independent living and mobility training is offered. People may remain in service for several months beyond the acquisition of new skills and stable living circumstances but support is always individualized.

#### Admission Criteria:

Referrals will originate with the CMU or with other case management entities associated with the Dauphin County MH/ID Program, which currently include the CMU and the Keystone Service Systems' Intensive Case Management Unit.

Candidates for the service must meet Federal PATH service eligibility criteria for homelessness or imminent homeless and for mental illness (according to federal PATH eligibility definitions), and be aged 16 or older. It is recommended that consumers be actively enrolled with the County MH/ID Program as PATH programming is initiated.

The candidate for CPSS services must be willing to work towards service goals to 1) attend work as scheduled; 2) be on time for work; 3) cooperate and listen to the instructions of the counselor and/or employer/supervisor on the job; 4) complete the assigned projects given by the instructor; and 5) miss no more than three appointments with agency staff.

Candidates for assistance toward improved life skills outside the context of vocational readiness may need (re)motivational interventions to engender interest and commitment in the services to be supplied.

#### Discharge Criteria:

- When it is determined by the consumer, CPSS, and the Case management entity that the goals have been reached or potential has been maximized

- If the person of his/her own free will chooses to end treatment for any reason;
- If CPSS decides that the consumer is not taking an active role in his/her treatment/service plan. In this event and prior to termination, a meeting first is held with the consumer and a family member, CPSS and the Case management entity and other interagency team members to determine the level of progress. Specific needs are discussed, services are evaluated and adjusted and made, is necessary. If, after modifications, the consumer remains inactive in the process, termination may result
- Funding exceeds the contract specifications

Other supportive services involved with the person are notified by telephone and letter of such terminations within 24 hours of the action.

Steps toward termination from this service will be tempered in recognition of the characteristic difficulty in relating to conventional system services that many people in this target group exhibit.

### Service Gaps

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 Human Services have attempted to provide access to appointments for individuals with urgent need to access psychiatric services. Service gaps will impact the efforts of Central Pennsylvania Supportive Services. Collaboration with mental health agencies and the opportunity to integrate supportive living with treatment will help to minimize them.

### Needs of the Co-Occurring Population

Addressing the complex needs of the co-occurring population in Dauphin County has been challenging. In order for this population to be served effectively, outpatient mental health providers should offer integrated treatment approaches with this population. Dauphin County is charged with assuring there are established services and contracts for 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 plan for but face barriers to implement integrated treatment to meet the needs of persons with co-occurring disorders. Dauphin County has two (2) COD clinic within licensed D&A outpatient programs. Among person who are medical assistance eligible services are administered through the same behavioral health managed care organization (PerformCare).

The services described in the section on Collaboration with Local Community Organizations provides a thorough outline of services available which are County funded and Medical Assistance funded for individuals with co-occurring disorders. Briefly, the co-occurring population has access to outpatient services, partial day programs, residential services, and

support services such as targeted case management, supportive living, social rehabilitation as well as inpatient care. Unfortunately, most services are delivered in a parallel or sequential method between mental health and drug and alcohol agencies.

Evidenced based and promising practices

Central Pennsylvania Supportive Services is knowledgeable about PATH and homelessness. The program has a well-established foundation on recovery and resiliency and more understanding and exposure to existing evidenced based and promising practices used in Dauphin County is planned such as:

ACT ( Assertive Community Treatment)  
Supported Employment  
DBT  
Family Psycho-education  
Illness Management and Recovery  
WRAP  
Peer specialists/recovery specialists  
MH and Drug Courts

Central Pennsylvania Supportive Services is very familiar with SAMHSA's model for supportive employment.

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.

Central Pennsylvania Supportive Services is readily available to working with anyone seeking assistance via PATH services who are eligible and may be 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 and/or 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 are part of the Project CONNECT outreach and follow-up.

As indicated in section titled Service Provision of the Comprehensive Intended Use Plan, Dauphin County embraces the Principles of Recovery and Resiliency. An Annual Plan submitted to the Commonwealth's Department of Public Welfare/Office of Mental Health and

Substance Abuse Services details all the transformation activities undertaken to move our system toward a recovery and resiliency orientation. 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. Dauphin County's MH/ID Program staff create opportunities and support recovery at all levels of the system.

## **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 and various agencies in the homeless provider network are 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 in Dauphin County to develop a work plan for implementation of HMIS for all PATH data entry and reporting as required by June 30, 2016.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH agency staff will be supported on a day-to-day basis by Dauphin County MH administrative staff.

## **ALIGNMENT WITH PATH GOALS**

Central Pennsylvania Supportive Services is committed to PATH goals for literally homeless persons and devotes PATH funds and other funds to this end. CPSS staff focus on conducting service by face-to-face contact in any setting, CPSS 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 have 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. CPSS has previously been very successfully supporting persons who are literally homeless establish supportive housing and skills.

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.

## **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 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.

Capital Area Coalition on Homelessness (CACH) as mentioned throughout the IUP is the designated local lead agency to implement the "Home Run", which is the Capital areas 10 year plan to end homelessness in the County of Dauphin and Harrisburg. CACH oversees the submission of the annual HUD Continuum of Care. The revised goals of the "Home Run" are as follows:

- To maintain and strengthen the Capital Area Coalition on Homelessness as the lead agency and facilitate and coordinate the organizational structure and planning for homelessness in Dauphin County
- To develop HMIS to its full potential to make service providers jobs easier, while significantly improving the use of consumer information in screening, planning and coordination of services for homeless. Consumer information will also be utilized to evaluate the effectiveness of the service delivery system and the need for new and revised services/programs
- To preserve existing resources and ensure the development of new, safe, decent, affordable housing opportunities for all homeless individuals and families.
- To ensure access to timely, appropriate, affordable and easily accessible services to end homelessness and prevent its recurrence
- To educate the community to raise awareness and public support for more resource partners in order to open up new doors to end homelessness in Dauphin County.
- To develop short and long term strategies to significantly prevent the occurrence of homelessness in our community

## **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. Dauphin County's HAP staff and providers collaborate with the Capital Area Coalition on Homelessness (CACH), the lead agency for the Harrisburg City/Dauphin County Continuum of Care to coordinate services, leverage funding from HUD, Emergency Solutions Grant, and local funding.

## **SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)**

In FY 2011-12 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 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. The process is very time-consuming, detail oriented and comprehensive. In FY 12-13 4 SOAR applications were granted; FY 2013-14 5 SOAR applications were completed and approved; in FY14-15 seven (7) were approved and in FY15-16 twelve have been completed and approved as of April 2016.

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. No PATH funded positions in Dauphin County complete the SOAR process. This individual also maintains a small case load of homeless individuals in addition to the SOAR responsibilities. The SOAR process has proved to be very effective in Dauphin County in assisting individuals in obtaining the income and benefits needed to manage their basic needs as well as securing housing and moving on toward their recovery. CPSS refers to the SOAR coordinator when appropriate.

## **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. CPSS 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
- Safe Haven, a housing first program for 8 homeless women

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.

Central Pennsylvania Supportive Services and 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. Dauphin County Local Housing Options Team (LHOT) has an active membership.

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.

The YWCA's Supportive Housing program recently received an award by the State for their housing program that supports veterans by using a housing first model in which they have successfully maintained 80% of the participants in permanent housing.

Paxton Ministries developed two (2) Community Lodges based on the Fairweather Lodge model in the Penbrook area for up to five individuals and in the Colonial Park area for up to three individuals. The Paxton Lodges are run and 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. The business model the Lodges developed is a cleaning company named Paxton Cleaning Solutions and has developed contracts with several area businesses to clean offices.

## **COORDINATED ENTRY**

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.

### 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.

Among this service population requesting emergency shelter:

1. The HELP Office will first divert those who are about to become unsheltered within 14 days but can through short term rental assistance be rapidly rehoused or prevented from being homeless through housing prevention through Rapid Rehousing Program (RRH) or Homeless Prevention (HP). The HELP Office may have to place RRH candidates into shelter initially if more time is needed to process them into RRH units.
2. Those who cannot be helped by rental assistance or rapid rehousing because of lack of funds or other reasons and likely require 1 to 3 months of emergency housing, as determined by intake assessment, will be referred to available emergency shelter.
3. Those who are likely to need more than 3 months will be targeted for State HAP funded Transitional housing (TH) referrals (YWCA Bridge and BHA Transitions programs). The HELP Office may have to refer candidates to ES in the event that TH is unavailable or requires more time.

#### Unsheltered Homeless Persons (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.

#### 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).

#### Rural 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.

#### Homeless Veterans:

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**

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 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's Mental Health Court has gone through a transition and has not been operating for quite some time. Ongoing negotiation and planning continues with plans to eventually reinstate this program in the future.

Dauphin County has a strong 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.

The Dauphin County SCA is also involved in a myriad of programs to assist those with substance use disorders in the criminal justice system. D&A has a staff person available to screen and assess individuals at the Judicial Center for diversion from incarceration.

At this point in time , MH/ID is not required to and 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 we could predict it could 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.

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 enacted to replace the State Civil Service system and County Human Resources Department who reviews and monitors staff composition and equal employment opportunity criteria. We will continue to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

## **CONSUMER INFORMATION**

Dauphin County is a third class county located in south central Pennsylvania with a population of 272,983 individuals in 2015. It is estimated that 13.4% of the individuals that reside in Dauphin County live at or below the poverty level.

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 2016-17 to be similar to the previous year's annual data on hand. 100% of the individuals served in 2014-15 were between ages 18-61. 35% were males and 64% were female. Percentages of males and females was the greatest change over time. Among individuals reporting race/ethnicity 41% were African American; 55% were Caucasian; less than 1% were Asian and less than 1% were Hispanic/Latino. 54% of the individuals served reported having a Co-occurring MH and Substance Abuse Disorder and 37% reported they only had a MH disorder. 93% of individuals served indicated they were not a veteran. Less than 4% indicated they were a veteran. The remaining 3% did not report a veteran status. 35% of the individuals served indicated they lived outdoors (e.g. street, abandoned or public building or automobile) and 16% of those served indicated they were residing in an emergency shelter or transitional housing. Other living arrangements are not reported.

The Capital Area Coalition on Homelessness conducted a 2016 Point-In-Time Survey (PIT) of individuals and families who experience homelessness and the services they request. This point in time survey tracked all participants through anonymous identifiers enabling an unduplicated count of homeless census participants at multiple locations. There were a total of 433 surveys completed. There were 433 persons of which 132 were children. A total of 248 or 57% of those surveyed were either unsheltered or in emergency shelters. Of the unsheltered and emergency shelter respondents (n=248), 43 or 17% were unsheltered, 205 or 82% were in emergency shelter. Of those in transitional housing and Safe Haven, 170 or 68% were in transitional housing and 15 or 16.53% were in safe havens. The majority of the homeless adult responses were male 71% with female responses at 28%. 230 or 53% of the responses were from persons self-identified as African American followed by Caucasian at 175 or 40%. Persons self-reporting as ethnically Hispanic were 125 or 28%. 8 individuals or .03% identified themselves as veterans. The highest percentage of participants 54% indicated they were single adults followed by 45% from households with children.

The CACH Service Delivery Committee held its sixth Project Homeless Connect (PHC) in November 2015. The 2015 PHC served 344 guests plus 31 children seeking various forms of assistance; with a total of 375 people, including three unaccompanied youth. There were more than 82 hours of case management services following the event through December 2015. The Project was supported by more than 460 volunteers and had 72 different service providers and agencies available to offer assistance. The Project used a new format this year that concentrated services on unsheltered individuals and those persons living in emergency shelters. This approach led to improved service accessibility for the most vulnerable members of our community. The effort was fully funded by more than \$25,500 in private donations.

## **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. Dauphin County recruits and trains volunteers on an ongoing basis and provides a stipend to conduct the satisfaction surveys, conduct focus groups. Volunteers are supported by County staff in their roles. 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 has handled complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns. Person experiencing homelessness, including chronic homelessness have been involved in these activities as leaders/volunteers.

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 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.

## **BEHAVIORAL HEALTH DISPARITIES**

Behavioral health and 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. We continue to evaluate how this engagement strategy has impacted the number of persons in the PATH eligible target group accessing mental health services. 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. Dauphin County will continue to track and monitor as well as create strategies with the provider organization.

The previous section on service provision illustrates the relationship we have on access not only to mental health services but health care as well. 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. Dauphin County maintains a contract with the International Service Center for ethnic-specific services to persons, typically recent immigrants, who are of Asian descent. Dauphin County agencies have contractual agreements with interpreter services based on the needs of the individuals they serve. 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. Unfortunately agencies continue to struggle with recruiting qualified employees.

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.

The Lesbian, Gay, Bi-sexual, Transgendered, Questioning and Intersex (LGBTQI) population has been an on-going subpopulation of concern. Training was conducted in Dauphin County in FY2012-13 for PATH, homeless providers and mental health agencies. Alder Health Care is an

established a licensed mental health outpatient psychiatric clinic co-located and integrated with their physical health services to serve individuals within the LGBTQI community.

Efforts to improve access to outpatient clinics have varied success and will continue to be prioritized. State-wide provider action to reduce psychiatrist's administrative burden in clinics through regulatory relief is still pending in State government. Provider-driven efforts to improve scheduling changes for medication clinic and evaluations are random and require psychiatric and management cooperation. One agency, NHS of PA has been successful in establishing an open clinic two days per week. Strengthening the clinical skills of therapists has been and will continue to be a concern. Tele-psychiatry has been expanded in Dauphin County to address the shortage of qualified psychiatrists available at clinic locations to expand capacity and reduce waiting time for access to treatment.

Issues of aging are complex in Dauphin County. Because we serve persons with a serious mental illness, we are a primary support system to person who stay in the county and receive MH services as they age. Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served. Trainings will be planned to assist case managers in understanding nursing home assessment criteria, alternative to nursing homes, and information on guardianships in FY 2016-17.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. There has been some confusion as to the exact age group TAY encompasses. Some OMHSAS information suggests persons age 16-24 years, SSA has referenced 18-24 year olds and SAMHSA PATH includes person ranging in ages from 18-30 years.

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 2014-15 28% of the individuals served were between the ages of 18-30 years. 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.

Local efforts began in the late 1990's to identify a set of needed supports and skills specific to person transitioning to adulthood. Based upon the work of Dr. Hewitt Clark at South Florida University and his TIP program, Dauphin County launched The JEREMY Project. JEREMY (Joint Efforts Reach and Energize More Youth) 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 JEREMY Project is in its 11<sup>th</sup> year of operation.

The area of employment is a major focus of individual sessions. The Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews. Additionally, in the large groups, employment soft skills are addressed and participants are connected to community resources to aid them in their employment goals. Participants have met with several employment agencies in order to access more resources and assistance with finding employment. Those individuals who meet criteria are also referred to the Office of Vocational Rehabilitation (OVR) to gain supports to meet their employment goals. The Transition Coordinator also collaborates with OVR and the school transition coordinators in order to set up gainful employment for the JEREMY Project participant.

### **CPSS BUDGET AND BUDGET NARRATIVE**

CPSS has a rate for ILR set by the PA Office of Vocational Rehabilitation. The rate was set in FY2003-2004. The fee-for-service rate is \$48.00 per hour. Dauphin County MH/ID Program has accepted this rate and will modify the rate, if and when the OVR approves a rate change.

**Dauphin County MH/ID Program  
FY 2016-17 PATH Central Pennsylvania Supportive Services IUP Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Case Manager				
<b>sub-total</b>			0	0
<b>Fringe Benefits</b>				
FICA Tax				
Health Insurance				
Retirement/Life Ins				
<b>sub-total</b>			0	0
<b>Travel</b>				
Local Travel for Outreach				
<b>sub-total</b>			0	0
<b>Equipment</b>				
(list individually)				
<b>sub-total</b>			0	0
<b>Supplies</b>				
Consumer-related items				
<b>sub-total</b>			0	0
<b>Other</b>				
Staff training				
1X rental assistance				
Security deposits				
Independent Living Resources			5,000	5,000
<b>sub-total</b>			5,000	<b>5,000</b>
<b>Total PATH Budget</b>				<b>5,000</b>

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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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b. Fringe Benefits	0.00 %	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other	\$ 0	\$ 0	\$ 0	
No Data Available				

i. Total Direct Charges (Sum of a-h)	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
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k. Grand Total (Sum of i and j)	\$ 0	\$ 0	\$ 0	
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Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Downtown Daily Bread will receive \$56,444 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	140	Estimated Number of Persons to be Enrolled:	100
Estimated Number of Persons to be Contacted who are Literally Homeless:	84		
Number Staff trained in SOAR in Grant year ended in 2014:	0	Number of PATH-funded consumers assisted through SOAR:	0

**Dauphin County MH/ID Program  
PATH Intended Use Plan with Downtown Daily Bread  
FY 2016-17**

**LOCAL PROVIDER DESCRIPTION**

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.

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.

Dauphin County MH/ID Program will contract with Downtown Daily Bread using \$ 56,444 in PATH funds for the Homeless Outreach Specialist position and related costs. Outreach is expected to include 380 persons of which 300 will be PATH enrolled and eligible in Dauphin County. Downtown Daily Bread has a goal to outreach to 140 persons and enroll 100 individuals. It is estimated that 60% of the person enrolled in PATH by Downtown Daily Bread will be literally homeless and 40% will be at risk of homelessness.

**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 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. Downtown Daily Bread is linked into the provider network via the PATH contract.

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.

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 PATH dollars.

CMU, Philhaven, and Keystone offer Certified Peer Specialist services that are approved by OMHSAS and credentialed by PerformCare (BH-MCO). Other agencies have Peer Specialist positions imbedded in their programs providing an ongoing focus on recovery. The total number of employed Certified Peer Specialists in Dauphin County was surveyed at 24 in the Fall 2015 and includes both full and part-time employees.

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. 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 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 provide integrated MH and D&A treatment.

The following chart best illustrates the a range of unique specializations and evidenced based interventions available for a diverse population at the outpatient level of care.

**Table 7 – Licensed Psychiatric Outpatient Service Providers 2016-17**

<b>Provider</b>	<b>Unique characteristics</b>
Adler Health Services	Integrated physical & behavioral health. Serves LGBTQI population. City location. Medicaid & Medicare.
Catholic Charities of the Capital Region	Homeless Clinic and works with Mission of Mercy. Medicaid and County funded.
Community Services Group	Children and families. Groups for adolescents. PCIT certified provider. Medicaid and County funded. DBT Teen in 2016.
Commonwealth Clinical Group	Specialized offender and at-risk offender services to adults and teens. City location. Medicaid and County funded.
NHS of PA Capital Region	Primary clinic co-located with CMU, PA model; tele-psychiatry, DBT and PCIT. Adults, older adults, children. City location & rural Northern Dauphin. Medicaid, Medicare and County funded. Open access clinic 2 days/week. DBT Teen in 2016.
Pennsylvania Psychiatric Institute (PPI)	Culture specific –Hispanic and geriatric clinics, Clozaril and dual diagnosis (MH/ID) clinics. Adults and children. CBT &DBT Trained. City location. Medicaid, Medicare and County funded.
Pennsylvania Counseling Services	Also a D&A outpatient provider. COD Integrated treatment. City & suburban sites, including school-based sites. Medicaid, Medicare and County funded.
Philhaven	Telepsychiatry, Trauma-informed care, community based location. Medicaid and Medicare.
Pressley Ridge	Staff trained Play Therapists, The Incredible Years used in school based clinics. Medicaid, Medicare and County funded. School, city & suburban sites. Also in rural Northern Dauphin.
TeamCare	Suburban site. Medicaid and Medicare.
TW Ponessa and Associates	Also a D&A outpatient provider. Trauma-informed care; CBT trained. City location. Medicaid, Medicare

	and County funded.
Youth Advocate Programs	Certified Registered Nurse Practitioner/Art Therapist Community and school-based site. Medicaid, Medicare and County funded.

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 facility based Psychiatric Rehabilitation Program that is funded with County dollars. Mobile services are planned.

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 Elwyn, (KMHS) Keystone Mental Health Services, NHS of PA, and Gaudenzia. KMHS opened in 2015 a licensed full-care CRR program for transition age population, ages 18-24 with a capacity to serve three individuals. NHS of PA using CHIPF funds in 2016 started a three-bed full-care CRR program using DBT to guide interventions. Supportive living services are provided by Volunteers of America (VOA), Keystone and Central Pennsylvania Supportive Services (CPSS). CPSS is a small provider of supportive services funded with PATH.

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 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. One short term residential bed was added in each program to specifically serve individuals with intellectual disabilities (ID) and mental illness (MH).

Dauphin County contracts with NHS PA and Keystone Service Systems for Specialized Care Residences (SCRs) licensed as Personal Care Homes (PCHs), but are exclusively for adults and older adults with serious mental illnesses. Staff has extensive mental health training, clinical support skills, which meet the unique characteristics of residents who also require PCH level of care. Personal care services include: assistance in completing tasks of daily living, social activities, assistance to use community services, and individualized assistance to enhance daily goals and life quality. Dauphin County also contracts with Paxton Ministries to provide personal care home services.

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 Systems Supportive Living Program has a designated staff that acts as a housing locator for individuals that secure HUD vouchers. Dauphin County MH/ID is implementing a Bridge Rental Subsidy program with HACD to serve approximately 6 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. Dauphin County has a Local Housing Options Team (LHOT) that meets regularly to improve working relationships with landlords around problem-solving to prevent homelessness.

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 now funded through Dauphin County funds. Most programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

A Safe Haven project is located in Dauphin County. The men's program is operated by Christian Churches United and offers transitional and "housing first" living for up to 25 men. The women's safe haven program had a capacity for 8 women and was operated by the YWCA of Greater Harrisburg. The YWCA has transitioned the program to a Permanent Supportive Housing Program. This transition has significantly improve 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. With the support of the US Department of Housing and Urban Development through the Continuum of Care Grant program, this new housing effort will become an established long-term resource in our community.

The 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 new HUD 811 project-based vouchers is a demonstration project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) make available safe and affordable permanent housing for individuals with disabilities. Dauphin County has two 2-bedroom apartments approved. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH). The vouchers are serving 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. Dauphin County is one of five Counties statewide in 2015 selected for this opportunity in permanent supportive housing.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals based upon the Fairweather Lodge model. This program has an employment component called Paxton Cleaning Solutions and has competitive contracts with local companies in the surrounding area.

Hamilton Health Center is a federally qualified health center and offers comprehensive medical services, including dental services. LCSW staff provide mental health counseling. Approximately 33% of the individuals served at Hamilton Health Center are uninsured.

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, supportive living, the Crisis Intervention Program and Downtown Daily Bread have access to limited 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, in which a portion of these funds are in Dauphin County's existing PATH budget.

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 Program**

Outreach services, specifically 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 for diagnostic treatment services** may be conducted by the Outreach Specialist at Downtown Daily Bread who has been trained to screen for mental health and drug & alcohol needs. Direct face to face interactions in locations that homeless persons are comfortable with allow for sustained contact for rapport and trust building. These are key factors in working with a populations of individuals who often experience or have experienced fear and distrust of formal community institutions and services. 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.

**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.

These services are consistent with the priorities and recommendations outlined by the Ad Hoc Shelter Committee of the Capital Area Coalition on Homelessness (CACH) and CACH's Blueprint to End Homelessness. Both services will be undertaken by one full-time position, Outreach Specialist, and work with the efforts of the Dauphin County Crisis Intervention Program (currently PATH funded). An administrative mental health case manager (not PATH funded) has been redesigned with a small homeless caseload and SOAR case coordination responsibilities. The staff person has experience and training to function in an outreach capacity with a reluctant and guarded population. No downtown Daily Bread staff are SOAR trained and no DDB staff will be processing SOAR referrals. The lead agency for SOAR is the CMU and Downtown daily Bread coordinates SOAR referrals with the CMU SOAR trained ( NOT PATH funded) staff.

The 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.

## Service Gaps

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.

PATH-funded services need to continue to be flexible and address the unique needs of the homeless individuals we serve in Dauphin County.

- Limited availability of emergency shelter space.
- Limited existing resources and long waiting lists for transitional, as well as, permanent housing resources.
- Programs continue to be challenged with complex mental health needs and the lack of appropriate services to meet the special needs of consumers with co-occurring disorders (mental illness and substance use). State regulations and licensing are the primary barrier to integrated treatment in Pennsylvania.
- The loss of General Assistance funds in Pennsylvania has exacerbated housing challenges for many PATH eligible persons.
- 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. State-level factors are prohibiting the system in moving in the right direction. Two different administrative entities, including licensing bureaus, add to the lack of common philosophies and views on how treatment is provided. Unfortunately, most co-occurring services are delivered in a parallel or sequential method between mental health and drug and alcohol agencies. Co-occurring training for professionals is essential for staff.

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: 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. Dauphin County in collaboration with PerformCare implemented two (2) COD clinics using the Hazelden model of integrated treatment.

The YWCA received a grant to work specifically with individuals with Co-occurring D&A and MH disorders. The grant provides evidence based interventions, such as Illness Management & Recovery (IMR) and Supported Employment to the homeless population. The program serves veterans and non- veterans.

Peer-run Double Trouble meetings similar to the 12 step AA/NA meetings are available throughout the week in Dauphin County for individuals experiencing co-occurring MH & D&A issues that need additional ongoing support. There is a Double Trouble Steering Committee composed of providers and peers that meets on a quarterly basis to assure there are adequate meetings and activities available to engage individuals to participate in throughout the County.

#### Evidenced based and Promising Practices

The Downtown Daily Bread Outreach Specialist position has oriented to street outreach methods promoted by PATH as well as the philosophy of “Housing First”. Further work on recovery and resiliency was completed and we continue to work on greater exposure to existing evidenced based and promising practices used in Dauphin County such as:

- ACT (Assertive Community Treatment)
- Supported Employment
- DBT (Dialectical Behavioral Therapy)
- Family Psycho-education
- Illness Management and Recovery
- WRAP
- Peer specialists/recovery specialists
- MH and Drug Courts

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.

As indicated in the Comprehensive Intended Use Plan, Dauphin County embraces the Principles of Recovery and Resiliency. A Block Grant Plan submitted to the Commonwealth's Department of Human Services/Office of Mental Health and Substance Abuse Services details all the transformation activities undertaken to move our system toward a recovery and resiliency orientation. 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. Dauphin County's MH/ID Program staff create opportunities and support recovery at all levels of the system.

## **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 and various agencies in the homeless provider network are 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 in Dauphin County to develop a work plan for implementation of HMIS for all PATH data entry and reporting as required by June 30, 2016.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH agency staff will be supported on a day-to-day basis by Dauphin County MH administrative staff.

Shelter and other service providers in the homeless provider network are entering their data into the HMIS system.

## **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.

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.

### **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.

Capital Area Coalition on Homelessness (CACH) as mentioned throughout the IUP is the designated local lead agency to implement the "Home Run", which is the Capital areas 10 year plan to end homelessness in the County of Dauphin and Harrisburg. CACH oversees the submission of the annual HUD Continuum of Care. The revised goals of the "Home Run" are as follows:

- To maintain and strengthen the Capital Area Coalition on Homelessness as the lead agency and facilitate and coordinate the organizational structure and planning for homelessness in Dauphin County.
- To develop HMIS to its full potential to make service providers jobs easier, while significantly improving the use of consumer information in screening, planning and coordination of services for homeless. Consumer information will also be utilized to evaluate the effectiveness of the service delivery system and the need for new and revised services/programs.
- To preserve existing resources and ensure the development of new, safe, decent, affordable housing opportunities for all homeless individuals and families.
- To ensure access to timely, appropriate, affordable and easily accessible services to end homelessness and prevent its recurrence.
- To educate the community to raise awareness and public support for more resource partners in order to open up new doors to end homelessness in Dauphin County.
- To develop short and long term strategies to significantly prevent the occurrence of homelessness in our community.

### **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.

### **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). All potential SOAR applicants are screened and the process has been used to secure benefits for 28 people since the initial training in FY2011-2012. The process is very time-consuming but the State BDD staff have appreciated the detailed and accurate information provided in the applications. The Downtown Daily Bread's Outreach Specialist is familiar enough with the program to make referrals for the service as a component of their PATH case management service plan. No PATH Funds are used for the SOAR coordinator /MH case manager for homeless persons at the CMU. Downtown Daily Bread staff are not PATH trained. However, DDB staff make SOAR referrals.

### **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.
- Safe Haven, a housing first program for 8 homeless women.

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.

Downtown Daily Bread continues to further develop potential partners with whom to improve relationship with such as Dauphin County's Department of Community and Economic Development and the Harrisburg City Housing Authority. Dauphin County Local Housing Options Team (LHOT) has an active membership.

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.

The YWCA's Supportive Housing program recently received an award by the State for their housing program that supports veterans by using a housing first model in which they have successfully maintained 80% of the participants in permanent housing.

Paxton Ministries developed two (2) Fairweather-type Community Lodges in the Penbrook area for up to five individuals and in the Colonial Park area for up to three individuals. The Paxton Lodges are run and 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. The business model the Lodges developed is a cleaning company named Paxton Cleaning Solutions and has developed contracts with several area businesses to clean offices.

**COORDINATED ENTRY**

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.

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.

Among this service population requesting emergency shelter:

1. The HELP Office will first divert those who are about to become unsheltered within 14 days but can through short term rental assistance be rapidly rehoused or prevented from being homeless through housing prevention through Rapid Rehousing Program (RRH) or Homeless Prevention (HP). The HELP Office may have to place RRH candidates into shelter initially if more time is needed to process them into RRH units.
2. Those who cannot be helped by rental assistance or rapid rehousing because of lack of funds or other reasons and likely require 1 to 3 months of emergency housing, as determined by intake assessment, will be referred to available emergency shelter.
3. Those who are likely to need more than 3 months will be targeted for State HAP funded Transitional housing (TH) referrals (YWCA Bridge and BHA Transitions programs). The HELP Office may have to refer candidates to ES in the event that TH is unavailable or requires more time.

Unsheltered Homeless Persons (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.

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).

Rural 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.

Homeless Veterans:

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**

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 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's Mental Health Court has gone through a transition and has not been operating for quite some time. Ongoing negotiation and planning continues with plans to eventually reinstate this program in the future.

Dauphin County has a strong 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.

The Dauphin County SCA is also involved in a myriad of programs to assist those with substance use disorders in the criminal justice system. D&A has a staff person available to screen and assess individuals at the Judicial Center for diversion from incarceration.

At this point in time , MH/ID is not required to and 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 we could predict it could 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.

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 enacted to replace the State Civil Service system and County Human Resources Department who reviews and monitors staff composition and equal employment opportunity criteria. We will continue to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

## **CONSUMER INFORMATION**

Dauphin County is a third class county located in south central Pennsylvania with a population of 272,983 individuals in 2015. It is estimated that 13.4% of the individuals that reside in Dauphin County live at or below the poverty level.

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 2016-17 to be similar to the previous year's annual data on hand. 100% of the individuals served in 2014-15 were between ages 18-61. 35% were males and 64% were female. Percentages of males and females was the greatest change over time. Among individuals reporting race/ethnicity 41% were African American; 55% were Caucasian; less than 1% were Asian and less than 1% were Hispanic/Latino. 54% of the individuals served reported having a Co-occurring MH and Substance Abuse Disorder and 37% reported they only had a MH disorder. 93% of individuals served indicated they were not a veteran. Less than 4% indicated they were a

veteran. The remaining 3% did not report a veteran status. 35% of the individuals served indicated they lived outdoors (e.g. street, abandoned or public building or automobile) and 16% of those served indicated they were residing in an emergency shelter or transitional housing. Other living arrangements are not reported.

The Capital Area Coalition on Homelessness conducted a 2016 Point-In-Time Survey (PIT) of individuals and families who experience homelessness and the services they request. This point in time survey tracked all participants through anonymous identifiers enabling an unduplicated count of homeless census participants at multiple locations. There were a total of 433 surveys were completed. There were 433 persons of which 132 were children. A total of 248 or 57% of those surveyed were either unsheltered or in emergency shelters. Of the unsheltered and emergency shelter respondents (n=248), 43 or 17% were unsheltered, 205 or 82% were in emergency shelter.

The CACH Service Delivery Committee held its sixth Project Homeless Connect (PHC) in November 2015. The 2015 PHC served 344 guests plus 31 children seeking various forms of assistance; with a total of 375 people, including three unaccompanied youth. There were more than 82 hours of case management services following the event through December 2015. The Project was supported by more than 460 volunteers and had 72 different service providers and agencies available to offer assistance. The Project used a new format this year that concentrated services on unsheltered individuals and those persons living in emergency shelters. This approach led to improved service accessibility for the most vulnerable members of our community. The effort was fully funded by more than \$25,500 in private donations.

## **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. Dauphin County recruits and trains volunteers on an ongoing basis and provides a stipend to conduct the satisfaction surveys, conduct focus groups. Volunteers are supported by County staff in their roles. 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 has handled complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns. Person experiencing homelessness, including chronic homelessness have been involved in these activities as leaders/volunteers.

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.

## **BEHAVIORAL HEALTH DISPARITIES**

Behavioral health and 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. We continue to evaluate how this engagement strategy has impacted the number of persons in the PATH eligible target group accessing mental health services. 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. Dauphin County will continue to track and monitor as well as create strategies with the provider organization.

The previous section on service provision illustrates the relationship we have on access not only to mental health services but health care as well. 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. 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. Dauphin County maintains a contract with the International Service Center for ethnic-specific services to persons, typically recent immigrants, who are of Asian descent. Dauphin County agencies have contractual agreements with interpreter services based on the needs of the individuals they serve. 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. Unfortunately agencies continue to struggle with recruiting qualified employees.

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.

The Lesbian, Gay, Bi-sexual, Transgendered, Questioning and Intersex (LGBTQI) population has been an on-going subpopulation of concern. Training was conducted in Dauphin County in FY2012-13 for PATH, homeless providers and mental health agencies. Alder Health Care has established a licensed mental health outpatient psychiatric clinic co-located and integrated with their physical health services to serve individuals within the LGBTQI community.

Efforts to improve access to outpatient clinic have varied success and will continue to be prioritized. State-wide provider action to reduce psychiatrist's administrative burden in clinics through regulatory relief is still pending in State government. Provider-driven efforts to improve scheduling changes for medication clinic and evaluations are random, and efforts to create more flexible walk-in medication clinic models for established stable individuals are in pilot status. Strengthening the clinical skills of therapists has been and will continue to be a concern. Tele-psychiatry has been expanded in Dauphin County to address the shortage of qualified psychiatrists available at clinic locations to expand capacity and reduce waiting time for access to treatment.

Issues of aging are complex in Dauphin County. Because we serve persons with a serious mental illness, we are a primary support system to person who stay in the county and receive MH services as they age. Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served. Several years ago alarmed by the death rate among persons with a serious mental illness, we examined unusual incidents particularly those leading to death. Our findings five years ago

led us to establishing a Wellness Initiative and Quality Management Plan driven by the need to educate and intervene to address rates of preventable deaths among person with a serious mental illness. Dauphin County has been instrumental in working with county-funded agencies and the Medicaid BH-MCO in designing and carrying out their own wellness initiatives.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. There has been some confusion as to the exact age group TAY encompasses. Some OMHSAS information suggests persons age 16-24 years, SSA has referenced 18-24 year olds and SAMHSA PATH includes person ranging in ages from 18-30 years.

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 FY13-14, 30% of the individuals served were between the ages of 18-30 years.

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.

Dauphin County launched The JEREMY Project. JEREMY (Joint Efforts Reach and Energize More Youth) 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 JEREMY Project is in its 11<sup>th</sup> year of operation.

The area of employment is a major focus of individual sessions. The Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews. Additionally, in the large groups, employment soft skills are addressed and participants are connected to community resources to aid them in their employment goals. Participants have met with several employment agencies in order to access more resources and assistance with finding employment.

A Community Residential Rehabilitation (CRR) program was opened in 2015 for three (3) transition age young adults (18-24) with a specific design to allow for more structured support to transitional age persons navigating their adult lifestyle and supporting their mental health needs. Recovery measures had suggested that transition –age adults need additional support and programming to achieve successful independent living specific to their emotional, social and developmental issues.

**DOWNTOWN DAILY BREAD BUDGET NARRATIVE**

**Personnel: (\$ 35,214):** Salary of the Full-Time Equivalent (FTE) position as an Outreach Specialist for a twelve month period.

**Fringe Benefits (45.8% percent of salary or \$16,147):** 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 (\$ 900):** 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 (\$2,183):** 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.

Security Deposits (\$0): This budget line represents a special cost in securing stable housing to resolve conditions of homelessness.

**Indirect Costs/Administrative Cost 4% @ \$2,183):** Four (4) percent of the PATH grant is allocated to cover administrative expenses at Downtown Daily Bread.

**Total Downtown Daily Bread PATH Request.....\$56,444**

**Dauphin County MH/ID Program  
FY 2016-17 PATH Downtown Daily Bread IUP Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Personnel Position</b>				
DDB Outreach Specialist	35,214	100%	35,214	35,214
<b>Salary sub-total</b>			<b>35,214</b>	<b>35,214</b>
<b>Fringe Benefits (45.8%)</b>				
DDB Outreach Spec (45.8%)				
FICA, Health, Ret/pens			16,147	16,147
<b>Fringe sub-total</b>			<b>16,147</b>	<b>16,147</b>
<b>Travel</b>				
Local Travel for Outreach DDB and parking			2,000	2,000
<b>Travel sub-total</b>			<b>2,000</b>	<b>2,000</b>
<b>Equipment</b>				
(list individually)			0	0
<b>sub-total</b>			<b>0</b>	<b>0</b>
<b>Supplies</b>				
Consumer-related items			900	900
<b>Supplies sub-total</b>			<b>900</b>	<b>900</b>
<b>Other</b>				
Staff training			0	0
One-time rental assistance			0	0
Security deposits			0	0
Independent Living Resource			0	0
<b>Other sub-total</b>			<b>0</b>	<b>0</b>
<b>Indirect Administration @ 4%</b>				<b>2,183</b>
<b>Total PATH Budget</b>				<b>\$56,444</b>

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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

c. Travel \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
----------	-------------------	-------------------	---------------	----------

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Dauphin County Mental Health and Intellectual Disabilities Program will receive \$39,917 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 240 Estimated Number of Persons to be Enrolled: 200

Estimated Number of Persons to be Contacted who are Literally Homeless: 144

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 12

**Dauphin County MH/ID Program  
Crisis Intervention Program  
FY16-17 PATH IUP**

**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](mailto:rschultz@dauphinc.org)

Frank Magel                                      MH Program Specialist 2      717/780-7045  
[fmagel@dauphinc.org](mailto:fmagel@dauphinc.org)

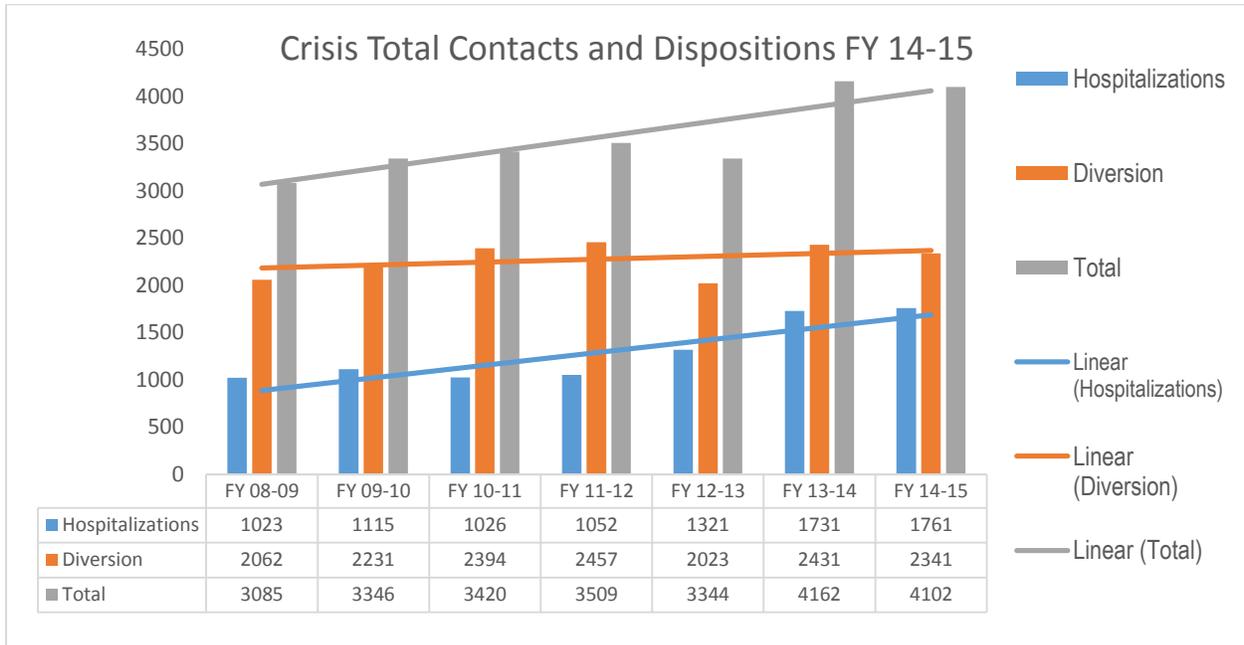
With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the County MH/ID Program office as OMHSAS does not have a contract directly with the Counties' PATH providers.

The Dauphin County Crisis Intervention Program (CIP), is a direct service of the Dauphin County MH/ID Program and is a 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.

Dauphin County is located in the South Central Pennsylvania and it is comprised of 40 municipalities and is a mix of rural, small urban and suburban areas. There are 525 square miles, and the Susquehanna River is one of its borders. Dauphin County includes the City of Harrisburg, which is also the State Capitol of the Commonwealth of Pennsylvania. According the US census data Dauphin County has an estimated population at 272,983 individuals in 2015. 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 FY2016-17 is \$101,361 of which \$25,340 consists of State Funds and \$76,021 are Federal Funds.

**Table 4 - Crisis Intervention Program Annual Data FY14-15**



Based on data collected in the PATH Annual Report for 2014-15, it is projected that outreach efforts will be made to approximately 380 individuals and approximately 300 individuals will be enrolled in PATH services for FY 2016-17. It is estimated that 180 individuals will be literally homeless or in short-term shelter at the time of enrollment and the remaining will be at imminent risk of homelessness. The Crisis Intervention Program of Dauphin County MH/ID will identify 240 individuals through outreach efforts and enroll 200 in PATH services. Downtown Daily Bread will identify 140 individuals through outreach efforts and enroll 100 individuals in PATH services during FY 2016-17. Among the 300 individuals enrolled in PATH, eight (8)-individuals will also receive services from CPSS.

**Table 5 – Estimated PATH Services by Provider FY 16-17**

<b>Provider</b>	<b>MH/ID Crisis Intervention Program</b>	<b>Downtown Daily Bread</b>	<b>Central PA Supportive Services</b>	<b>TOTAL</b>
<b>Estimated Number Outreach</b>	240	140	Doesn't conduct outreach	380
<b>Estimated Number enrollment</b>	200	100	Accepts persons enrolled; est. 8 enrollees	300
<b>Estimated Number &amp; % Literally Homeless</b>	120/60%	60/60%	Eight (8) persons should be literally homeless	180/60%

**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 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.

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 be 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 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. SOAR offers quicker access and approval of Social Security benefits for persons who are homeless. SOAR is not funded with PATH dollars. No PATH funded staff were trained in SOAR in FY 2011-12. 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. The total number of employed Certified Peer Specialists in Dauphin County was surveyed at 24 in the Fall 2015 and includes both full and part-time employees. Fifteen (15) are employed in Medicaid funded CPS programs.

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 of the clinics 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. 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.

The following chart best illustrates the range of unique specializations and evidenced based interventions available for a diverse population at the outpatient level of care:

**Table 6 – Licensed Psychiatric Outpatient Service Providers 2016-2017**

<b>Provider</b>	<b>Unique characteristics</b>
Adler Health Services	Integrated physical & behavioral health. Serves LGBTQI population. City location. Medicaid & Medicare.
Catholic Charities of the Capital Region	Homeless Clinic and works with Mission of Mercy. Medicaid and County funded.
Community Services Group	Children and families. Groups for adolescents. PCIT certified provider. Medicaid and County funded. Adding DBT Teen in 2016.
Commonwealth Clinical Group	Specialized offender and at-risk offender services to adults and teens. City location. Medicaid and County funded.
NHS of PA Capital Region	Primary clinic co-located with CMU, PA model; tele-psychiatry, DBT and PCIT, open access clinic. Adults, older adults, children. City location & rural Northern Dauphin. Medicaid, Medicare and County funded. Adding DBT Teen in 2016..
Pennsylvania Psychiatric Institute (PPI)	Culture specific –Hispanic and geriatric clinics, Clozaril and dual diagnosis (MH/ID) clinics. Adults and children. CBT & DBT trained. City location. Medicaid, Medicare and County funded.
Pennsylvania Counseling Services	Also a D&A outpatient provider. COD Integrated treatment. City & suburban sites, including school-based sites. Medicaid, Medicare and County funded.
Philhaven	Tele-psychiatry, Trauma-informed care, community based location. Medicaid and Medicare.
Pressley Ridge	Staff trained Play Therapists, The Incredible Years used in school based clinics. Medicaid, Medicare and County funded. School, city & suburban sites. Also in rural Northern Dauphin.
TeamCare	Suburban site. Medicaid and Medicare.
TW Ponessa and Associates	Also a D&A outpatient provider. Trauma-informed care; CBT trained. City location. Medicaid, Medicare and County funded.
Youth Advocate Programs	Certified Registered Nurse Practitioner/Art Therapist Community and school-based site. Medicaid, Medicare and County funded.

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

facility based Psychiatric Rehabilitation Program that is funded with County dollars and opened in 2014. Mobile Psychiatric Rehab services are planned. 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 Elwyn, (KMHS) Keystone Mental Health Services, NHS of PA and Gaudenzia. KMHS opened in 2015 a licensed full-care CRR program for transition age population, ages 18-24 with a capacity to serve three individuals. NHS –PA opened a DBT full-care residential program using CHIPP funds in 2016. Supportive living services are provided by Volunteers of America (VOA), Keystone and Central Pennsylvania Supportive Services (CPSS). CPSS is a small provider of supportive services funded with PATH.

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 contracts with NHS PA and Keystone Service Systems for Specialized Care Residences (SCRs) licensed as Personal Care Homes (PCHs), but are exclusively for adults and older adults with serious mental illnesses. Staff has extensive mental health training, clinical support skills, which meet the unique characteristics of residents who also require PCH level of care. Personal care services include: assistance in completing tasks of daily living, social activities, assistance to use community services, and individualized assistance to enhance daily goals and life quality. Dauphin County also contracts with Paxton Ministries to provide personal care home 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 HACD to serve approximately 6 individuals who have a serious mental illness beginning in FY15-16. Crisis Intervention participates in the LHOT.

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.

One Safe Haven project is located in Dauphin County. The men's program is operated by Christian Churches United and offers transitional and "housing first" living for up to 25 men.

The women's safe haven program had a capacity for 8 women and was operated by the YWCA of Greater Harrisburg. The YWCA transitioned the 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. With the support of the US Department of Housing and Urban Development through the Continuum of Care Grant program, this new housing effort will become an established long-term resource in our community.

The new HUD 811 project-based vouchers are a demonstration project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) make 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 has leased up individuals in 2016. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH). 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. Dauphin County is one of five Counties statewide first selected for this opportunity in permanent supportive housing. Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals based upon the Fairweather Lodge model. This program has an employment component called Paxton Cleaning Solutions and has competitive contracts with local companies 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, supportive living (CPSS) 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, in which a portion of these funds are in Dauphin County's existing PATH budget.

## **SERVICE PROVISION**

A list and description of services to be provided using PATH funds in Dauphin County during Fiscal Year 2016-17 include:

1. Outreach services (partially funded)
2. Screening and assessment for treatment services (partially funded)

3. Habilitation and rehabilitation (partially funded)
4. Staff training (partially funded)
5. Case management (partially funded)
6. 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 MH/ID Program Crisis Intervention 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.

CMU (Case Management Unit) provides homeless outreach to PATH eligible individuals to assist in registering those with a serious mental illness and those with co-occurring disorders into the community mental health system through intake at CMU. A homeless case worker position is not PATH funded, and staff is SOAR trained and processes all Dauphin County SOAR applications for SSI/SSDI.

### Screening for diagnostic 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.

### 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 topics may also be proposed by the Capital Area Coalition for Homelessness (CACH)'s Service Delivery Committee where there is cross-representation among homeless, basic needs, mental health and drug & alcohol programs. The training reflects a commitment to the fundamentals of recovery and resiliency in the mental health system. Training in 2016 is scheduled on Gender and Trauma: How Men and Women Differ in their Experiences and will be conducted by Drexel University.

### Case Management

Case management services provided Crisis Intervention Program staff and the 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 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 and 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 Crisis Intervention Program staff and Outreach Specialist at Downtown Daily Bread 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.

- **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.
- **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. Dauphin County, including the Crisis Intervention Program, Downtown Daily Bread, and other mental health agencies continue to participate in Project CONNECT events.

- 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. The Dauphin County Local Housing Options Team (LHOT) has been instrumental in developing a master list of landlords in conjunction with the local housing authorities and has revised the landlord –tenant protocol. The protocol found at [www.parecovery.org](http://www.parecovery.org) was developed to address landlord-tenant issues before legal problems or eviction occurs. 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. CACH reviews applications for completeness and eligibility criteria and forwards applications to building managers/owners for their consideration as potential new tenants.
- Security Deposits: Dauphin County can assist PATH eligible individuals with funds for security deposits or first/last month rents. CIP and case management entities provide this assistance. This service can provide quicker access to more permanent housing options for individuals, rather than relying on limited shelter space.
- 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. CIP and all case management entities have access to limited 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. CIP and all case management entities have access to limited funds for preventing eviction on a one-time basis.

### 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.
- Limited existing resources and long waiting lists for transitional, as well as, permanent housing resources.
- Programs continue to be challenged with complex mental health needs .
- The loss of General Assistance funds in Pennsylvania has exacerbated housing challenges for many PATH eligible persons.
- 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. State-level factors are prohibiting the system in moving in the right direction. Two different administrative entities, including licensing bureaus, add to the lack of common philosophies and views on how treatment is provided. Unfortunately, most co-occurring services are delivered in a parallel or sequential method between mental health and drug and alcohol agencies. Co-occurring training for professionals is essential for staff.

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: 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. Dauphin County in collaboration with PerformCare have implemented two (2) COD clinics using the Hazelden model of integrated treatment in licensed Drug & alcohol clinics. Integrated treatment was disallowed in a licensed MH clinic. The start-up was funded with HealthChoices re-investment funds.

The YWCA received a grant to work specifically with individuals with Co-occurring D&A and MH disorders. The grant provides evidence based interventions, such as Illness Management & Recovery (IMR) and Supported Employment to the homeless population. The program serves veterans and non- veterans.

Peer-run Double Trouble meetings similar to the 12 step AA/NA meetings are available throughout the week in Dauphin County for individuals experiencing co-occurring MH & D&A issues that need additional ongoing support. There is a Double Trouble Steering Committee composed of providers and peers that meets on a quarterly basis to assure there are adequate meetings and activities available to engage individuals to participate in throughout the County.

### 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. The following are evidence based and promising practices that are available in Dauphin County currently:

ACT (Assertive Community Treatment) – There are limited County-funds available for persons to receive these services until other benefits and entitlements are secured. ACT is Medicaid funded under HealthChoices, not MA Fee-for-Service.

Supported Employment –Dauphin County contracts with the YWCA of Greater Harrisburg to provide evidence-based Supported Employment program after a SAMHSA grant funding ended in September 2014. Dauphin County suspended its policy requiring first going through OVR (State Office of Vocational Rehabilitation) to access employment resources and supports. The process was too lengthy and yielded few positive results of eligibility for OVR services. Since these factors were not consistent with SAMHSA’s supported employment principles, rapid access to competitive employment resources at the YWCA will reduce barriers to employment services.

Family Psycho-Education – NAMI Dauphin County offers several classes per year for family members in the Family-to-Family Program. NAMI has also introduced Peer to Peer training for individuals as well. This resource is valuable for peers and family members to better understand their relative, spouse, parent or child.

Integrated Treatment for Co-occurring Disorders (COD) – PATH funds continue to support the co-occurring training needs of the homeless network in Dauphin County. Two outpatient psychiatric clinics have D&A outpatient clinic licenses. Two (2) COD clinics integrated treatment clinic are operational and Medicaid HealthChoices and County funded. Dauphin

County has one (1) residential program based upon a therapeutic community model and persons referred must also be forensically involved; many individuals are also COD.

Illness Management and Recovery (IMR) – Several agencies use this program in small groups and individually in social rehabilitation, psychiatric rehabilitation, and residential services in Dauphin County.

Wellness Recovery Action Plans (WRAP) - Many individuals have been trained in WRAP and, as WRAP facilitators, are able to run groups. Certified Peer Support Programs have individuals who can assist in facilitating an individual's WRAP plan or can conduct WRAP training in a group setting. Ongoing training efforts continue with providers in further understanding how WRAP can be used to assist individuals in successfully moving forward in their recovery journey.

Additional recovery-oriented and promising practices such as Advanced Directives, Certified Peer Specialists, Double Trouble Groups, and Fairweather Lodges have been described in other sections of the PATH Intended Use Plan. Forensic Blended Case Management, Mental Health Court (currently suspended) and Drug Courts are also available to individuals that qualify for alternative sentencing and treatment options instead of incarceration. Two of Dauphin County's mental health outpatient clinics and the NHS PA ACT team have been trained in the Seeking Safety model. Additional training and certification of therapist in three (3) MH outpatient clinics in Cognitive Behavioral Therapy and Dialectical Behavioral Therapy have been completed. NHS PA provides OP DBT groups and individual therapy and has recently developed an open access walk in OP clinic that started in 2015. Training in DBT Teen will be completed in Spring 2016 with several agencies.

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.

A program developed by Volunteers of America (VOA) and funded by a grant from US Department of Veterans Affairs provides supportive services for low-income veterans and their families aimed at preventing homelessness and improving stability. These services include case management, transportation assistance, housing counseling, financial planning, legal services, employment search assistance, temporary financial assistance as well as assistance with obtaining VA and other public benefits. Capital Area Coalition on Homelessness (CACH) was

actively involved in the planning process with the Veterans Affairs in order to eliminate homelessness for veterans.

As indicated throughout the Intended Use Plan, 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. The CSP leadership provides an ongoing monthly calendar of recovery events that provides an opportunity for individuals to participate in moving toward their own recovery. As a Block Grant County, Dauphin MH/ID Program documents their recovery and resilience priorities and activities.

CACH is the local lead agency that leverages HUD funding through the Continuum of Care in Dauphin County that provides and support and assistance in identifying the local needs of the homeless population and prioritizes funding for EBP and trainings for local PATH-Funded staff training activities to support the collection of PATH data in HMIS.

Dauphin County MH/ID Program uses a mix of County Base funds and HealthChoices funding through PerformCare, a Behavioral Health MCO, to fund EBPs that meet the needs of the MH population in Dauphin County.

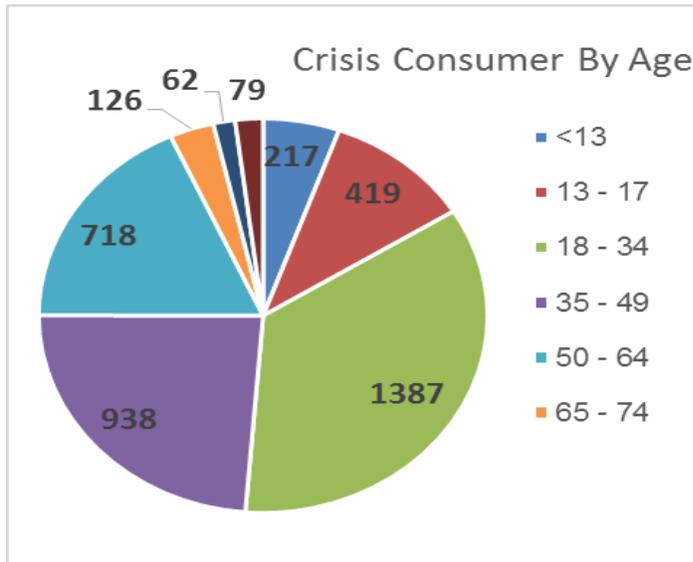
Dauphin County MH/ID and its contracted PATH providers are not required to follow 42 CFR Part 2 regulations since they do not provide any direct drug & alcohol services, diagnosis or treatment to PATH funded individuals. Referral are made as needed with the assistance of PATH providers to drug & alcohol treatment as needed, however they are not involved in providing any direct treatment services.

## **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 and various agencies in the homeless provider network are 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 in Dauphin County to develop a work plan for implementation of HMIS for all PATH data entry and reporting as required by June 30, 2016.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH agency staff will be supported on a day-to-day basis by Dauphin County MH administrative staff.

Crisis Intervention Program data was shared for FY 14-15 previously. The age breakout for Crisis Intervention Services including PATH funded services reflects the following age span:



### **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. 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.

Disaster planning and coordination is another function of the Crisis Intervention Program. All CI staff are trained in and participate in the County's Disaster Crisis Outreach Response Team (DCORT). DCORT participates in regular training exercises and pursues various disaster preparedness initiatives via membership in the Pennsylvania South Central Task Force.

All CI staff members have completed the required certification process in NIMS (National Incident Management System). CI also participates with and oversees the County's Critical Incident Management (CISM) team, which provides debriefing services to first responders. The CISM team is comprised of over 60 representatives from various behavioral health organizations, police departments, fire departments and other emergency response workers from Central Pennsylvania.

## **ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS**

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.

Capital Area Coalition on Homelessness (CACH) is the designated local lead agency to implement the "Home Run", which is the Capital areas 10 year plan to end homelessness in the County of Dauphin and Harrisburg. MH/ID Crisis Intervention is a CACH member. CACH oversees the submission of the annual HUD Continuum of Care. The revised goals of the "Home Run" are as follows:

- To maintain and strengthen the Capital Area Coalition on Homelessness as the lead agency and facilitate and coordinate the organizational structure and planning for homelessness in Dauphin County.
- To develop HMIS to its full potential to make service providers jobs easier, while significantly improving the use of consumer information in screening, planning and coordination of services for homeless. Consumer information will also be utilized to evaluate the effectiveness of the service delivery system and the need for new and revised services/programs.
- To preserve existing resources and ensure the development of new, safe, decent, affordable housing opportunities for all homeless individuals and families.
- To ensure access to timely, appropriate, affordable and easily accessible services to end homelessness and prevent its recurrence.
- To educate the community to raise awareness and public support for more resource partners in order to open up new doors to end homelessness in Dauphin County.
- To develop short and long term strategies to significantly prevent the occurrence of homelessness in our community.

## **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. Dauphin County's HAP staff and providers collaborate with the Capital Area Coalition on Homelessness (CACH), the lead agency for the Harrisburg City/Dauphin County Continuum of Care to coordinate services,

leverage funding from HUD, Emergency Solutions Grant, and local funding. The use of data through HMIS continues to be refined. HAP providers also collaborate with CACH for the annual CACH Project Homeless Connect.

## **SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)**

In FY 2011-12 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 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. The process is very time-consuming, detail oriented and comprehensive. In FY 12-13 4 SOAR applications were granted; FY 2013-14 5 SOAR applications were completed and approved; in FY14-15 seven (7) were approved and in FY15-16 twelve have been completed and approved as of April 2016.

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. No PATH funded positions in Dauphin County complete the SOAR process. This individual also maintains a small case load of homeless individuals in addition to the SOAR responsibilities. The SOAR process has proved to be very effective in Dauphin County in assisting individuals in obtaining the income and benefits needed to manage their basic needs as well as securing housing and moving on toward their recovery.

## **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 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. Dauphin County Local Housing Options Team (LHOT) has an active membership.

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.

The YWCA's Supportive Housing program recently received an award by the State for their housing program that supports veterans by using a housing first model in which they have successfully maintained 80% of the participants in permanent housing.

Paxton Ministries developed two (2) Fairweather-type Community Lodges in the Penbrook area for up to five individuals and in the Colonial Park area for up to three individuals. The Paxton Lodges are run and 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. The business model the Lodges developed is a cleaning company named Paxton Cleaning Solutions and has developed contracts with several area businesses to clean offices.

## **COORDINATED ENTRY**

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. MH/ID Crisis Intervention is involved in these efforts.

### 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.

Among this service population requesting emergency shelter:

1. The HELP Office will first divert those who are about to become unsheltered within 14 days but can through short term rental assistance be rapidly rehoused or prevented from being homeless through housing prevention through Rapid Rehousing Program (RRH) or Homeless Prevention (HP). The HELP Office may have to place RRH candidates into shelter initially if more time is needed to process them into RRH units.
2. Those who cannot be helped by rental assistance or rapid rehousing because of lack of funds or other reasons and likely require 1 to 3 months of emergency housing, as determined by intake assessment, will be referred to available emergency shelter.
3. Those who are likely to need more than 3 months will be targeted for State HAP funded Transitional housing (TH) referrals (YWCA Bridge and BHA Transitions programs). The HELP Office may have to refer candidates to ES in the event that TH is unavailable or requires more time.

### Unsheltered Homeless Persons (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.

### 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).

### Rural 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.

### Homeless Veterans:

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 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's Mental Health Court has gone through a transition and has not been operating for quite some time. Ongoing negotiation and planning continues with plans to eventually reinstate this program in the future.

Dauphin County has a strong 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.

The Dauphin County SCA is also involved in a myriad of programs to assist those with substance use disorders in the criminal justice system. D&A has a staff person available to screen and assess individuals at the Judicial Center for diversion from incarceration.

At this point in time we are not required to and 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 we could predict it could 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.

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 enacted to replace the State Civil Service system and County Human Resources Department who reviews and monitors staff composition and equal employment opportunity criteria. We will continue to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

## **CONSUMER INFORMATION**

Dauphin County is a third class county located in south central Pennsylvania with a population of 272,983 individuals in 2015. It is estimated that 13.4% of the individuals that reside in Dauphin County live at or below the poverty level.

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 2016-17 to be similar to the previous year's annual data on hand. 100% of the individuals served in 2014-15 were between ages 18-61. 35% were males and 64% were female. Percentages of males and females was the greatest change over time. Among individuals reporting race/ethnicity 41% were African American; 55% were Caucasian; less than 1% were Asian and less than 1% were Hispanic/Latino. 54% of the individuals served reported having a Co-occurring MH and Substance Abuse Disorder and 37% reported they only had a MH disorder. 93% of individuals served indicated they were not a veteran. Less than 4% indicated they were a veteran. The remaining 3% did not report a veteran status. 35% of the individuals served indicated they lived outdoors (e.g. street, abandoned or public building or automobile) and 16% of those served indicated they were residing in an emergency shelter or transitional housing. Other living arrangements are not reported.

The Capital Area Coalition on Homelessness conducted a 2016 Point-In-Time Survey (PIT) of individuals and families who experience homelessness and the services they request. This point in time survey tracked all participants through anonymous identifiers enabling an unduplicated count of homeless census participants at multiple locations. There were a total of 433 surveys completed. There were 433 persons of which 132 were children. A total of 248 or 57% of those surveyed were either unsheltered or in emergency shelters. Of the unsheltered and emergency shelter respondents ( n=248) , 43 or 17% were unsheltered, 205 or 82% were in emergency shelter .Of those in transitional housing and Safe Haven, 170 or 68% were in transitional housing and 15 or 16.53 % were in safe havens. The majority of the homeless adult responses were male 71% with female responses at 28%. 230 or 53% of the responses were from persons self-identified as African American followed by Caucasian at 175 or 40%. Persons self-reporting as ethnically Hispanic were 125 or 28%. 8 individuals or .03% identified themselves as veterans. The highest percentage of participants 54% indicated they were single adults followed by 45% from households with children.

The CACH Service Delivery Committee held its sixth Project Homeless Connect (PHC) in November 2015. The 2015 PHC served 344 guests plus 31 children seeking various forms of assistance; with a total of 375 people, including three unaccompanied youth. There were more than 82 hours of case management services following the event through December 2015. The Project was supported by more than 460 volunteers and had 72 different service providers and agencies available to offer assistance. MH/ID Crisis Intervention is involved in this effort.

## **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. Dauphin County recruits and trains volunteers on an ongoing basis and provides a stipend to conduct the satisfaction surveys, conduct focus groups. Volunteers are supported by County staff in their roles. 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 has handled complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns. Person experiencing homelessness, including chronic homelessness have been involved in these activities as leaders/volunteers.

## **BEHAVIORAL HEALTH DISPARITIES**

Behavioral health and 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. We continue to evaluate how this engagement strategy has impacted the number of persons in the PATH eligible target group accessing mental health services. 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. Dauphin County will continue to track and monitor as well as create strategies with the provider organization.

The previous section on service provision illustrates the relationship we have on access not only to mental health services but health care as well. 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. Dauphin County maintains a contract with the International Service Center for ethnic-specific services to persons, typically recent immigrants, who are of Asian descent. Dauphin County agencies have contractual agreements with interpreter services based on the needs of the individuals they serve. 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. Unfortunately agencies continue to struggle with recruiting qualified employees.

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.

The Lesbian, Gay, Bi-sexual, Transgendered, Questioning and Intersex (LGBTQI) population has been an on-going subpopulation of concern. Training was conducted in Dauphin County in FY2012-13 for PATH, homeless providers and mental health agencies. Alder Health Care is an established a licensed mental health outpatient psychiatric clinic co-located and integrated with their physical health services to serve individuals within the LGBTQI community.

Efforts to improve access to outpatient clinics have varied success and will continue to be prioritized. State-wide provider action to reduce psychiatrist's administrative burden in clinics through regulatory relief is still pending in State government. Provider-driven efforts to improve scheduling changes for medication clinic and evaluations are random and require psychiatric and management cooperation. One agency, NHS of PA has been successful in establishing an open clinic two days per week. Strengthening the clinical skills of therapists has been and will continue to be a concern. Tele-psychiatry has been expanded in Dauphin County to address the shortage of qualified psychiatrists available at clinic locations to expand capacity and reduce waiting time for access to treatment.

Issues of aging are complex in Dauphin County. Because we serve persons with a serious mental illness, we are a primary support system to person who stay in the county and receive MH services as they age. Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served. Trainings will be planned to assist case managers in understanding nursing home assessment criteria, alternative to nursing homes, and information on guardianships in FY 2016-17.

Dauphin County has been instrumental in working with county-funded agencies and the Medicaid BH-MCO in designing and carrying out their own wellness initiatives. Some activities that have been successful include:

- Wellness events on health topics open to individuals using mental health services and professionals.
- Toolkits and training for persons in services have assisted with communication with physicians, psychiatrists, and pharmacists.
- Health oriented activities in partial hospitalization programs, drop-in centers, and social rehabilitation, psychiatric rehabilitation, residential programs and at a 1:1 level with Certified Peer Specialist.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. There has been some confusion as to the exact age group TAY encompasses. Some OMHSAS information suggests persons age 16-24 years, SSA has referenced 18-24 year olds and SAMHSA PATH includes person ranging in ages from 18-30 years.

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 2014-15 28% of the individuals served were between the ages of 18-30 years.

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.

Local efforts began in the late 1990's to identify a set of needed supports and skills specific to person transitioning to adulthood. Based upon the work of Dr. Hewitt Clark at South Florida University and his TIP program, Dauphin County launched The JEREMY Project. JEREMY (Joint Efforts Reach and Energize More Youth) 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 JEREMY Project is in its 11<sup>th</sup> year of operation.

The area of employment is a major focus of individual sessions. The Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews. Additionally, in the large groups, employment soft skills are addressed and participants are connected to community resources to aid them in their employment goals. Participants have met with several employment agencies in order to access more resources and assistance with finding employment.

**MH/ID CRISIS INTERVENTION PROGRAM (CIP) BUDGET NARRATIVE**

**Personnel (\$ 20,399):** \$20,399 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 (\$9,708):** Conforming to methodology for ascertaining personnel costs, or \$9,708 or 47.59% 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 (\$900):** 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 (\$7,039):** **Staff Training (\$2,346):** 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 (\$2,347):** 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 (\$2,346):** 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% @ \$1,871):** Four (4) percent of the PATH grant is allocated to cover administrative expenses at MH/ID.

**Total MH/ID Crisis Intervention Program PATH Request.....\$39,917.00**

**Dauphin County MH/ID Program Crisis Intervention Program  
FY 2016-17 PATH IUP Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Personnel Position</b>				
Crisis Caseworker	40,798	50%	20,399	20,399
<b>Salary sub-total</b>			<b>20,399</b>	<b>20,399</b>
<b>Fringe Benefits (47.59%)</b>				
Crisis (47.59%)				
FICA, Health, Ret, Life			9,708	9,708
<b>Fringe sub-total</b>			<b>9,708</b>	<b>9,708</b>
<b>Travel</b>				
Mileage			0	0
<b>Travel sub-total</b>			<b>0</b>	<b>0</b>
<b>Equipment</b>				
(list individually)			0	0
<b>sub-total</b>			<b>0</b>	<b>0</b>
<b>Supplies</b>				
Consumer-related items			900	900
<b>Supplies sub-total</b>			<b>900</b>	<b>900</b>
<b>Other</b>				
Staff training			2,346	2,346
One-time rental assistance			2,347	2,347
Security deposits			2,346	2,346
<b>Other sub-total</b>			<b>7,039</b>	<b>7,039</b>
<b>Indirect Administration @ 4%</b>				<b>\$ 1,871</b>
<b>Total PATH Budget</b>				<b>\$39,917</b>

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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 119,968 \$ 39,989 \$ 159,957

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 119,968	\$ 39,989	\$ 159,957	Detailed budgets and narratives are included in individual provider IUPs.

i. Total Direct Charges (Sum of a-h) \$ 119,968 \$ 39,989 \$ 159,957

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 119,968 \$ 39,989 \$ 159,957

Source(s) of Match Dollars for State Funds:

The total for Delaware Co overall is \$159,957 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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

## 2016-2017 PATH IUP

### Delaware County Office of Behavioral Health Comprehensive

#### *Local Provider Description*

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 Association of Southeast PA. 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 16-17 Horizon House's allocation amount is \$ 115,934 and Mental Health Association's allocated amount is \$ 44,023 in federal and state funding.

PDX Provider: Delaware: Delaware County Office of Behavioral Health  
20 South 69<sup>th</sup> Street  
Upper Darby, PA 19082

### ***Collaboration with HUD Continuum of Care (CoC) Program***

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 \$4.5 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 membership 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 Association are longstanding members of the HSC and both have seats on the governing board, standing committees and HSC committees.

### ***Collaboration with Local Community Organizations***

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.

### ***Service Provision***

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 Association of SEPA. 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***

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. The HMIS Director is Greg Coelho. 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. By July 1, 2016 both PATH providers will be completely on line to fully utilize HMIS for PATH services.

## ***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 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 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.

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.

### ***Alignment with State Plan to End Homelessness***

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

### ***Other Designated Funds***

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. MH Block Grant does support the Horizon House programs, specifically for case management for those who become permanently housed.

### ***SSI/SSDI Outreach, Access, Recovery (SOAR)***

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. The MHA was recently awarded the HOST program, which includes funding for a SOAR attorney to review SOAR applications. Please refer to each agency description for specific SOAR trained staff and numbers.

### ***Housing***

Delaware County, through its Continuum of Care, has over 240 beds of permanent housing for single adults and over 60 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 carrying 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***

The PA-502 Continuum of Care for Delaware County 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 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 is in the process of expanding the current CE System adding additional Coordinated Entry locations and staff, providing 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.

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***

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. Approximately 35% of our PATH clients have a criminal history.

<b>Forensic ACT (FACT) Team</b>	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.
<b>MH Court</b>	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.
<b>Forensic Peer Support</b>	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.
<b>OBH Forensic Specialist</b>	In FY 13-14, OBH hired a dedicated Forensic Specialist to help oversee the myriad of forensic initiatives targeted to the justice-involved population.
<b>Behavioral Health Liaisons</b>	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.
<b>DOC Max-out Tracking</b>	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 50%
- Black/African American 25%
- Asian 25%

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**

We expect to outreach to 310 people.

	<b>Horizon House</b>	<b>Mental Health Association</b>
<b>Black/ African Americans</b>	<b>52%</b>	<b>65%</b>
<b>White</b>	<b>41%</b>	<b>30%</b>
<b>Hispanic/ Latino /mixed/native</b>	<b>7%</b>	<b>5%</b>
<b>Male</b>	<b>65</b>	<b>70</b>
<b>Female</b>	<b>35</b>	<b>30</b>
<b>62+</b>	<b>3%</b>	<b>10 %</b>
<b>51-61</b>	<b>32%</b>	<b>45%</b>
<b>31-50</b>	<b>44%</b>	<b>35%</b>
<b>18-30</b>	<b>21%</b>	<b>10%</b>
<b>% Literally Homeless</b>	<b>100%</b>	<b>100%</b>
<b>Projected number to be enrolled in 2016-17</b>	<b>150</b>	<b>110</b>

***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 Association (MHA) 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: 40 Total (30 HH and 10 MHA)**

- **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.

*Delaware County  
Horizon House Inc. & Mental Health Association  
PATH Program  
FY 2015-2016 Budget*

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>PATH TOTAL</b>
<b>Position</b>				
Director	\$110,336	0.01	1103	
Program Director	\$68,634	0.04	2745	
Administrative Manager	53965	0.01	540	
Administrative Assistant	33020	0.01	330	
QI Manager	45558	0.01	456	
QI Specialist	37965	0.01	380	
Team Leader	52929	.22	11644	
Behavioral Health Spec.	29911	.4	11965	
Nurse	52832	0.11	5812	
Housing 1st BHS	32156	.99	31834	
Clinical Specialist	50491	.03	1387	
CPS Outreach Worker	31446	1.00	31446	
<b>Other Direct Support</b>		.073	4606	
<b>sub-total</b>				<b>\$104,247</b>
<b>Benefits</b>				
FICA Tax			7975	
Health Insurance			\$17536	
Retirement			2787	
unemployment			218	
<b>sub-total</b>				<b>28516</b>
<b>Travel</b>				
Local Travel for Outreach/Supportive Services			15045	0

Travel to training and workshops			2132	0
<b>sub-total</b>				<b>17,117</b>
<b>Occupancy</b>				
Rent			4158	
Utilities			708	
Maintenance			1538	
<b>sub-total</b>				<b>6,484</b>
<b>Supplies</b>				
Office Supplies			905	
Consumer-related items			1266	
<b>sub-total</b>				<b>2171</b>
<b>Communication</b>				
Telephone/Postage			1422	
<b>sub-total</b>				<b>1422</b>
<b>Administrative Expense</b>			14024	14024
<b>sub-total</b>				
<b>Total PATH Budget</b>				<b>\$159,957</b>

## **FY 2016-2017 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, @ 38% including FICA Tax, Health Insurance, Retirement, Life Insurance

**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 15% MHA

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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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h. Other \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Horizon House, Inc. will receive \$115,934 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 200 Estimated Number of Persons to be Enrolled: 150  
 Estimated Number of Persons to be Contacted who are Literally Homeless: 194  
 Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Horizon House, Inc. PATH Program – PATH Intended Use Plan**

Delaware County, Pennsylvania

2016-2017

- **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.

Horizon House Inc.  
1601 Parklane Rd.  
Swarthmore, PA 19081

PDX: Horizon House, Inc.

Horizon House, Inc. is a private, non-profit agency providing community-based services to individuals with psychiatric or 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 **\$115,934 (\$84,284 Federal and \$31,650 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 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.

The PA 502 Continuum of Care for Delaware County 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. 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. 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 is 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
- Housing First Disposition Committee
- Participant Focus Group

Horizon House has been actively involved in program coordination initiatives including coordinated entry and in 2016-2017 the PATH services will become an integral component of 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, 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.

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, ACT (Assertive Community Treatment), and HUD S+C (housing subsidies).

Horizon House has also developed ACT services specifically targeted for transitional age youth (TAY)/young adults, which is 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 has also expanded its 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.

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 has also been 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 County and OBH has initiated planning meetings to strategically plan and coordinate activities as well as to further develop the coordinated entry process.

- **Service Provision**

Services are provided through two program components: the PATH outreach team and the PATH Housing First team. The CoC has strategically moved forward in developing coordinated entry and it is intended that the PATH outreach services will be part of the coordinated entry process.

The PATH outreach team focuses its efforts on outreach, engagement, assessment, screening, and referrals for homeless services, housing, and other community supports/services. Frequency and intensity of services varies based upon need and individual readiness. Staff engage homeless individuals through outreach targeting those who are literally and chronically homeless; assess the individual's needs, barriers, resources, and preferences; and assist the individual in accessing CoC services and other community supports. In addition to initial outreach and engagement 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.

Referrals and coordination of services may include areas, such as health, mental health/substance abuse, job training, education, income/benefits, and housing referral services. A client record is maintained for all clients served documenting referrals and services received.

The PATH Housing First staff provides 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 satisfying 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 population are the most vulnerable adults who are literally and chronically homeless.

Staff routinely visits locations where literally and chronically homeless are located, including: emergency shelters, warming centers, and homeless drop in centers. Street outreach is conducted periodically and 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.

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 is actively working with the CoC of Delaware County Office of Behavioral Health and Connect to assess the current street outreach activities and facilitate improvements. It is expected that street outreach will increase.

Horizon House continues to work with Connect's street outreach team ongoing promoting collaboration of services to better reach homeless persons. We continue to increase and improve efforts to reach all homeless persons in need of our services.

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.

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

- **Provide 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 an outreach team and a Housing First team. Additional resources are leveraged to fully support the teams and PATH client 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
- HUD funds awarded 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 services
- Access to other mainstream funds/services (i.e. income benefits, nutrition assistance, health benefits)

- **Describe any gaps that exist in the current service system.**

The elimination of general public cash assistance to single homeless individuals continues to create many barriers for individuals to access and maintain housing. It creates challenges for individuals to meet even basic needs such as soap, shampoo, personal hygiene products, etc. This also limits persons' 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 application and appeal process.

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. The PATH service provides case management and linkages to assist with health care issues.

The program 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.

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.

- **Provide a 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), and the Pennsylvania Certification Board through Eagleview Hospital.

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.

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 (Eagleview Hospital, Mirmont, Fairmount Behavioral Health, Keystone, Kirkbride, Brookglenn), Outpatient Treatment (Holcomb, Northwestern Human Services, American Day, OMNI, Crozer Chester Medical Center)

- **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.**

Horizon House and the County have included the migration of PATH data into the HMIS system throughout the development and implementation of the 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 evidenced 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 specific 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 and are not required to follow these regulations.

- **Data**

The PATH program has been an active participant in the planning of the County's HMIS system since 2007. PATH data is currently entered into the HMIS system and all staff receives HMIS training upon hire. 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. Farea Graybill is the designated PATH HMIS Coordinator. Greg Coelho is the HMIS Director.

- **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 serious mental illness and substance use disorders who experience homelessness or are at imminent risk of becoming homeless.” The 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. 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.

Historically the Horizon House PATH outreach has included street, homeless drop in centers, warming centers, and shelters. Increasing street outreach is a goal of the service.

- **Alignment with State Mental Health Services Plan**

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 individual access to mainstream services that promote successful community living and independence.

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.

- **Alignment with State Plan to End Homelessness** – 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 Horizon House PATH services directly address and support the efforts to reduce and eliminate chronic homelessness in the state. The PATH services will target 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.

- **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. Within these 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.

One Horizon House PATH staff has completed the SSI/SSDI Outreach, Access and Recover SOAR Online Course during the 2016 grant year. Six Horizon House PATH staff also participated in the SOAR webinar training. To date, there have been no SOAR applications submitted directly by Horizon House staff. 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 at the Social Security office for eligible participants. Participants are informed that it must be clarified at time of application that they are homeless and have a mental health disability to be SOAR eligible. 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.

During the 2016 grant year: 23 individuals were assisted by PATH in the application/eligibility process and received SSI/SSDI benefits, 22 Individuals were assisted by PATH and a decision is pending, and 3 individuals were assisted by PATH in the appeal process.

During the 2017 grant year, Horizon House will assess the current process and implement modification as needed to improve the accurate, timely completion of mainstream benefit applications and timely determination of eligibility.

- **Housing**

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, other community networks, 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 two Shelter Plus Care grants managed by OBH and Horizon House and two Permanent Supported Housing grants 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), Local Housing Option Team (LHOT), Office of Behavioral Health, and other County and HUD funded providers.

The PATH Team provides outreach to homeless individuals who are living on the streets or in emergency shelters to determine appropriateness for PATH-Housing First service. Following the engagement and assessment process, the staff assists individuals to locate subsidized apartments using a variety of sources of TBRA funding. The PATH-Housing First option represents a significant component of permanent housing within the Continuum of Care. 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 your organization is part of a coordinated entry program. If so, explain the coordinated entry process and through whom it is governed/monitored.

Horizon House CoC services will participate in coordinated entry and the PATH services specifically will be a part of the Coordinated Entry process.

The coordinated entry program will be governed/monitored through the CoC/Board with support through the Delaware County Division of Adult and Family Services.

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 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 is in the process of expanding the current CE System adding additional Coordinated Entry locations and staff, providing 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.

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 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**

Horizon House and the PATH services actively participate in developing, coordinating and/or utilizing a range of options to support individuals with criminal 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. Where individuals are not able to obtain a lease, Master Leased apartments available through Horizon House and other County funded providers are utilized. Employers who will consider individuals with a criminal history are identified. 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 program also utilizes forensic resources available through the County system including Forensic ACT and Forensic Peer Support.

The percentage of PATH clients with a criminal history is 52%. Horizon House PATH staff work with probation officers as needed.

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.

<b>Forensic ACT (FACT) Team</b>	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.
<b>MH Court</b>	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.
<b>Forensic Peer Support</b>	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.
<b>OBH Forensic Specialist</b>	In FY 13-14, OBH hired a dedicated Forensic Specialist to help oversee the myriad of forensic initiatives targeted to the justice-involved population.
<b>Behavioral Health Liaisons</b>	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.
<b>DOC Max-out Tracking</b>	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**

The demographics of the PATH staff are as follows:

Race/Ethnicity	Black/African American	50%
	White	38%
	Hispanic	12%
Gender	Male	13%
	Female	87%

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.

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 Public Welfare – 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**

Current demographic data on the PATH population served is approximately as follows:

Race/Ethnicity:	Black/African American	51%
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	White	42%
	Asian	1%
Mixed	1%	
Native American	1%	
Hispanic/Latino	4%	
Gender:	Male	65%
	Female	35%
Age:	62+	3%
	51-61	32%
	31-50	44%
	18-30	21%

Horizon House estimates that 200 clients will be contacted. It is estimated that 150 consumers will be enrolled in PATH funded services in FY 15-16.

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**

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 assessments completed 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. 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**

- 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 \$23,000 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 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:
  - **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

- **Budget Narrative** – Provide a 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.

See attached

Delaware County  
Horizon House Inc.  
PATH Program  
FY 2016-2017 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

**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: \$84,284  
State Match: \$31,650  
County Allocation: \$194,169

Delaware County  
Horizon House Inc.  
PATH Program  
FY 2016-2017 Budget

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>PATH TOTAL</b>
<b>Position</b>				
Director	\$110,336	0.01	\$1,103	
Program Director	\$68,634	0.04	\$2,745	
Administrative Manager	\$53,965	0.01	\$540	
Administrative Assistant	\$33,020	0.01	\$330	
QI Manager	\$45,558	0.01	\$456	
QI Specialist	\$37,967	0.01	\$380	
Team Leader	\$52,929	0.22	\$11,644	
Behavioral Health Spec.	\$29,911	0.40	\$11,964	
Nurse	\$52,832	0.11	\$5,812	
Housing 1st BHS	\$32,156	.99	\$31,834	
Clinical Specialist	\$50,491	0.03	\$1,387	
<b>sub-total</b>				<b>\$68,195</b>
<b>Benefits</b>				
FICA Tax			\$ 5,217	
Health Insurance			\$ 8,320	
Retirement			\$ 1,705	
Life Insurance			\$ 784	
<b>sub-total</b>				<b>\$16,026</b>
<b>Travel</b>				
Local Travel for Outreach/Supportive Services			\$15,045	
Travel to training and workshops			\$2,132	
<b>sub-total</b>				<b>\$17,177</b>
<b>Occupancy</b>				
Rent			\$4,158	
Utilities			\$708	
Maintenance			\$1,538	

<b>sub-total</b>				<b>\$6,484</b>
<b>Supplies</b>				
Office Supplies			\$905	
Consumer-related items			\$1266	
<b>sub-total</b>				<b>\$2,171</b>
<b>Communication</b>				
Telephone/Postage			\$1,422	
<b>sub-total</b>				<b>\$1,422</b>
<b>Administrative Expense @ 4%</b>			\$4,459	
<b>sub-total</b>				<b>\$4,459</b>
<b>Total PATH Budget</b>				<b>\$115,934</b>

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Mental Health Association of Southeastern PA will receive \$44,023 in federal and state PATH funds.

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 ended in 2014: 5 Number of PATH-funded consumers assisted through SOAR: 23

**Mental Health Association of Southeastern Pennsylvania PATH Program  
7200 Chestnut Street, Upper Darby, PA 19082**

**PATH Intended Use Plan 2016-2017  
Delaware County, Pennsylvania**

**Local Provider Description**

The Mental Health Association of Southeastern Pennsylvania (MHASP) 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. MHASP is active in all five counties of the Southeastern Pennsylvania region: Philadelphia, Chester, Montgomery, Bucks and Delaware Counties.

MHASP was founded in 1951. For almost six decades, MHASP has been organizing, educating, and advocating for the rights of people with mental health and co-occurring substance use challenges. During that time, MHASP 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 MHASP operations as board members, employees, and volunteers. The involvement of consumers and family members in all operational roles gives MHASP a unique perspective and authority. Since the 1980s, MHASP has been a catalyst in creating behavioral health policy that supports recovery, self-determination, community inclusion and integration. MHASP has the proven expertise in the field of recovery services and education to conduct the proposed project in a successful manner.

In Delaware County MHASP 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, to 50 or more people every night of the year.

The primary geographic focus of the MHASP 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. The Connect PATH program receives \$44,023 in PATH and state funds. Provider name appears as Mental Health Association of SEPA in PDX.

### **Collaboration with HUD Continuum of Care Program**

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.

### **Collaboration with Local Community Organizations**

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 are beginning an affiliation with ChesPenn's primary care practice as well. We work closely with case management services from NHS, Mercy Fitzgerald Hospital and Community Hospital to connect those eligible for targeted case management service. 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 training and job placement. 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.

## **Service**

**MHASP 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

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, and shopping centers, 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.

**Describe any gaps that exist in the current service systems.**

The gaps 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. Many who have had some inpatient treatment must return to Connect which is not well-equipped to support people new to recovery from drugs and alcohol

**Provide a brief description of the services available to clients who have both a serious mental illness and a substance use 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 OBH and Magellan, our staff people assist participants with accessing appropriate services and supports. Our staff people are familiar with an array of services providing inpatient and outpatient treatment, detox, crisis, and rehabilitation services. We have a useful referral relationship with NHS and Holcomb Behavioral Health for dual diagnosis treatment and are beginning a relationship with Omni Services.

**Describe how the local provider agency pays for and otherwise supports evidence-based practices, trainings for local PATH-funded staff, and training and activities to support migration of PATH data into HMIS.**

MHASP 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. MHASP has completed a year 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 and other topics. MHASP 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.

**Provide information on whether or not your agency is required to follow 42 CFR regulations. If you do, explain your system to ensure those regulations are followed.**

MHASP 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*

MHASP employees receive HIPAA training annually and the Director of Compliance monitors and addresses any violations in these areas.

**Data**

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 Connect staff people meet monthly for refresher training on HMIS operations and data fidelity work. The PATH CPS/outreach specialist recently attended the state wide HMIS PATH TA conference held at state college on 4/19/16-4/21/16, 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. Greg Coelho is the HMIS Director.

### **Alignment with PATH goals**

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 attempt to persuade hard to reach participants to access services more 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.

During the upcoming program year the Connect PATH CPS/Outreach Specialist will make referrals from among his assigned participants to a Peer Support program affiliated with the MHASP to provide the support available from this evidence based practice.

### **Alignment with State Mental Health Services Plan**

PATH services provided are consistent with the PA 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 worker 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.

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 in put in place prior to the event.

With respect to fire safety and evacuations, regular fire drills are conducted at both the Connect site and the shelter 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.

### **Alignment with State Plan to end**

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. 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.

### **Other Designated**

All PATH funding received are designated solely to providing services for PATH eligible participants who are experiencing both homelessness and serious mental illness. No funds are specifically earmarked for MHA of SE PA.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

Approximately 5 staff have been trained in SOAR, however no participants were assisted through SOAR this year. The PATH CPS/outreach specialist assists PATH participants to apply for all mainstream benefits for which they are eligible, but may not be receiving.

MHASP 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 is a year-long opportunity to work towards more integrated health/recovery services to homeless people in these counties. The PATH CPS/outreach specialist will also be able to collaborate with this team to expand the resources available to PATH participants.

### **Housing**

Our staff persons work with participants to access the entire range of housing options maintained by Delaware County. By maintaining membership on the Housing Option Committee our staff people remain aware of opportunities for supportive housing.

Our staff are familiar with the housing options available with Delaware County's continuum of care: shelters (including specialized domestic abuse and family programs), transitional housing (including specialized housing for MH, D&A, Dual diagnosis, domestic violence and HIV), CRRs, personal care homes, among others.

In addition, we maintain a relationship with Horizon House to make appropriate referrals to their Housing first program, as well as senior housing where age appropriate. We have also had much success recently through referrals of veterans to VA services and VASH vouchers.

### **Coordinated Entry**

The PATH Program is not currently part of a Coordinated Entry Program but will be moving towards this in the near future. The PA-502 Delaware County CoC is implementing a CE system. MHA will be a partner in that program.

### **Justice Involved**

The current percentage of clients with a criminal history is 35%. The PATH CPS/Outreach Specialist works in conjunction with other social services agencies, such as OMNI, NHS and Horizon House, to support these individuals in all needed areas such as assistance with housing and employment. In addition to partnering with other agencies, the PATH CPS/Outreach Specialist also engages these individuals by connecting them to the numerous groups and activities that are available at the Connect Program.

### **Staff Information**

Demographics of all Connect Staff:

Race/Ethnicity:	Black/African American:	90%
	White:	10%
Gender:	Male:	25%
	Female:	75%
Age:	62+:	10%
	51-61:	30%
	31-50:	50%
	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 male in his 30's with a certified peer specialist credential.

The staff of MHASP'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 MHASP staff for assistance with translation and interpreting when necessary.

## Client Information

Race/Ethnicity:	Black/African American:	65%
	White:	30%
	Hispanic/Latino	5%
	Asian:	0%
Gender:	Male:	70%
	Female:	30%
Age:	62+:	10%
	51-61:	45%
	31-50:	35%
	18-30:	10%

One hundred percent of the adult clients served using PATH funds are literally homeless. MHASP estimates that 110+ people will be engaged and 20 enrolled in PATH services in the coming program year.

## Consumer Involvement

Consumer and family member involvement are central to the recovery transformation that MHASP is currently undergoing. MHASP has developed a new vision statement and a new mission statement

- **MHASP'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.
- **MHASP'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. Every week at Connect begins with a community meeting open to all participants and staff. The community 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. Focus groups will also be implemented on a quarterly basis to ensure the quality of services.

MHASP 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.

### **Health Disparities Impact Statement**

Currently the CPS/outreach specialist has not encountered any transitional aged youth and 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.

### **Budget Narrative**

Personnel:

Funding of \$31,446 is being requested to provide for the full-time salary, 100% time, of an Outreach Liaison (Certified Peer Specialist). These positions will be located in at the Mental Health Association of Southeastern Pennsylvania, 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 \$31,446.

Fringe Benefits:

Funding of \$12,578 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 \$2,406, unemployment insurance at \$1,157, retirement at \$943, life insurance, disability and health insurance at \$8072. Total request for fringe benefits is \$12,578.

Travel:

Total travel request: \$0.00.

Supplies:

Total supplies/equipment request: \$0.00.

Other:

Total request for other expenses: \$0.00.

In-Kind:

In-kind services provided toward the project include the following items as outlined below at a value of \$29,312:

MHASP Support Staff	\$4,606
Fringe Benefits for Support Staff	\$1,843
Supplies/Consumer Related Items	\$150
Staff Training	\$2,335
Other Expenses	\$10,812
Rent, utilities, insurance, phone	
Administrative Expenses @ 15%	\$9,565

**MHASP BUDGET PA-602: Delaware County**  
**PATH Program FY 2016-2017 Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Outreach Liaison (Certified Peer Specialists)	31,446	1 FTE	\$31,446	31,446
Other Direct Support Staff		.073 FTE	\$4,606	\$4,606
<b>sub-total</b>			\$36,052	\$36,052
<b>Fringe Benefits – 40% of salary</b>				
FICA Tax			2,758	2,758
Unemployment			1,365	1,365
Retirement			1,082	1,082
Health, Life and Disability Insurance			9,216	9,216
<b>sub-total</b>			\$14,420	14,420
<b>Travel</b>				
Local Travel for Outreach			0	0
Travel to training and workshops				
<b>sub-total</b>			0	0
<b>Supplies/Equipment</b>				
Consumer-related items				
<b>sub-total</b>			150	150
<b>Other</b>				
Staff training			835	835
One-time rental assistance			0	0
Security deposits/Other			12,311	12,311
<b>sub-total</b>			\$13,146	\$13,146
<b>Admin – 15% of Direct</b>				
<b>Sub-total</b>			\$9,565	\$9,565
<b>Total PATH Budget</b>			<b>\$73,335*</b>	

\*Of this total, only \$44,023 is PATH funding. In-kind funding totals \$29,312.

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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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g. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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h. Other \$ 89,582 \$ 29,861 \$ 119,443

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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Office: Other (Describe in Comments) \$ 89,582 \$ 29,861 \$ 119,443 Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 89,582 \$ 29,861 \$ 119,443

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 89,582 \$ 29,861 \$ 119,443

Source(s) of Match Dollars for State Funds:  
Erie County Care Management will receive \$119,443 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 600 Estimated Number of Persons to be Enrolled: 200

Estimated Number of Persons to be Contacted who are Literally Homeless: 480

Number Staff trained in SOAR in Grant year ended in 2014: 0 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 2016-2017**

**1. Local Provider Description:**

Provider name as it appears in PDX:  
Erie County Care Management, Inc.  
Non-profit 501 (c) 3 Corporations  
1601 Sassafra 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 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 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 individuals who meet the threshold for Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and Serious Emotional Disturbance (SED) -at risk). 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 2016-17 Total = \$119,443
- Federal Funds = \$89,582.00
- State Funds = \$29,861.00 \*Block Grant County

## **2. Collaboration with HUD Continuum of Care Program:**

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. Collaboration with Local Community Organizations:**

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 stable 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 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 plan 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. 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.

## **11. 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, but 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.

## **12. Coordinated Entry:**

Erie County's Continuum of Care Home Team GAPS committee, which addresses system gaps, has worked to create a Coordinated Entry process utilizing the VI-SPDAT assessment tool. On 11/16/15 providers met with the CoC committee members and were introduced to the tool. Initial training on how to use the tool was provided. The initiation of the process is still in its infancy and Coordinated Entry remains a goal of the CoC Home Team.

## **13. 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.

**14. 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 female, age 62)
- \*Team Leader (Caucasian male, age 51)
- \*Homeless Case Manager (Currently in the process of hiring)
- \*Homeless Case Aide (Currently in the process of hiring)

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.

**15. Client Information:**

Adults Consumers Contacted 600

Adults Consumers Enrolled \*200

\*Number based on full homeless case management compliment 2 FTE Case Managers and 1 FTE Case Aide

Percent of Consumers Contacted Literally Homeless 80%

Percent of Consumers Enrolled Literally Homeless 95 %



## **17. Behavioral Health/Health Disparities Impact Statement:**

The PATH consumers are identified and Erie County MH/MR 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 2016-17 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 2016-17.

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.

**Erie County Mental Health and Intellectual Disabilities (MH/ID)**  
**Erie County Care Management, Inc.**  
**PATH 2016-2017 Budget Narrative**

**18. Budget Narrative:**

Director of Supportive Housing and Forensic Services: \$7,604 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: \$27,502 or 60%

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: \$23,325 or 58%

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: \$20,142 or 58%

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: \$35,485, social security, retirement, and insurances for assigned personnel.

Travel: \$2,400, \$0.54 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: \$1,190, 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: \$1,795, 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**

	<b>Annual Salary</b>	<b>PATH-Funded FTE</b>	<b>PATH-Funded Salary</b>	<b>TOTAL</b>
<b>Position</b>				
Director of Supp. Housing	\$50,693	.15 FTE	\$7,604	\$7,604
Team Leader	\$45,836	.60 FTE	\$27,502	\$27,502
Case Manager	\$40,216	.58 FTE	\$23,325	\$23,325
Case Aide	\$34,728	.58 FTE	\$20,142	\$20,142
Sub-total			\$78,573	\$78,573
<b>Fringe Benefits</b>				
FICA Tax				0
Unemployment				0
Retirement				\$4,715
Life Insurance				0
Insurance				\$24,760
Social Security				\$6,010
Sub-total				\$35,485
<b>Travel</b>				
Local Travel for Outreach				\$2,400
Travel to training and workshops				
Sub-total				\$2,400
<b>Supplies/Equipment</b>				
Consumer-related items				\$1,795
Sub-total				\$1,795
<b>Other</b>				
Staff training				\$1,190
One-time rental assistance				
Security deposits				
Sub-total		1.91 FTE		\$1,190
<b>Total PATH Budget</b>				\$119,443



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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 49,485 \$ 22,632 \$ 72,117

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 49,485	\$ 22,632	\$ 72,117	Detailed budgets and narratives are included in individual provider IUPs.

i. Total Direct Charges (Sum of a-h) \$ 49,485 \$ 22,632 \$ 72,117

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 49,485 \$ 22,632 \$ 72,117

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: City Mission-Living Stones, Inc will receive \$72,117 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 450 Estimated Number of Persons to be Enrolled: 60

Estimated Number of Persons to be Contacted who are Literally Homeless: 382

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 6

**Fayette County Behavioral Health Administration**  
**PATH Intended Use Plan**  
**2016-2017**

**Local Provider Description**

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. PDX ID is Fayette: City Mission-Living Stones, Inc.

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 eight units of permanent supportive housing. During the past few 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 four units are all occupied by formerly homeless families/individuals. Additionally, City Mission recently completed our newest project Stone Ridge Apartments, which is a six-unit apartment complex which opened in September 2015. These permanent supportive housing units prioritize serving individuals with mental health disability.

In August, 2016, City Mission will open 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. Once Promise House is operational, it will provide accountability, life skills programming, along with safe, decent 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 25 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. \$ 72,117

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, and client rental assistance. Please see the attached budget for more detail.

### **Collaboration with HUD Continuum of Care (CoC) Program**

City Mission has been an active participant in the Western PA HUD Continuum of Care process since its inception. The City Mission 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, a member of City Mission has always actively participated in the process as a member of the SWRHAB and attends all scheduled meetings of the RHAB. At present, the City Mission shelter supervisor is the City Mission representative to the SWRHAB. As a member of the RHAB he 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 participates 100% and is a part of subcommittees to address youth need and Rating & monitoring programs. At this time there is no specific PATH subcommittee, however the group as a whole had the opportunity to discuss the process of PATH data being entered into HMIS and the issues some providers may be facing.

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 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 shelter programs such as HOME AGAIN and Promise House.

### **Collaboration with Local Community Organizations**

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 also 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. 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 Treatment Court continues to be very active. Highlands Hospital continues to provide Mental Health inpatient 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 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 the contingency/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.

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 individual and group therapy 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) along with the development of Fayette Apartments, a 10-unit permeant supportive housing complex in Uniontown for chronically homeless 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. 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: Workshop, 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.

Community Support Services: A number of local organizations provide concrete goods, including food, clothing and household items. Among them are local churches, 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, including 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, and the Fayette County Partnership for Housing and Homelessness and its Local Housing Options Team (LHOT). City Mission is one of the community's primary providers 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 two-day training which provided intensive step-by-step instruction on completing SSI/SSDI applications.

## **Service Provision**

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. 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.

- **Provide 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. Community Action, 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 access financial support for PATH individuals through Fayette County Behavioral Health Administration's contingency/stabilization funds. These funds assist with rental assistance and household items that help support independence.

- **Describe any gaps that exist in the current service systems.**

While service delivery in the current service system has shown some improvements, it remains 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 require 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. 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.

- **Provide a brief description of the 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 provides weekly individual and group therapy at the Gallatin School Living Centre for eligible clients with co-

occurring disorders. Along with weekly group sessions to address the unique therapeutic 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 VA 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.

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.

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. Many free

trainings are available online and via conference call for PA HMIS. In addition, the federal PA HMIS TA training in State College in April 2016 was free.

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 confidentiality 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.

## **Data**

City Mission has been utilizing the PA Housing Management Information System (PA 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 PA 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 PA 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. DCED facilitates PA HMIS and Brian Miller is the PA HMIS Director.

## **Alignment with PATH Goals**

Fayette County is a rural community with few street homeless. However, the PATH Case Manager continues to provide ongoing in-reach 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 include, 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 Mental Health Services Plan**

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.

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.

### **Alignment with State Plans to End Homelessness**

As stated previously Fayette County is a rural community with few street homeless. However, the PATH Case Manager continues to provide ongoing in-reach 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.

### **Other Designated Funds**

No specific funding is earmarked for PATH services in the county under the Mental Health or Substance Abuse sections of the Human Service Plan 15-16. This previous plan focuses 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.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

Fayette County's PATH program Case Manager was trained in SOAR in 2010. Over the past three years six PATH consumers have successfully received benefits (SSI/SSDI) from directly working with the PATH Case Manager who is SOAR trained. At this time, City Mission does not see a need for additional staff to be trained, however City Mission is always willing to respond to the area's need and make necessary adjustments to better serve the community. Fayette County continues to assess the overall need for SOAR trained individuals throughout the county. Fayette County Community Action is working on a grant through the Staunton Farm Foundation that will expand SOAR training throughout the region. This program is in the beginning stages and feedback continues to be shared within the county's Local Housing Options Team (LHOT) meeting.

## Housing

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, decent, 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 residents) personal care homes that provide housing for individuals with mental illness.

## **Coordinated Entry**

At this time City Mission is not directly involved with the Coordinated Entry process. However, Fayette County is currently a pilot county for the Coordinated Entry process. City Mission is working with our pilot agency Fayette County Community Action Agency in understanding the process and requirements. This will be an ongoing process as Fayette County's housing providers learn and grow in their understanding of Coordinated Entry. Coordinated Entry is being discussed at the Western CoC, but no formal plan has been developed at this time. The subcommittee on coordinated entry is focused on the best ways to categorize clients while continuing to address client need and their ability to access services.

## **Justice Involved**

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 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 case management services for PATH clients who have been detained. Approximately 70% of PATH clients have been involved with the Criminal Justice System.

## **Staff Information**

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

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.

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. 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.

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.

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.

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—16<sup>th</sup> 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
- Federal PA PATH HMIS TA in State College, April 2016

## **Client Information**

City Mission expects to provide outreach to approximately 450 homeless clients primarily at our two emergency homeless shelters. City Mission anticipates enrolling approximately 50-60 adult clients using PATH funds in FY 2016-2017.

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.

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 2015- June 2016

**Total number of clients as of April 2016.....50**

<u>Gender</u>	<u>Race/Ethnicity</u>
Female – 23	White – 27    Hispanic
Male – 26	Black – 23
24	Entered the program from the emergency shelter (Two of which were housed in our Emergency apartment)
1	Entered from the Domestic Abuse Shelter
23	Staying with family or friend
1	Hospital
1	Fayette County Jail

**Consumer Involvement**

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**

In August, 2016, City Mission will open 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. Once Promise House is operational, it will provide accountability, life skills programming, along with safe, decent 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, when Promise House, the agency's newest facility opens in August of 2016. 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.

- **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 and MISA services and rental assistance used during period of transition from Promise House into the community.

- **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**

Promise House will fill the current gap in service that exists as far as TAY are concerned. The program will specifically target the needs of TAY where before their only option was the homeless shelters. Promise House will consist of a comprehensive curriculum consisting of life skills programming and other elements designed to meet the specific needs of TAY.

## **Budget Narrative**

When reviewing the overall budget for the Fayette County PATH program, fiscal year 2016-2017, the majority of the expenditures are prioritized for professional expenses. These include PATH case manager and benefits, totaling \$48,842. 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 \$250. Housing related expenses, including one-time rental assistance and Security deposits, total \$3,575. Individual and group therapy sessions will be provided by a Master's level Social Worker employed by City Mission to help support PATH clients and staff weekly

at the Gallatin School Living Centre location is allocated for \$2,000. Transportation expenses include bus tokens, fuel, and insurance coverage estimated at an increased amount of \$10,379. Other PATH related expenses include Office Supplies, Equipment/Furnishings, internet cost, and other consumer-related items estimated at 4,300. Administration cost of monitoring the PATH program funding is 2,771. The total budgeted cost for the PATH program is \$72,117.

**Fayette County  
City Mission – Living Stones  
PATH Program  
FY 2016-2017 Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Case Manager	\$43,000	1 FTE	\$43,000	\$43,000
<b>sub-total</b>	\$43,000		\$43,000	\$43,000
<b>Fringe Benefits</b>				
FICA Tax	\$3,302	1 FTE	\$3,302	\$3,302
Retirement	\$1,290	1 FTE	\$1,290	\$1,290
Life Insurance/WC	1,250	1 FTE	\$1,250	\$1,250
<b>sub-total</b>	\$5,842		\$5,842	\$5,842
<b>Travel</b>				
Travel to training and workshops	\$250		\$250	\$250
<b>sub-total</b>	\$250		\$250	\$250
<b>Equipment/Furnishings</b>				
As needed furnishings				
<b>sub-total</b>				
<b>Supplies</b>				
Office Supplies	\$500		\$500	\$500
Postage	\$50		\$50	\$50
Telephone/internet	\$3,000		\$3,000	\$3,000
Consumer-related items	\$750		\$750	\$750
<b>sub-total</b>	\$4,300		\$4,300	\$4,300
<b>Therapy Sessions</b>				
Support group and Individual sessions provided by Master's level social worker.	\$2,000		\$2,000	\$2,000
<b>sub-total</b>	\$2,000		\$2,000	\$2,000

<b>Rental Assistance</b>				
One-time rental assistance	\$2,575		\$2,575	\$2,575
Security deposits	\$1,000		\$1,000	\$1,000
<b>Sub-total</b>	<b>\$3,575</b>		<b>\$3,575</b>	<b>\$3,575</b>
<b>Transportation</b>				
Transportation	\$10,379		\$10,379	\$10,379
(includes bus tokens, fuel,				
insurance for van and to purchase truck to move clients into housing.				
<b>sub-total</b>	<b>\$10,379</b>		<b>\$10,379</b>	<b>\$10,379</b>
<b>Administration</b>				
(includes 4% allowable costs)	\$2,771		\$2,771	\$2,771
<b>Sub-total</b>	<b>\$2,771</b>		<b>\$2,771</b>	<b>\$2,771</b>
<b>Total PATH Budget</b>			<b>\$72,117</b>	

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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 31,578	\$ 14,442	\$ 46,020	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 31,578	\$ 14,442	\$ 46,020	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 31,578	\$ 14,442	\$ 46,020	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 31,578	\$ 14,442	\$ 46,020	

Source(s) of Match Dollars for State Funds:  
 Forest Warren Economic Opportunity Council will receive \$46,020 in federal and state PATH funds.

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: 7  
 Number Staff trained in SOAR in Grant year ended in 2014: 0      Number of PATH-funded consumers assisted through SOAR: 0

**Warren and Forest Counties  
Economic Opportunity Council  
PATH Intended Use Plan  
FY 2016-2017**

**Local Provider Description**

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, 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 \$46,020.

The Warren-Forest Counties Economic Opportunity Council, Inc. (EOC) is a private, non-profit Community Action Agency that serves those in need throughout Northwestern Pennsylvania's Warren and Forest Counties. Established in 1965, our agency provides an array of supportive services and programs to low-income families and individuals in our community. The Agency operates programs designed to help individuals/families become self-sufficient, programs include: Head Start, Housing Rehabilitation, Weatherization, Employment and Training, Energy Assistance, Homeless Assistance, Transitional Housing for Victims of Domestic Violence, Homelessness Prevention and Rapid Rehousing Program, Housing Counseling and Housing Management.

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 \$46,020.00

### **Collaboration with HUD Continuum of Care (CoC) Program**

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 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. The EOC Housing Specialist chairs the Local Housing Options Team that encompasses staff from Mental Health, Drug and Alcohol, Mental Retardation, Housing Authority, Warren-Forest EOC, local CSP, landlords, Community Resources for Independence, Warren County Jail, Area Agency on Aging, Veterans Affairs and local tenants. The LHOT is continuing to expand their representation of service providers and Mental Health consumers. In addition, the Housing Specialist organizes the “Point in Time Survey” conducted yearly and attends quarterly meetings for the Western Regional Housing Options Coalition. The Warren Forest EOC is the designated Homeless Assistance Program (HAP) coordinating Agency for Warren County.

### **Collaboration with Local Community Organizations**

The EOC 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 and 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 EOC is the only PATH provider in Warren and Forest Counties, no coordination between outreach teams is required.

### **Service Provision**

Warren Forest EOC 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 EOC works in conjunction with the Salvation Army to provide HAP 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 EOC Housing program also provides a permanent housing 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 are occurring for many consumers are low incomes or 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 MH Consumers, and social supports within the counties. Housing for young adults, state hospital discharges, previously jailed, dual diagnosed and low income families also seem to be target populations that have difficulty finding and maintaining housing.

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.

The Housing Specialist works with the dual diagnosis and coordinates with the various staff of these programs to assure PATH eligible clients receive services while they remain in their home. Consumers, teens to the elderly, with co-occurring disorders are a challenge and frequently use the costliest services. The combination of problems increases the severity of the MH and substance 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.

Mental Health services are provided by Forest Warren Human Services, 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, and Dubois Regional Medical Center.

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 and Venango Training Development Center in Oil City, Pa. Consumers can also utilize Career Link and OVR services for employment opportunities.

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 has completed a number of credits in an accredited, graduate counseling program that requires the student to be well versed in this area. The Warren Forest EOC PATH program supports and funds all trainings for the housing specialist.

Warren Forest EOC 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. Housing Specialist recently attended the free federal PATH HMIS TA in State College, PA.

The Housing Specialist and EOC will continue to participate in the mandated PATH HMIS system.

Warren Forest EOC is not required to follow 42 CFR Part 2 regulations.

## **Data**

Warren-Forest Counties EOC has fully utilized PA HMIS for several years. EOC 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, if offered, and they will attend webinars. Staff will function as mentors as new staff are familiarized with HMIS. Currently, Brian Miller is the HMIS director for Warren-Forest EOC. EOC is the organization in charge of HMIS as we are the only provider in the area for PATH. EOC enters data into HMIS for our PATH and ESG Shelter/Rapid Re-housing programs.

## **Alignment with PATH Goals**

Warren-Forest EOC uses its PATH funds to maximize both street outreach and case management. EOC is located in a rural community where many individuals are able to stay with family and friends rather than on the street. There are also several campgrounds where homeless individuals can go making street outreach more difficult. Staff does work closely with other local agencies to identify and assist those who are homeless and living in campgrounds, with friends and family, or on the street. Clients residing in EOC'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 EOC's other programs such as budget counseling and employment and training, and, when applicable, referrals are made to such programs by the housing specialist.

### **Alignment with State Mental Health Services Plan**

Warren-Forest EOC'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 EOC 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 EOC 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. EOC is aware of the need to develop and integrate disaster preparedness and an emergency response plan and will be working with Forest Warren Human Services and coordinated response information.

Forest Warren Human Services actively participates in the Local Emergency Planning Committee; Forest Warren Human Services participates in the county wide disaster drills; and also keeps an updated list of the most vulnerable consumers in the event there is a disaster.

### **Alignment with State Plan to End Homelessness**

Warren Forest EOC, serving two rural counties, does not encounter much of the literal homelessness as seen in the urban centers. Individuals often stay with family or friends, thus making them harder to identify. Warren-Forest EOC will use PATH funds to increase collaboration between EOC and service providers in the two 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 substance abuse issue 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. EOC 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 before they become chronically homeless. For both the chronically homeless, as well as the situational/transitional homeless, PATH funds will be used to provide transitional supportive housing for up to 24 months. During this time, 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 CAP programs, budget counseling, home ownership education, and termination assistance programs for utilities). The PATH housing specialist will also work closely with interagency colleagues in an effort to prepare PATH clients for EOC permanent housing when vacancies arise.

### **Other Designated Funds**

Forest Warren Human Services has Special Grant funding designated specifically for homeless/housing.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

Currently, Warren-Forest EOC is in the process of beginning the web-based SOAR training. 3 staff will be trained on SOAR, including the PATH housing specialist. 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.

There is no current system in place, similar to SOAR, in Warren-Forest Counties. 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**

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 transitional 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 EOC 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 EOC currently manages 3 apartment units in Tionesta, and 26 throughout the City of Warren.

EOC 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.
- 2 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 House(EOC)-permanent supportive housing in Warren County
- 3 Unit Fair Weather Lodge House which is currently under renovation (EOC) permanent supportive housing in Warren County
- 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**

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 4/5/16, 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 during the pilot stages and then the system will be introduced to the entire Continuum of Care region.

## **Justice Involved**

Warren Forest EOC has a large population of clients with a criminal history which presents challenges in searching for affordable permanent housing. The PATH housing specialist works closely with Warren-County Probation and Parole to successfully rehouse individuals who have criminal records. Effective collaboration between housing specialist and the local criminal

justice system is key for clients to achieve success. PATH housing specialist assists clients with housing subsidy applications, such as the Northwest 9, for those clients who are denied by the Housing Authority for either housing or Section 8 vouchers. PATH housing specialist also makes referrals to our employment and training program in an effort to assist clients to develop a resume, interviewing skills, etc. which are necessary to obtaining employment. EOC also focuses on educating criminal justice clients regarding bonding as an option as they are considered “at risk” job seekers. In addition, the PATH housing specialist works closely with individual probation officers to ensure client follow up with job applications, mental health/substance abuse appointments, housing applications, etc. to ensure that clients are working at their maximum potential in order to increase the chances of obtaining permanent affordable housing. Approximately 75% of PATH clients served by Warren-Forest EOC currently have criminal records.

One of the Transitional Houses is designated for Forensic; Forest Warren Human Services actively participates in the local Criminal Justice Advisory Board in both Forest and Warren Counties; The Warren County Prison Social Worker is an active participant in our Local Housing Options Team meeting.

### **Staff Information**

EOC staff serving these populations is three females between the ages of 21-40 and one late 30's male. The Warren Forest counties EOC delivers services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, traditions, beliefs, 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. Housing specialist receives periodic training in cultural competency from local trainings as well as pursuing graduate education requiring classes in cultural competency and counseling of diverse populations.

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**

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 is less than 50,000 persons with a declining population. Rural communities need to improve access to services, but too often, policies and practices are developed for metropolitan 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 FY 2016-2017 that 75 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 EOC. 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.

### **Consumer Involvement**

The Warren Forest Counties EOC 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 EOC and have had PATH clients as volunteers to the agency.

LHOT does consist of PATH clients as members. Clients participating in LHOT may participate in all discussion and future housing needs assessments.

PATH clients participate in CFST surveys. Consumers and their families are invited and do participate in the local LHOT meetings. Forest Warren Human Services has not hired any PATH clients as employees.

### **Health Disparities Impact Statement**

The Warren-Forest Counties E.O.C. expects to serve approximately 6 to 7 unduplicated transitional age youth in the 2016-2017 year. Warren-Forest Counties E.O.C. expects to spend roughly \$3500-\$5000 dollars on services for the TAY population.

TAY individuals will receive similar services to those of the general population. Warren-Forest EOC 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 (WCSD) 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 WCSD homeless liaison will also be able to assist the housing specialist in being able to identify and outreach to TAY individuals.

First and foremost, the TAY population will need 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. Warren-Forest E.O.C. will implement a tripartite approach to assisting 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. Housing specialist will also guide them through the maze of available services in order to demonstrate how one navigates the system. Second, EOC provides the TAY population with

budget counseling and a prepared renter program. EOC 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.

**Budget Narrative**

**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.

<b>Total Federal PATH Allocation.....</b>	<b>\$ 31,578</b>
<b>Total State PATH Allocation.....</b>	<b>\$ 14,442</b>
<b>Total PATH Allocation.....</b>	<b>\$ 46,020</b>

**In-Kind Supports:** Forest-Warren Human Services will provide monitoring and support services with a Project Director, Service Coordinator and clerical services.

Wages	\$ 6,531
Benefits	\$ 3,611
Operating Costs	\$ 1,813
Agency Overhead	\$ 647
Total	\$ 12,602

**Warren-Forest Counties  
Economic Opportunity Council Inc.  
FY 2016-2017 PATH Budget**

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
<b>Position</b>				\$25,989
<b>Supportive Housing Specialist</b>	\$27,846	0.865	\$24,087	
<b>Community Services Director</b>	\$38,043	0.05	\$1,902	
<b>Fringe Benefits</b>				\$10,136
<b>Travel</b>				\$339
<b>Equipment</b>				\$0
<b>Supplies</b>				\$185
<b>Other</b>				\$1,574
<b>Indirect</b>				\$7,797
<b>Total</b>				\$46,020

Position	Annual Salary*	PATH-funded FTE	PATH-funded Salary	Total
Supportive Housing Specialist	\$27,846	0.865	\$24,087	
Community Services Director	\$38,043	0.05	\$1,902	
<b>Subtotal Position</b>				\$25,989
Fringe Benefits (39%)			\$10,136	
<b>Subtotal Fringe Benefits</b>				\$10,136
Travel Local travel 600 miles @ \$.54/mile			\$324	
Travel to training, workshops and Statewide meetings			\$15	
<b>Subtotal Travel</b>				\$339
Supplies Office Supplies			\$101	
Postage \$7.00/month			\$84	
<b>Subtotal Supplies</b>				\$185
Training & Technical Assistance			\$50	
Telephone \$59.00/month			\$708	
Space Costs \$50.00/month			\$600	
Insurance \$18.00/month			\$216	
<b>Subtotal Other</b>				\$1,574
Indirect Costs – Administrative Costs @ 30% of Salaries				\$7,797
<b>TOTAL</b>				\$46,020

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 7/1/2016 to 6/30/2017

\* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>a. Personnel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>c. Travel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>d. Equipment</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>e. Supplies</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>f. Contractual</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>g. Construction (non-allowable)</b>				
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Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 49,485	\$ 16,495	\$ 65,980	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 49,485	\$ 16,495	\$ 65,980	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
<b>j. Indirect Costs (Administrative Costs)</b>	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 49,485	\$ 16,495	\$ 65,980	

Source(s) of Match Dollars for State Funds:

Franklin-Fulton MH/ID/EI will receive \$65,980 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	100	Estimated Number of Persons to be Enrolled:	40
Estimated Number of Persons to be Contacted who are Literally Homeless:	60		
Number Staff trained in SOAR in Grant year ended in 2014:	18	Number of PATH-funded consumers assisted through SOAR:	13

**Franklin/Fulton County  
PATH Intended Use Plan  
FY 2016-2017**

**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 offices are located at 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, Social Rehabilitation, Drop-In Center, Administrative, Crisis Intervention Team (CIT) training and coordination, Resource Coordination and Intensive Case management, Community Support Program (CSP), Vocational, Transitional and Supported Employment, SSI/SSDI Outreach, Access, and Recovery (SOAR) Program, Certified Peer Specialist Services, Psychiatric Rehabilitation, Student Assistance Program and Family-Based Mental Health Services. This joinder is known as Franklin/Fulton: Franklin/Fulton MH/ID/EI in PATH PDX.

Franklin/Fulton MH will receive \$65,980 in total PATH funds (\$16,495 State Match, \$49,485 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 Eastern PA HUD Continuum of Care (CoC) program. For planning purposes, the CoC is divided into 5 regions and managed by a Regional Homeless Advisory Board (RHAB). Franklin/Fulton is part of the South Central RHAB. 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.

Within the HUD Continuum of Care, 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 and the regional CoC meetings to network and collaborate with other members of the CoC on these efforts. The Franklin County Grants Manager periodically attends CoC meetings and works closely with the Mental Health Housing Program Specialist II to seek appropriate grants related to new housing opportunities. 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 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.

Three formal collaborative partnerships between the County and local housing entities exist through the TrueNorth Wellness Services, New Visions 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.

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 working on a proposal for a Mental Health Re-Entry Housing Program.

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, 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, 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 is contracted 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. 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 system, linking individuals with representative payee services, 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.

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.

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.

Maranatha Ministries, through their financial counseling program, provides financial counseling, representative payee services, and personal finance/budgeting instruction. They also provide transitional housing throughout the county. CandleHeart, an entity of Maranatha Ministries, provides budgeting, parenting, anger management, and life recovery programs.

Family Care Services provides representative payee services for individuals with mental illness.

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.

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 through 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. 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, 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. 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, 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 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 affordable, adequate housing and supports in the two-county area
- Lack of human service and disability knowledge among local landlords

Specifically, in regards to the mental health population served, the lack of residential services available for individuals with mental health illness who are ex-offenders has been identified as a top priority. The Housing Task Force and Franklin County Re-Entry Coalition are working to address the housing needs of the mental health service system, specifically individuals with a mental illness who are eligible for PATH assistance. The Mental Health Housing Program Specialist II is working with the Grants Manager in identifying grant opportunities for the creation of a Mental Health Re-Entry Housing Program to serve individuals with mental illness being released to Franklin County through a master leasing and supportive service program.

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, 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 rental payments to landlords. 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 rent for those facing homelessness to maintain 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, 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. In addition, the federal PA PATH HMIS TA was offered for free in State College, PA in April 2016.

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 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. Some individuals are supported by providing permanent housing through our additional housing programs. Franklin County MH/ID/EI and the Franklin County LINK/211 program sponsored a PREP Training for interested local agencies and providers in 2015 and was able to train staff from a variety of local agencies as trainers. These new trainers are now utilizing this training to reach a larger number of individuals experiencing homelessness or near homelessness in Franklin County.

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 attend 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 2015-2016 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 25<sup>th</sup>, 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, 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. 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

**Housing Support Services:**

Franklin/Fulton County Homeless Assistance Program  
Waynesboro Human Services  
Various Area Churches (seasonally)  
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 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, 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
- 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 70-100 individuals throughout 2016-2017. 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 35-40 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 35-40 individuals will be served throughout the 11th 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. 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 \$16,527.42 is being requested to provide for the full-time salary, 28.85% time, of a MH Housing Program Specialist II and funding of \$17,620.83 to provide for the full-time salary, 36.15% 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 \$34,148.25.

### **Fringe Benefits:**

Funding of \$9,720.39 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 \$2,454.28, health insurance at \$4,388.43, retirement at \$2,731.86, life insurance at \$21.80, and state unemployment at \$124.02. Total request for fringe benefits is \$9,720.39.

### **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 \$72.00, lodging at \$400.00, gas & maintenance of county vehicles at \$100.00 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 \$1100.00. Total travel request: \$1,972.00.

### **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, 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/hygiene/habilitation supplies at \$2,366.93 for a total of \$2,616.93 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 35-40 individuals experiencing homelessness or at imminent risk at approximately \$500 each, not to exceed \$13,196.00. Internet/computer service for a year at \$1,955.65, 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%, \$2,639.20, 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:  
\$17,890.85.

**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)	\$461.99
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 2016-2017 Budget**

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
<b>Position</b>				
Program Specialist I	\$ 49,968.02	36.19%	\$18,083.43	\$18,083.43
Program Specialist II	63,470.15	28.30%	\$17,962.05	\$17,962.05
<b>sub-total</b>	113,438.17		36,045.48	36,045.48
<b>Fringe Benefits</b>				
FICA Tax	7,769.91		2,487.81	2,487.81
Health Ins	7,205.52		2,607.68	2,607.68
State Unemployment	381.60		123.05	123.05
Worker's Comp	286.96		92.32	92.32
Retirement	6,675.21		2,123.42	2,123.42
Life Insurance	62.81		20.46	20.46
<b>sub-total</b>	22,382.01		7,454.74	7,454.74
<b>Travel</b>				
Local Travel for Outreach	800.00		800.00	800.00
Travel to training and workshops	300.00		300.00	300.00
Staff Training/Registrations	300.00		300.00	300.00
Lodging for Trainings	400.00		400.00	400.00
Meals	72.00		72.00	72.00
Gas/Maint - Cty Vehicles	100.00		100.00	100.00
<b>sub-total</b>	1,972.00		1,972.00	1,972.00
<b>Equipment</b>				
<b>Supplies</b>				
Office Supplies	250.00		250.00	250.00
Safety and Emergency Supplies	2,366.93		2,366.93	2,366.93
<b>sub-total</b>	2,616.93		2,616.93	2,616.93
<b>Other</b>				
Rental Assist/Security Deposits	13,196.00		13,196.00	13,196.00
Postage	100.00		100.00	100.00
Internet/Computer	1,955.65		1,955.65	1,955.65
Administrative Costs	4,184.04		2,639.20	2,639.20
<b>sub-total</b>	19,435.69		17,890.85	17,890.85
				65,980.00

27. Grapevine Center

140 North Elm Street

Butler, PA 16001

Contact:

Contact Phone #:

Has Sub-IUPs: No

Provider Type: Community mental health center

PDX ID:

State Provider ID:

Geographical Area Served: Western Region

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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g. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

28. Greene County Department of Human Services

19 South Washington Street

Waynesburg, PA 15307

Contact: Zabryna Kames

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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
h. Other	\$ 29,148	\$ 9,716	\$ 38,864	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 29,148	\$ 9,716	\$ 38,864	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
i. Total Direct Charges (Sum of a-h)	\$ 29,148	\$ 9,716	\$ 38,864	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
k. Grand Total (Sum of i and j)	\$ 29,148	\$ 9,716	\$ 38,864	

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Greene County Department Human Services will receive \$38,864 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 40 Estimated Number of Persons to be Enrolled: 40

Estimated Number of Persons to be Contacted who are Literally Homeless: 12

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 6

**Greene County  
PATH IUP  
2016-2017**

**Local Provider Description**

PA-069 Greene County – Greene County Human Services, 19 South Washington Street, 3<sup>rd</sup> Floor, Waynesburg PA 15370. The Greene County Department of Human Services is the provider organization requesting \$38,864 to implement the PATH Intended Use Plan for Greene County. Greene County Human Services will be also allocating \$13,801 from the DHS Block Grant for a total of \$52,665 for the intended use of PATH.

The Greene County Human Services Department provides administrative oversight 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**

Greene County Human Services Department is one of two Greene County voting participants on the Southwest RHAB and is also a 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, Community Action Southwest, Catholic Charities, Greene County ESG Program, the two local Oxford Houses; one for women and one for men, 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.

### **Collaboration with Local Community Organizations**

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, a federally qualified health center, provides a majority of health care and dental services to our individuals.

Mental Health services are provided by Greene County Human Services Mental Health Program, Centerville Clinics MH, Inc., SPHS, The Stern Center 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 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.

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 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 in Greene County Housing Program assists prospective residents who meet eligibility.

### **Service Provision**

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. The assessment that we use is the most current centralized intake that is a part of the current centralized intake pilot project from the Western PA COC. 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.

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 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 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.

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. GCHSHP has challenges as 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 have look to overcome this obstacle 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. This past January and February were our first time to open such a services. It was completely run by volunteers, donations and great collaboration. We had 4 sites that offered a warm place for individuals and families to go when the temperature was 20 degrees or below. Each site was open for a two week period. Individuals could register through our Mental Health Crisis hotline. The name of the program was “Warm Nights. 20 and Below” The Executive Committee has already decide to expand this service next year from 20 degrees to 25 degrees and for an additional month. This community effort ended up serving 7 individuals over a 12 night period. All individuals were connect through services from the G-PATH program to help them long term.

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, so this collaboration is growing.

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.

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.

Greene County Human Services supports and funds evidence based programs throughout the categoricals provided by Greene County Human Services. During fiscal year 2014-2015, 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 2015-2016 our G-PATH program staff have 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.

Greene County Human Services (GCHS) does follow the 42 CFR Part 2 Regulations. GCHS also includes under its umbrella of services the Drug and Alcohol Program. This 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.

## **Data**

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](http://www.newpa.com/pahmis) website. All Greene County Housing Program staff will continue to utilize HMIS on an ongoing base. DCED is the guiding organization for PA HMIS. Brian Miller is the PA HMIS Director.

## **Alignment with PATH goals**

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.

## **Alignment with State Mental Health Services Plan**

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, Visits 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. 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 all 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**

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, ESG 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.

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 tenants 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.

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**

There are Block Grant Dollars that are specifically ear marked for serving people who experience homelessness and have a serious mental illness. This is 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.

**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.**

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 are trained in SOAR. In February 2014 a new lead person trained via web based and has become certified. The PATH Program will continue to work with this lead person to make sure that those who need SOAR services are referred. During the FY of 2014-2015 as of April, the SOAR certified person has worked on 3 cases. Referrals are being seen from the local hospital and other agencies to the lead person. In FY 2015-2016 as of May 1<sup>st</sup>, the SOAR certified person has worked with 6 individuals, completing 3 of those applications, two of the three have been accepted and one was denied. The other three individuals did not finish the application and have lost contact with the

SOAR liaison. The SOAR Liaison did also help 18 other individuals with Social Security related information so far this current FY.

## **Housing**

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 Leasing 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 January and February of 2016, a new collaborative program called Warm Nights 20 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**

G- PATH Outreach Specialist is currently the single point of contact for those who are homeless or at eminent risk of being homeless, providing an assessment that can be used to referral the person to the appropriate services while also making sure that those services are rendered. The Western PA COC has a subcommittee for Coordinated Entry. This subcommittee in September 2015 released a Standardized Coordinated Entry Assessment that will be used for all that are homeless. There are five counties in the Continuum that are pilot counties using this document to track and prioritize homeless individuals. Greene County is not named as a pilot county but Washington County is. The Agency selected in Washington County is the same agency that we subcontract our HUD PSH dollars to. With this close connection we have been able to stay current with the COC's Coordinated Entry subcommittee, while also using the most recent draft of the Coordinated Entry Assessment. The Coordinated Entry Assessment is scheduled to be utilized by the entire COC in October of 2016. Greene County will utilize it and HMIS to help services those who are homeless or are at risk.

## **Justice Involved**

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 will help 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 serve 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.

The Master Leasing Housing Program will also be case managed by the Forensic Reentry Specialist.

## **Staff Information**

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 provides 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 have 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.

Greene County Human Services Department Housing Program co-chairs the GCHOP/LHOT meeting that currently has about 45 people/stakeholders on the mailing list. GPATH activities are a regular 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 college.

As a part of the Department of Human Services 2014-2015 Block Grant, a work group for LGBTQI issues has been in operation. The initiative hopes to provide specific trainings for professionals and support to individuals in the LGBTQI population.

### **Client Information**

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. The projected number of adult clients to be contacted using PATH funds will be 40. Approximately 40 adult clients will be enrolled (as in seen for outreach services) using PATH funds. Approximately 30% of the adult clients served with PATH funds are projected to be "literally" homeless.

### **Consumer Involvement**

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**

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 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 \$17,119.41 from the Human Services Block Grant/County Match to ensure that the PATH program can operate to its fullest.

Our state Allocation will be \$9,716.00 and our Federal Allocation utilized will be \$29,148.00.

**Greene County  
PATH Program  
FY 2016-2017 Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing Case Manager	6,762.68	.14 FTE	6,762.68	6,762.68
Outreach Specialist (Certified Peer Specialists)	25,339.86	1 FTE	25,339.86	25,339.86
<b>sub-total</b>	32,102.54		32,102.54	32,102.54
<b>Fringe Benefits</b>				
FICA Tax	2,030.67		2,030.67	2,030.67
Unemployment, WC, Health	19,409.76		19,409.76	19,409.76
Retirement	1,756.00		1,756.00	1,756.00
Life Insurance	109.44		109.44	109.44
<b>sub-total</b>	23,305.87		23,305.87	23,305.87
<b>Travel</b>				
Local Travel for Outreach	150.00		150.00	150.00
Travel to training and workshops	150.00		150.00	150.00
<b>sub-total</b>	300.00		300.00	300.00
<b>Supplies/Equipment</b>				
Consumer-related items	150.00		150.00	150.00
<b>sub-total</b>	150.00		150.00	150.00
<b>Other</b>				
Staff training	125.00		125.00	125.00
One-time rental assistance				
Security deposits				
<b>sub-total</b>	125.00		125.00	125.00
<b>Total PATH Budget</b>			<b>\$55,983.41</b>	

We will utilize our State Allocation of \$9,716, Federal Allocation of \$29,148 and an addition of \$17,119.41 state funds from the Human Services Block Grant/ County Match.

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:  
 For source of match dollars for state funds: Service Access and Management, Inc. will receive \$32,479 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 175 Estimated Number of Persons to be Enrolled: 18

Estimated Number of Persons to be Contacted who are Literally Homeless: 25

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Huntingdon, Mifflin and Juniata Counties  
Service Access and Management Inc.  
PATH Intended Use Plan  
FY 2016-2017**

**Local Provider Description**

Service Access and Management Inc  
HMJ Base Service Unit  
100 East Market Street  
Lewistown, PA 17044

Service Access and Management 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 13 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 will be assuming the role as PATH Coordinator effective July 1, 2016. SAM Inc. will begin assuming case management duties during the transition period effective May 2, 2016 and will assume overall PATH program management including fiscal duties effective July 1, 2016.

The Service Access and Management Base Service Unit Housing Specialist will work with Juniata Valley Behavioral Health and Developmental Services office and the previous PATH Coordination agency Shelter Services Inc. to transition all current PATH program participants without any disruption in PATH services.

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 transitional 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 \$32,479 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 \$22,411 in federal funds with a state match of \$10,068.

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 7 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 potentially 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 or Master Leasing. We consider this to be an extra layer of support while the individual is also being seen by other agency representatives. Huntingdon Co technically is in the South Central RHAB of the Eastern PA CoC while Mifflin and Juniata Counties fall in the Central Valley RHAB of the Eastern CoC.

### **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 42 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.

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.

## Service Provision

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 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. In addition, Clear Concepts Counseling will be able to continue an increased level of services to the target population by three (3) hours per week and assessment services by two (2) per month.

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 pursuing 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.

The implementation of the Tri-County PATH Program is the first time JVBDS has developed a contract with a local drug and alcohol provider. From the inception of the idea 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 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.

## **Data**

In coordination with the Mifflin/Juniata Human Services Department, Service Access and Management Inc. will enter PATH data into the PA HMIS system which is administered by DCED. JVBDS will assist SAM Inc Information & Technology staff to establish initial access to the PA HMIS system. PATH Coordinator and the PATH Coordinator Supervisor will receive all necessary training related to PA HMIS system use. Data will continue to be collected in the manner that is consistent with PATH requirements including demographic data, case notes and outreach efforts.

SAM Inc. will begin data entry into the PA HMIS system as soon as they are providing case management services and are set up in the system. Shelter Services will complete any 2015/2016 reporting and SAM Inc. will assume all data entry and reporting on July 1, 2016.

## **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 8<sup>th</sup> and 9<sup>th</sup>, 2013. Because of the transition of PATH Case Management services from Shelter Services Inc. to Service Access and Management Inc. for FY 2016/2017 the Base Service Unit Housing Specialist will receive

SOAR training upon availability of training with the target date for SOAR training to be completed during the first quarter of the fiscal year. Data regarding the number of PATH participants assisted through SOAR during FY 2015/2016 is not available due to the change in provider agencies.

## **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 for 3 years 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.

Shelter Services, Inc. in coordination with Mifflin/Juniata Human Services have constructed two transitional housing units that are currently vacant and are planning to be used by PATH eligible individuals. Also, there are several tax-credit projects slated to begin construction in Mifflin County in the upcoming year. These will have a percentage of units set aside for low-income individuals with disabilities. The County MH/MR Program has written a letter of support for one such project and is anticipating that those units will be available for PATH eligible clients.

## **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.

The 2015/2016 data regarding the percentage of PATH clients with criminal history was not available from the previous provider for this report. The 2014/2015 data indicated that 21% of the individuals had criminal justice involvement and that percentage is likely to be consistent or slightly increase during FY 2016/2017 as we anticipate an increase in individuals being released earlier from criminal justice institutional settings and returning to their county of residence.

## **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 and is currently working with Juniata Valley Behavioral and Developmental Services to provide a local training Transgender Best Practices Training.

## **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.

Due to the change in the PATH provider agency from Shelter Services Inc. to Service Access and Management Inc. 2015/2016 fiscal year data regarding the homeless population was not available.

Based on the local homeless shelter being at full capacity on several occasions during fiscal year 2015/2016 it would be expected that the anticipated number of individuals who will be enrolled in PATH during FY 2016/2017 will increase by at least 25-50% over FY 2015/2016. The percentage of clients to be served who are literally homeless would be 100%.

Based on the most recent caseload provided by Shelter Services Inc there are currently 6 individuals enrolled in the HMJ PATH Program. The projected number of individuals to be enrolled in PATH during 2016/2017 is 18.

### **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 and all stakeholders including Shelter Services and Clear Concepts during an annual meeting to facilitate future PATH planning and improve service delivery.

## **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 18-23 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.

**Budget Narrative** – Please see below.

**Huntingdon, Mifflin, Juniata Counties  
Service Access and Management, Inc.  
FY 2016-2017 PATH Budget**

	Annual Salary	PATH- funded FTE	PATH- funded salary	TOTAL
<b>Position</b>				
Housing Case Manager	\$29523	.4 FTE	\$11809	\$11809
<b>sub-total</b>	\$29523	.4		\$11809
<b>Fringe Benefits</b>				
FICA Tax	\$2259	.4		\$904
Dental/Vision Insurance	\$95	.4		\$38
Worker's Comp	\$1804	.4		\$722
Life Insurance	\$66	.4		\$26
<b>sub-total</b>	\$4224	.4		\$1690
<b>Travel</b>				
Local Travel for Outreach				\$1000.00
Travel – Trainings/workshops				\$500.00
Cell/Communicatons				\$172
<b>sub-total</b>				\$1672
<b>Supplies/Equipment</b>				
Consumer-related items				\$4398
Admin, Check Processing, HMIS readiness				\$2910
<b>sub-total</b>				\$7308
<b>Other</b>				
One-time rental assistance				\$5000.00
Security deposits				\$5000.00
<b>sub-total</b>				\$10000.00
<b>Total PATH Budget</b>				<b>\$32479</b>

**PATH Budget Narrative  
FY 2016-2017**

**Funding Breakdown**

Service Access and Management, Inc. will be allocated \$32,479 in total PATH funds. \$22,411 of these funds will be federal while \$10,068 will be state match.

**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 \$1690 which equals 5% of the total funds.

**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.

30. Huntingdon/Mifflin/Juniata County

399 Green Ave  
Lewistown, PA 17044

Contact: Bob Henry

Contact Phone #: 7172426467

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID:

State Provider ID:

Geographical Area Served: Central Region

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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g. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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h. Other \$ 29,148 \$ 13,331 \$ 42,479

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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Office: Other (Describe in Comments) \$ 29,148 \$ 13,331 \$ 42,479

Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 29,148 \$ 13,331 \$ 42,479

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 29,148 \$ 13,331 \$ 42,479

Source(s) of Match Dollars for State Funds:  
H/M/J gets a total of \$42,479 for the whole county. 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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Huntingdon, Mifflin and Juniata Counties  
Comprehensive PATH Intended Use Plan  
FY 2016-2017**

**Local Provider Description**

Juniata Valley Behavioral and Developmental Services  
399 Green Avenue Extended, Suite 200  
Lewistown, PA 17044

The Juniata Valley Tri-County Area is composed of three primarily rural counties in Central Pennsylvania: Huntingdon, Mifflin and Juniata. With a land area of 1,678 square miles, it is home to approximately 114,450 individuals. Juniata Valley Behavioral and Developmental Services (JVBDS) serves approximately 850 individuals with serious mental illness and/or intellectual disabilities across the three counties. JVBDS is a quasi-governmental agency that provides no direct care services, but contracts with providers to implement the mental health services in the Tri-County. JVBDS will be the recipient of 2015-2016 PATH funds and will contract with two local providers to implement the PATH program. These two providers will be Service Access and Management, Inc. (SAM, Inc.) and Clear Concepts Counseling (CCC).

SAM, Inc. will assume all PATH coordination responsibilities as of July 1, 2016. New Shelter Services will not be a PATH provider after that date, but will continue to work collaboratively with SAM, Inc. to enroll individuals in the program. SAM, Inc. is a non-profit organization that provides Base Service Unit functions, blended and administrative case management, and supports coordination. Data is not available for the current fiscal year due to staffing changes and a transition to new leadership at the midway point of the year. These statistics will be tracked currently and available for future reporting.

PATH funding will provide resources for SAM, Inc. to maintain a dedicated case manager charged with these service linkages, assisting persons with a transitional to permanent housing and follow-up with the individual for a period of time to ensure success. SAM, Inc. will be allocated \$32,479 to provide the PATH case management. Of this allocation, \$22,411 will be federal funds and \$10,068 will be state match.

Clear Concepts Counseling (CCC) is a locally based non-profit organization that provides addictions counseling and assessments in Mifflin and Juniata Counties. CCC is a licensed drug and alcohol agency that has been providing services for 20 plus years. Clear Concepts and Shelter Services have a well-developed history of working together to serve the PATH target population and also work closely with JVBDS to serve individuals diagnosed with a serious mental illness. Clear Concepts Counseling provides assessments, addiction counseling and anger management with individuals residing at the Shelter and who meet the definition of the target population for PATH funding. Outside of PATH funding, CCC also provides screenings, individual and intensive outpatient services. So far this fiscal year, there have been 21 anger management counseling sessions with 16 residents, 28 individual D&A counseling sessions, 38 D&A group counseling sessions and 6 individuals enrolled in intensive outpatient counseling.

Clear Concepts Counseling will be allocated \$10,000 to provide clinical services to the PATH population. Of these funds, \$6,900 will be federal and \$3,100 will be state match.

Clear Concepts Counseling and will work closely with Service Access and Management, Inc. (SAM, Inc.) to implement the 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 coordinated jointly by the BSU and The Advocacy Alliance. The Master Leasing Program currently has 13 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 potentially 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 or Master Leasing. 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**

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 JVBDS:

- **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, 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.
- **The Advocacy Alliance:** Warm Line and Consumer/Family Satisfaction Team can provide employment opportunities for PATH eligible individuals.
- **Service Access and Management:** Base Service Unit, Administrative Case Management, Forensic Case Management and Blended Case Management.
- **Northwestern Human Services Juniata River Center:** Blended Case Management.
- **Keystone Human Services, CSG and Advocacy Alliance/Peer Star:** Certified Peer Specialist.

## Service Provision

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.

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. CTI is an evidence based program. The SAM, Inc. PATH Coordinator and supervisor will attend CTI training in fiscal year 2016/2017.

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 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. In addition, Clear Concepts Counseling will be able to continue an increased level of services to the target population by three (3) hours per week and assessment services by two (2) per month.

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 pursuing 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.

SAM, Inc. staff will attend all free PA HMIS trainings as well as the free HMIS Technical Assistance Conference.

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.

The implementation of the Tri-County PATH Program is the first time JVBDS has developed a contract with a local drug and alcohol provider. From the inception of the idea 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 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.

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.

Currently, Shelter Services enters all PATH data into the PA HMIS system. Data being collected is consistent with PATH requirements including demographic data, case notes and outreach efforts.

## **Data**

In coordination with the Mifflin/Juniata Human Services Department, Service Access and Management Inc. will enter PATH data into the PA HMIS system which is administered by DCED. JVBDS will assist SAM Inc Information & Technology staff to establish initial access to the PA HMIS system. PATH Coordinator and the PATH Coordinator Supervisor will receive all necessary training related to PA HMIS system use. Data will continue to be collected in the manner that is consistent with PATH requirements including demographic data, case notes and outreach efforts.

SAM Inc. will begin data entry into the PA HMIS system as soon as they are providing case management services and are set up in the system. Shelter Services will complete any 2015/2016 reporting and SAM Inc. will assume all data entry and reporting on July 1, 2016.

## **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 8<sup>th</sup> and 9<sup>th</sup>, 2013. Because of the transition of PATH Case Management services from Shelter Services Inc. to Service Access and Management Inc. for FY 2016/2017, the Base Service Unit Housing Specialist will receive SOAR training upon availability of training with the target date for SOAR training to be completed during the first quarter of the fiscal year. Data regarding the number of PATH participants assisted through SOAR during FY 2015/2016 is not available due to the change in provider agencies.

## **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 are individuals who have past and present credit issues, criminal histories, poor rental histories, and substance abuse issues. Shelter Services, Inc. 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. Shelter Services, Inc. then signs a 3-year 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 for 3 years whether the unit is occupied or not. Shelter Services, Inc. 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.

Shelter Services, Inc. in coordination with Mifflin/Juniata Human Services have constructed two transitional housing units that are currently used by PATH eligible individuals. Also, there are several tax-credit projects that have been completed in recent years. These have a percentage of units set aside for low-income individuals with disabilities. JVBDS has written a letter of support for one such project and is anticipating that those units will be available for PATH eligible clients.

### **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.

The 2015/2016 data regarding the percentage of PATH clients with criminal history was not available from the previous provider for this report. The 2014/2015 data indicated that 21% of the individuals had criminal justice involvement and that percentage is likely to be consistent or slightly increase during FY 2016/2017 as we anticipate an increase in individuals being released earlier from criminal justice institutional settings and returning to their county of residence.

### **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.

Service Access and Management provides annual Cultural Competence training for all staff and is currently working with Juniata Valley Behavioral and Developmental Services to provide a local training Transgender Best Practices Training.

Clear Concepts Counseling staff will provide the assessment and substance use counseling and is staffed with experienced Certified Addictions Counselors. PATH funded counseling will be provided by a Caucasian female. The staff who provide the services have had cultural competency training and are aware of the need all types of population and their needs. Counselors assess the group at all times and if there is any problem with cultural issues of any kind it is addressed at that time. CCC also has incorporated into their psycho social, an area that specifically addresses the needs of LGBTQ. CCC feels it is important to know these issues to better serve these clients specific needs.

## **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.

Due to the change in the PATH provider agency from Shelter Services Inc. to Service Access and Management Inc. 2015/2016 fiscal year data regarding the homeless population was not available.

Based on the local homeless shelter being at full capacity on several occasions during fiscal year 2015/2016 it would be expected that the anticipated number of individuals who will be enrolled in PATH during FY 2016/2017 will increase by at least 25-50% over FY 2015/2016. The percentage of clients to be served who are literally homeless would be 100%.

Based on the most recent caseload provided by Shelter Services Inc there are currently 6 individuals enrolled in the HMJ PATH Program. The projected number of individuals to be enrolled in PATH during 2016/2017 is 18.

## **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 and all stakeholders including Shelter Services and Clear Concepts during an annual meeting to facilitate future PATH planning and improve service delivery.

### **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 18-23 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.

**Budget Narrative: Please see below.**

**Huntingdon, Mifflin, Juniata Counties  
FY 2016-2017 PATH Budget**

	Annual Salary	PATH- funded FTE	PATH- funded salary	TOTAL
<b>Position</b>				
Housing Case Manager	\$29523	.4 FTE	\$11809	\$11809
<b>sub-total</b>	\$29523	.4		\$11809
<b>Fringe Benefits</b>				
FICA Tax	\$2259	.4		\$904
Dental/Vision Insurance	\$95	.4		\$38
Worker's Comp	\$1804	.4		\$722
Life Insurance	\$66	.4		\$26
<b>sub-total</b>	\$4224	.4		\$1690
<b>Travel</b>				
Local Travel for Outreach				\$1000.00
Travel – Trainings/workshops				\$500.00
Cell/Communicatons				\$172
<b>sub-total</b>				\$1672
<b>Supplies/Equipment</b>				
Consumer-related items				\$4398
Admin, Check Processing, HMIS readiness				\$2910
<b>sub-total</b>				\$7308
<b>Other</b>				
One-time rental assistance				\$5000.00
Security deposits				\$5000.00
Purchase of Services (Clear Concepts Counseling)				\$10000
<b>sub-total</b>				\$20000.00
<b>Total PATH Budget</b>				<b>\$42479</b>

## Budget Narrative

### Funding Breakdown

Service Access and Management, Inc. will be allocated \$32,479 in total PATH funds. \$22,411 of these funds will be federal while \$10,068 will be state match.

Clear Concepts Counseling will be allocated \$10,000 in total PATH funds. \$6,900 of these funds will be federal while \$3,100 will be state match.

### 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 \$1690 which equals 5% of the total funds.

### 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.

31. Huntingdon/Mifflin/Juniata County - Clear Concepts

24 N Main St, Lewistown

Lewistown, PA 17044

Contact: Jill Pecht

Contact Phone #: 7172423070

Has Sub-IUPs: No

Provider Type: Substance use treatment agency

PDX ID: PA-072

State Provider ID: 4272

Geographical Area Served: Central Region

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Clear Concepts Counseling will receive \$10,000 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 10 Estimated Number of Persons to be Enrolled: 10

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

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Huntingdon, Mifflin and Juniata Counties  
Juniata Valley Behavioral and Developmental Services**

Clear Concepts Counseling  
PATH INTENDED USE PLAN  
FY 2016-2017

**Local Provider Description**

Clear Concepts Counseling  
24 N. Main Street  
Lewistown, PA 17044

Clear Concepts Counseling (CCC), known as HMJ – Clear Concepts Counseling in PDX, is a locally based non-profit organization that provides addictions counseling and assessments in Mifflin and Juniata Counties. CCC is a licensed drug and alcohol agency that has been providing services for 20 plus years. Clear Concepts and Shelter Services have a well-developed history of working together to serve the PATH target population and also work closely with JVBDS to serve individuals diagnosed with a serious mental illness. Clear Concepts Counseling provides assessments, addiction counseling and anger management with individuals residing at the Shelter and who meet the definition of the target population for PATH funding. Outside of PATH funding, CCC also provides screenings, individual and intensive outpatient services. Clear Concepts Counseling will be allocated \$10,000 to provide clinical services to PATH participants including D&A assessments, individual counseling, group counseling, and anger management counseling. \$6,900 of these funds will be federal while \$3,100 of the funding will be state match.

Clear Concepts Counseling will work closely with the Tri-County Base Service Unit (BSU) that is operated by Service Access and Management, Inc. (SAM, Inc.) to implement the 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 coordinated jointly by the BSU and Advocacy Alliance. The Master Leasing Program currently has 13 units to serve individuals who may otherwise not be eligible for subsidized housing options.

**Collaboration with HUD Continuum of Care Program**

The Tri-County currently has no providers participating in the HUD Continuum of Care program. Although 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 potentially PATH eligible individuals is for rapid re-housing following a period of homelessness with the appropriate supports in place.

The Mifflin/Juniata Human Services Department facilitates a Housing Coalition which looks at housing needs from a broader perspective that includes assessment of available housing stock

and meeting basic needs for individuals struggling to find or maintain housing. Service Access and Management, Inc. sits on the MJ Housing Coalition focusing on the needs of individuals with serious mental illness who are homeless. Through the PATH program we have been able to assist more homeless individuals to access public housing and Section 8.

### **Collaboration with Local Community Organizations**

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 through a system called “Coalition of Hopes” 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.

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 JVBDS:

- **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, 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:** Warm Line and 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 Services.

### **Service Provision**

CCC and the Shelter Services have worked together for many years. Clients are identified by the shelter and referred for an assessment and if appropriate referred to the PATH program. CCC

provides drug and alcohol assessments and continues to develop programming as we see need for the PATH clients. One specific group developed for the PATH clients is the Anger Management Group. This group is run weekly and a variety of topics are used to help this population develop appropriate coping skills to control their anger. CCC will use work books, work sheets and discussion as a means to help develop these skills. CCC will implement a new project in May a group for just the PATH clients looking at vision chart/ goals, successes and do journaling and fun activities with this group. It will also give the PATH clients support and a place to share issues in their lives.

- **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 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. In addition, Clear Concepts Counseling will be able to continue an increased level of services to the target population by three (3) hours per week and assessment services by two (2) per month.

- **Provide a brief description of the services available to clients who have both a serious mental illness and a substance use disorder.**

The implementation of the Tri-County PATH Program is the first time JVBDS has developed a contract with a local drug and alcohol provider. From the inception of the idea 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). The PATH planning committee recognizes that 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 to access the appropriate services for each individual and will monitor participation and progress through team meetings and individual meetings with each client. CCC uses multiple evidence based cognitive behavioral therapies including:

- Individual drug and alcohol counseling
- Group drug and alcohol counseling
- Assessment and diagnosis
- Anger management group

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.

Clear Concepts Counseling is required to adhere to 42 CFR Part 2 regulations and ensure employees are well versed on confidentiality law. Each employee is required to read Confidentiality regulations 255.5 and 42 CFR and then sign a form indicating that they read and understand the regulations. Confidentiality regulations are reviewed and reinforced at monthly staff meetings.

- **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.**

Clear Concepts Counseling has a purchase of service agreement with JVBDS to provide assessment, diagnosis, individual D&A counseling, group D&A counseling and anger management group counseling to PATH enrolled individuals.

## **Data**

For fiscal year 2016/2017, there will be a change in the provider agency who provides coordination of the PATH program as well as data entry into PA HMIS. Service Access and Management, Inc. will assume responsibilities for these tasks on July 1, 2016. Leading up to that date, SAM, Inc. staff will obtain access to PA HMIS systems and will be trained to begin entering data on the contract beginning date. Clear Concepts Counseling staff has accessed the free PA HMIS trainings as well as attended the free PA HMIS Technical Assistance Conference. DCED is the PA HMIS administrator with Brian Miller as the PA HMIS Director.

## **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.

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:**

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.

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. CCC will be part of this emergency planning for each PATH individual and will be aware of each participant’s specific plan.

## **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 8<sup>th</sup> and 9<sup>th</sup>, 2013. Because of the aforementioned restructuring of Shelter Services and loss of staff, SOAR efforts in HMJ will be minimal until new staff is in place and more training can be accessed. This remains true as of May 2016 and will be a focus of the PATH program in fiscal year 2016/2017.

## **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 are individuals who have past and present credit issues, criminal histories, poor rental histories, and substance abuse issues. Advocacy Alliance and the SAM, Inc. 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 3-year 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 for 3 years whether the unit is occupied or not. Advocacy Alliance 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.

Shelter Services, Inc. in coordination with Mifflin/Juniata Human Services have constructed two transitional housing units that are currently vacant and are planning to be used by PATH eligible individuals. Also, there are several tax-credit projects that have recently been completed in Mifflin County. These will have a percentage of units set aside for low-income individuals with disabilities. The County MH/ID Program has written a letter of support for one such project and is anticipating that those units will be available for PATH eligible clients.

## **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.

The 2015/2016 data regarding the percentage of PATH clients with criminal history was not available from the previous provider for this report. The 2014/2015 data indicated that 21% of the individuals had criminal justice involvement and that percentage is likely to be consistent or slightly increase during FY 2016/2017 as we anticipate an increase in individuals being released earlier from criminal justice institutional settings and returning to their county of residence.

## **Staff Information**

The staff who provide the services have had cultural competency training and are aware of the need all types of population and their needs. Counselors assess the group at all times and if there is any problem with cultural issues of any kind it is addressed at that time. CCC also has incorporated into their psycho social, an area that specifically addresses the needs of LGBTQ. CCC feels it is important to know these issues to better serve these clients specific needs.

## **Client Information**

Based on previous years' statistics, Clear Concepts Counseling anticipates completing 3 assessments, 14 individual counseling sessions, 20 intensive outpatient groups, and 33 anger management groups. All individuals who receive these services will be enrolled in and referred by PATH case management. It is estimated that 10 people will be served by Clear Concepts Counseling via PATH funding during the fiscal year and that 100% will be literally homeless due to the referral mechanism in place with the SAM, Inc. PATH Coordinator.

## **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 and all stakeholders including Shelter Services and Clear Concepts during an annual meeting to facilitate future PATH planning and improve service delivery.

### **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 18-23 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.

**Budget Narrative** – Please see below.

**Huntingdon, Mifflin, Juniata Counties  
PATH Program  
FY 2016-2017 Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Case Manager				
Case Manager				
<b>sub-total</b>				
<b>Fringe Benefits</b>				
FICA Tax				
Health Insurance				
Retirement				
Life Insurance				
<b>sub-total</b>				
<b>Travel</b>				
Local Travel for Outreach				
Travel to training and workshops				
<b>sub-total</b>				
<b>Equipment</b>				
Cell and Data Service				
<b>sub-total</b>				
<b>Supplies</b>				
Office Supplies				
Consumer-related items				
<b>sub-total</b>				
<b>Other</b>				
Individual D&A Counseling				6,000
Assessment and Diagnosis				2,000
Group D&A Counseling				1,000
Anger Management				1,000
<b>sub-total</b>				10,000
<b>Total PATH Budget</b>			<b>10,000</b>	

## CLEAR CONCEPTS COUNSELING

### PATH 2016 – 2017 Budget Narrative

Clear Concepts Counseling will be allocated \$10,000 in PATH funds for fiscal year 2016/2017. \$6,900 of these funds will be federal while \$3,100 will be state match.

- **Drug and Alcohol Services: Clear Concepts Counseling (CCC)** will increase their individual counseling for the target population by three (3) hours per week and increase assessment services by two (2) per month. Clear Concepts Counseling will also provide group Drug and Alcohol services at **Shelter Services, Inc.** during the months of May, June and July. Historically, funding used to provide group services is depleted prior to the last quarter of the fiscal year. PATH funds will be used as a stop-gap measure so that these services can continue without interruption for the target population. JVBDS has developed a contractual relationship with CCC in order to purchase these additional services.
- **In-Kind Services**
  - Travel: 100.00
  - Copies:  $.06 \times 2400 = 144.00$
  - Prep Time: (2 groups  $\frac{1}{2}$  hour each a week) ; 1 hour a week 30.00 an hour, 1400.00

32. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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g. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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h. Other \$ 82,930 \$ 27,643 \$ 110,573

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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Office: Other (Describe in Comments) \$ 82,930 \$ 27,643 \$ 110,573

Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 82,930 \$ 27,643 \$ 110,573

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 82,930 \$ 27,643 \$ 110,573

Source(s) of Match Dollars for State Funds:

Lancaster Co overall will receive a total of \$110,573 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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Lancaster County  
Comprehensive PATH Programs Overview  
FY 2016-2017**

**1. Local Provider Description**

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. LCBHDS allocates PATH funds to two subcontracted mental health provider agencies and retains a portion for security deposits to people enrolled in the PATH program and HMIS implementation.

- 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 \$74,391 in PATH funds 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. LCBHDS – is the local mental health governmental agency that oversees the PATH funds to the community and provides the fiduciary services for the contingency funds and HMIS implementation. LCBHDS will receive \$2,180 to provide security deposits and HMIS oversight.

County of Lancaster  
Behavioral Health and Developmental Services  
150 N Queen St  
Suite 610  
Lancaster, PA 17603  
717-299-8027

PDX Name – PA-039 Lancaster: Lancaster County MH/MR/EI

- C. 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 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

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 \$110,573 of which \$82,930 are federal PATH funds, \$27,643 is state match. LCBHDS allocates an additional \$13,760 to PATH funded services from Lancaster’s HSBG to make the total spent on PATH funded services \$124,333.

## 2. Collaboration with HUD Continuum of Care (CoC) Program

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 three 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.

Tabor Community Services	Member of the Coalition to End Homeless. Provides housing supports, housing outreach services, subsidized housing, and budgeting services.
LCBHDS	LCBHDS is a member of LCCEH’s Leadership Council, Homeless Provider Network and Homeless Support Network. Provides and/or funds mental health, intellectual disabilities and early intervention services. Participates in the Human Services Block Grant (HSBG) planning as a county agency.
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 provide oversight of the county’s homeless system. Lancaster County contracts with Lancaster General Hospital for \$799,000 to provide this oversight. LCBHDS will continue to meet on a bi-monthly 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 funds.

There are separate IUPs included on each provider regarding their responsibilities.

### **3. Collaboration with Local Community Organizations**

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 Manager 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. Neighborhood Services – housing support, representative payee
18. Arch Street Center – mental health drop-in center
19. ICAN of Lancaster – mental health drop-in center
20. Council of Churches – food bank, emergency winter shelter
21. Philhaven Hospital – mental health treatment services, mental health diversion program
22. Lebanon Veterans Administration – Federal veteran services
23. Lancaster County Veteran Affairs Office – Local government veteran assistance office
24. Various Landlords in the community
25. Community Basics – housing development
26. Housing Development Corp – housing development
27. Holcomb Behavioral Health – crisis diversion

28. Lancaster County Drug and Alcohol Commission – drug and alcohol services
29. Compass Mark – drug and alcohol services
30. Various housing development companies
31. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
32. 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.

#### **4. Service Provision**

##### **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. LCBHDS**

Will provide fiduciary oversight of security deposits to roughly 2 individuals enrolled in the PATH program. In addition, with the implementation of HMIS with Lancaster County's PATH funded programs, LCBHDS will serve as the PATH lead agency to review and aggregate the data and assure the data is correct and timely.

The services include: Security Deposits, HMIS oversight.

##### **C. 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.

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 (7, 2015 PIT Count; 10, 2014 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. 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.

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 programs, 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, Master Leasing and supportive housing services 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. 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.

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 outreach services like doubling up with family or friends temporarily, 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 and they become homeless for a portion of each month due to using all their financial means. The PATH CTI Grant will support people who fall into one of these gaps to support them in attaining permanent safe and affordable housing. This program will focus on those in the transitional age group who are literally homeless. 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, which Lancaster identifies as ages 18-24. In the first year of focusing on this group has in theory significant results. In 2015, this age group represented 10% (2014 PIT 15.1%) of those who were in emergency shelter and 6.4% (2014 PIT 12.8%) were in a homeless transitional housing program were 18-24. This group represent 8.7% (2014 PIT 13.8%) of the total HUD defined homeless population in Lancaster County. This also represents a 52.2% decrease of those 18-24 who are experiencing homelessness from the 2014 PIT count to the 2015 PIT count. The total decrease of those people experiencing homelessness in Lancaster County and City CoC was 24.1%. LCBHDS has worked with the transitional age populations with mental illness through specialized programs to include targeted case management, residential rehabilitation and support groups.

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.

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 attended the SOAR training conducted 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. LCBHDS does require a person to open with one of Lancaster's level of mental health case management to access LCBHDS 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.

While the HMIS lead agency separated from LCBHDS, LCBHDS Housing Specialist is still involved in HMIS 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.

All three agencies are not drug and alcohol service providers and are not required to follow the 42 CFR Part 2 regulations.

## **5. Data**

LCBHDS transitioned the HMIS lead agency responsibility to another entity, LCCEH. LCBHDS will continue to be 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. There will be on-going training for current staff and training new

staff and providers as they enter the system. Each contract with the PATH providers require the entry of data in HMIS as part of the service provision. Lancaster is fully utilizing HMIS as of July 1, 2015, for the PATH data points. LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. June 30, 2016, Lancaster will be fully utilizing HMIS for the PATH programs.

## **6. Alignment with PATH goals**

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. This program has been a key supportive housing service to LCBHDS's HUD Permanent Supportive Housing Program (HUD PSHP), especially to the transitional age adults. LCBHDS's has had a 65% successful graduation rate from these programs. Successful graduation is defined as attaining an income that allows a person to sustain permanent housing, having the ability to self-advocate in housing and being a good tenant.

## **7. Alignment with State Mental Health Services Plan**

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 resources specifically 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.

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. 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.

## **8. Alignment with State Plan to End Homelessness**

PATH HOCM is integral in meeting the state's plan to end homelessness, through the outreach to those who are literally homeless. The Case Manager 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 (7, 2015 PIT Count; 10, 2014 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.

## **9. Other Designated Funds**

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. 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 \$13,760 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded services \$124,333. Pennsylvania reduced the state allocation several years ago. Lancaster decided these programs should remain whole and reallocated base funds to cover the decrease. The state and federal allocation is \$110,573.

## **10. SSI/SSDI Outreach, Access, Recovery (SOAR)**

As March 31, 2016, 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 14 consumers supported by PATH Outreach Case Management and 2 consumers through PATH CTI program with a SOAR application in 2014-15. 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.

## **11. Housing**

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, Neighborhood Services, Ingerman and The Lodge Life Services. LCBHDS was awarded its third 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 subsidizing 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 an agency that the landlords are willing to partner with. LCBHDS has become an active member of Lancaster County Landlord's Association and is providing on-going training to landlords on mental illness and the services. 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. In addition to the literature, the 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.

## **12. Coordinated Entry**

All three agencies 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 HOCCM utilizes 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 2015 PIT count reflects this investment, in that only 14.0% of those counted reported a mental illness, while Pennsylvania is at 23.1% and the United States is at 18.4%. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's mental health case manager or LCBHDS's Housing Specialist.

### **13. Justice Involved**

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, LCBHDS 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 to.

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.

### **14. Staff Information**

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.

## **15. Client Information**

All three 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.

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.

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 2016-2017 is 30. Estimated percent of the clients to be literally homeless is 70%.

The projected number of contacted clients for LCBHDS would be 2 and of those will be enrolled in PATH funded service will be 2 for 2016-2017 fiscal year. Estimated percent of the clients to be literally homeless is 100%.

The projected number of contacted clients that will receive PATH HOCM services for FY 2016-2017 is 380 people. The PATH HOCM will enroll an estimated 140 clients. Estimated percent of the clients to be literally homeless is 100%.

## **16. Consumer Involvement**

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 Quality Improvement Council, 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.

## **17. Budget Narrative**

### 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.

### 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.

### 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.

### Supplies:

Costs associated with office supplies needed to do day to day business of the PATH program.

### 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. Security deposits will be provided to PATH CTI consumers based on financial need to support acquiring housing. 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. HMIS data entry is to pay for LCBHDS staff to oversee the HMIS data entry for accuracy and timeliness.

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.

**Lancaster County  
FY 2016-17 Total PATH Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
CTI Worker	\$33,842	1 FTE	\$33,842	\$33,842
Team Leader	\$47,288	0.09 FTE	\$4,256	\$4,256
Outreach Case Manager	\$29,790	.8 FTE	\$29,790	\$29,790
Outreach CM Supervisor	\$48,000	0.1 FTE	\$4,800	\$4,800
<b>sub-total</b>	<b>\$158,920</b>	<b>1.99 FTE</b>	<b>\$72,688</b>	<b>\$72,688</b>
<b>Fringe Benefits</b>				
FICA Tax			\$5,561	\$5,561
Health Insurance			\$8,595	\$8,595
Retirement			\$1,450	\$1,450
Other Benefits			\$1,149	\$1,149
<b>sub-total</b>			<b>\$16,755</b>	<b>\$16,755</b>
<b>Travel</b>				
Local Travel for Outreach			\$5,556	\$5,556
<b>sub-total</b>			<b>\$5,556</b>	<b>\$5,556</b>
<b>Equipment</b>				
Replacement and/or maintenance of existing equipment			\$747	\$747
<b>sub-total</b>			<b>\$747</b>	<b>\$747</b>
<b>Supplies</b>				
Office Supplies			\$1,233	\$1,233
Consumer-related items			\$500	\$500
<b>sub-total</b>			<b>\$1,733</b>	<b>\$1,733</b>
<b>Other</b>				
Staff training			\$800	\$800
Security deposits			\$1,180	\$1,180
Building and Equipment Maintenance			\$1,158	\$1,158
Purchased Services			\$3,474	\$3,474
Protective Payee Services			\$2,201	\$2,201
Communication			\$2,351	\$2,351

Utilities			\$856	\$856
Admin Costs			\$12,979	\$12,979
Office Rent			\$642	\$642
HMIS			\$500	\$500
Insurance			\$697	\$697
<b>sub-total</b>			<b>\$26,838</b>	<b>\$26,838</b>
<b>Total PATH Budget</b>			<b>\$124,333</b>	

Please note: LCBHDS allocates an additional \$13,760 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded services \$124,333.

33. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Community Services Group will receive \$47,761 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	380	Estimated Number of Persons to be Enrolled:	140
Estimated Number of Persons to be Contacted who are Literally Homeless:	380		
Number Staff trained in SOAR in Grant year ended in 2014:	2	Number of PATH-funded consumers assisted through SOAR:	14

**Lancaster County  
Community Services Group  
PATH Homeless Outreach Case Management  
PATH Intended Use Plan  
FY 2016-17**

**1. Local Provider Description**

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 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

**2. Collaboration with HUD Continuum of Care (CoC) Program**

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 bi-monthly.

**3. Collaboration with Local Community Organizations**

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. Neighborhood Services – housing support, representative payee
18. Arch Street Center – mental health drop-in center
19. ICAN of Lancaster – mental health drop-in center
20. Council of Churches – food bank, emergency winter shelter
21. Philhaven Hospital – mental health treatment services, mental health diversion program
22. Lebanon Veterans Administration – Federal veteran services
23. Lancaster County Veteran Affairs Office – Local government veteran assistance office
24. Various Landlords in the community
25. Community Basics – housing development
26. Housing Development Corp – housing development
27. Holcomb Behavioral Health – crisis diversion
28. Lancaster County Drug and Alcohol Commission – drug and alcohol services
29. Compass Mark – drug and alcohol services
30. Various housing development companies
31. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
32. 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.

#### **4. Service Provision**

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

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, obtaining benefits and linkage to housing services, especially those in the transitional-age group.

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.

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.

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.

Community Services Group's PATH funded employees have attended the SOAR training conducted by Mid Penn Legal Services.

While the HMIS lead agency separated from LCBHDS, LCBHDS Housing Specialist is still involved in HMIS 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, Case Worthy, on July 1, 2015. 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.

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## **5. Data**

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## **6. Alignment with PATH goals**

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.

## **7. Alignment with State Mental Health Services Plan**

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.

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to take during an emergency/disaster. The supportive housing programs teach each person how they would be alerted through this system and informed about their options during an emergency/disaster.

## **8. Alignment with State Plan to End Homelessness**

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 (7, 2015 PIT Count; 10, 2014 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.

## **9. Other Designated Funds**

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. 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 \$13,760 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded services \$124,333. Pennsylvania reduced the state allocation several years ago. Lancaster decided these programs should remain whole and reallocated base funds to cover the decrease. The state and federal allocation is \$110,573.

## **10. SSI/SSDI Outreach, Access, Recovery (SOAR)**

As March 31, 2016, 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 14 consumers supported by PATH HOCM with a SOAR application in 2014-2015. Lancaster estimates that 20-25 people could be SOAR eligible who have been enrolled with the PATH HOCM program.

## **11. Housing**

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.

## **12. Coordinated Entry**

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 2015 PIT count reflects this investment, in that only 14.0% of those counted reported a mental illness, while Pennsylvania is at 23.1% and the United States is at 18.4%. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's mental health case manager or LCBHDS's Housing Specialist.

## **13. Justice Involved**

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 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, LCBHDS 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 to.

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 is 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.

#### **14. Staff Information**

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. In addition, the contracts executed with LCBHDS have a clause that the provider must provide services to English limited people and have an ability to provide or access interpretation services.

#### **15. Client Information**

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.

The projected number of contacted clients that will receive PATH HOCM services for FY 2016-2017 is 380 people. The PATH HOCM will enroll an estimated 140 clients. Estimated percent of the clients to be literally homeless is 100%.

#### **16. Consumer Involvement**

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.

## **17. Budget Narrative**

### **Personnel:**

Cost associated with a portion of the salary for the Case Manager who will provide the direct service provision.

### **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 MH/MR/EI.

### **Travel:**

Provide mileage reimbursement to employee for utilizing their own vehicles to provide services to participants in the PATH funded program within the community.

### **Supplies:**

Costs associated with office supplies needed to do day to day business of the PATH program.

### **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.

### **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.

**Lancaster County  
Community Services Group  
FY 2016-2017 PATH Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Outreach Case Managers	\$29,790	0.8 FTE	\$29,790	\$29,790
Outreach CM Supervisor	\$48,000	0.1 FTE	\$4,800	\$4,800
<b>sub-total</b>	<b>\$77,790</b>	<b>.9 FTE</b>	<b>\$34,606</b>	<b>\$34,606</b>
<b>Fringe Benefits</b>				
Payroll tax			\$2,646	\$2,646
Health Insurance			\$1,800	\$1,800
Retirement			\$500	\$500
Other Benefits			\$350	\$350
<b>sub-total</b>			<b>\$5,296</b>	<b>\$5,296</b>
<b>Travel</b>				
Local Travel for Outreach			\$2,356	\$2,356
<b>sub-total</b>			<b>\$2,356</b>	<b>\$2,356</b>
<b>Equipment</b>				
Replacement and/or maintenance of existing equipment			\$300	\$300
<b>sub-total</b>			<b>\$300</b>	<b>\$300</b>
<b>Supplies</b>				
Office Supplies			\$600	\$600
Consumer-related items			\$0	\$0
<b>sub-total</b>			<b>\$600</b>	<b>\$600</b>
<b>Other</b>				
Staff training			\$400	\$400
Communication			\$1,000	\$1,000
Admin Costs			\$2,953	\$2,953
Insurance			\$250	\$250
<b>sub-total</b>			<b>\$4,603</b>	<b>\$4,603</b>
<b>Total Community Services Group PATH Budget</b>			<b>\$47,761</b>	

34. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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b. Fringe Benefits	0.00 %	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)				
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h. Other	\$ 0	\$ 0	\$ 0	
No Data Available				

i. Total Direct Charges (Sum of a-h)	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
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k. Grand Total (Sum of i and j)	\$ 0	\$ 0	\$ 0	
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Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Tabor Community Services will receive \$74,391 in federal and state PATH funds.

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:	25		
Number Staff trained in SOAR in Grant year ended in 2014:	1	Number of PATH-funded consumers assisted through SOAR:	2

**Lancaster County  
Tabor Community Services  
Critical Time Intervention Program  
PATH Intended Use Plan  
FY 2015-16**

**1. Local Provider Description**

Tabor Community Services is a non-profit community services organization that specializes in supportive housing, credit counseling, homeless services and community development. Tabor serves 4,000 people per year within Lancaster County. Tabor receives \$74,391 in PATH funds for the Critical Time Intervention (PATH CTI) program.

Tabor Community Services  
308 E King St  
PO Box 1676  
Lancaster, PA 17608  
717-397-5182

PDX Name – PA-051 Lancaster: Tabor Community Services

**2. Collaboration with HUD Continuum of Care (CoC) Program**

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. Tabor is a leading agency within the coalition in designing programs that meet the community needs including those experience homelessness and mental illness. Tabor's President is on LCCEH Leadership Council.

**3. Collaboration with Local Community Organizations**

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. Neighborhood Services – housing support, representative payee
18. Arch Street Center – mental health drop-in center
19. ICAN of Lancaster – mental health drop-in center
20. Council of Churches – food bank, emergency winter shelter
21. Philhaven Hospital – mental health treatment services, mental health diversion program
22. Lebanon Veterans Administration – Federal veteran services
23. Lancaster County Veteran Affairs Office – Local government veteran assistance office
24. Various Landlords in the community
25. Community Basics – housing development
26. Housing Development Corp – housing development
27. Holcomb Behavioral Health – crisis diversion
28. Lancaster County Drug and Alcohol Commission – drug and alcohol services
29. Compass Mark – drug and alcohol services
30. Various housing development companies
31. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
32. 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.

#### 4. Service Provision

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.

The PATH CTI program is a medium term supportive housing 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 established, the PATH CTI worker will back out to allow the longer term 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.

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.

A gap of services to the homeless people of 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 outreach services like doubling up with family or friends temporarily, 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 and they become homeless for a portion of each month due to using all their financial means. The PATH Grant will 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 is those who are homeless or at risk of homelessness that are transitional age, which Lancaster identifies as ages 18-24. The first year of focusing on this group has in theory significant results. In 2015, this age group represented 10% (2014 PIT 15.1%) of those who were in emergency shelter and 6.4% (2014 PIT 12.8%) were in a homeless transitional housing program were 18-24. This group represent 8.7% (2014 PIT 13.8%) of the total HUD defined homeless population in Lancaster County. This also represents a 52.2% decrease of those 18-24 who are experiencing homelessness from the 2014 PIT count to the 2015 PIT count. The total decrease of those people experiencing homelessness in Lancaster County and City CoC was 24.1%. LCBHDS has worked with the transitional age populations with mental illness through specialized programs to include targeted case management, residential rehabilitation and support groups.

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.

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. LCBHDS does require a person to open with one of Lancaster's level of mental health case management to access LCBHDS 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. Trainings that have been utilized in the past include motivational interviewing, homelessness, housing first, mental health disorders, local services and clinical approaches.

While the HMIS lead agency separated from LCBHDS, LCBHDS Housing Specialist is still involved in HMIS 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. Tabor has "superusers" that have full system access and participates in the HMIS planning. 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.

Tabor is not drug and alcohol service provider and is not required to follow the 42 CFR Part 2 regulations.

## **5. Data**

LCBHDS transitioned the HMIS lead agency responsibility to another entity, LCCEH. LCBHDS will continue to be 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. 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. There will be on-going training for current staff and training new staff and providers as they enter the system. Each contract with the PATH providers require the entry of data in HMIS as part of the service provision. Lancaster is fully utilizing HMIS as of July 1, 2015, for the PATH data points. LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. June 30, 2016, Tabor will be fully utilizing HMIS for the PATH program.

## **6. Alignment with PATH goals**

Tabor's PATH CTI program prioritizes people who are literally homeless Half of the PATH CTI's worker's caseload is working with adults 18-24 who are literally homeless. The people enrolled in the PATH CTI program will have a serious mental illness as part of the criteria for the program. This program has been a key supportive housing service to LCBHDS's HUD Permanent Supportive Housing Program (HUD PSHP), especially to the transitional age adults. LCBHDS's has had a 65% successful graduation rate from these programs. Successful graduation is defined as attaining an

income that allows a person to sustain permanent housing, having the ability to self-advocate in housing and being a good tenant.

## **7. Alignment with State Mental Health Services Plan**

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.

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.

## **8. Alignment with State Plan to End Homelessness**

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 (7, 2015 PIT Count; 10, 2014 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.

## **9. Other Designated Funds**

Tabor PATH CTI participants have full access to LCBHDS services and/or resources as they are open with the county agency. 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. 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 \$13,760 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded services \$124,333. Pennsylvania reduced the state allocation several years ago. Lancaster decided these programs should remain whole and reallocated base funds to cover the decrease. The state and federal allocation is \$110,573.

## **10. SSI/SSDI Outreach, Access, Recovery (SOAR)**

As March 31, 2014, the CTI worker funded by PATH has attended the SOAR training provided by Mid Penn Legal Services, Valerie Case. There were 2 consumers through PATH CTI program with a SOAR application in 2014-15. We estimate that around 4-6 people a year could be SOAR eligible, as half the caseload is for those who are HUD defined homeless.

## **11. Access to Housing**

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. LCBHDS was awarded its third 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 companies to set aside LIHTC properties for those experiencing mental illness.

## **12. Coordinated Entry**

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 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 2015 PIT count reflects this investment, in that only 14.0% of those counted reported a mental illness, while Pennsylvania is at 23.1% and the United States is at 18.4%. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's Mental Health Case Manager or LCBHDS's Housing Specialist.

### **13. Justice Involved**

Tabor 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. 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, LCBHDS 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 to.

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.

### **14. Staff Information**

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.

### **15. Client Information**

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 2015-2016 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 70%.

## **16. Consumer Involvement**

Tabor has hired people who have experienced homelessness in their own life for services provided 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.

## 17. Budget Narrative

### **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.

### **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.

### **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.

### **Supplies:**

Costs associated with office supplies needed to do day to day business of the CTI program.

### **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.

**Lancaster County  
Tabor Community Service  
FY 2016-17 PATH Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
CTI Worker	\$33,842	1 FTE	\$33,842	\$33,842
Team Leader	\$47,288	0.09 FTE	\$4,256	\$4,256
<b>sub-total</b>	<b>\$81,130</b>	<b>1.09 FTE</b>	<b>\$38,098</b>	<b>\$38,098</b>
<b>Fringe Benefits</b>				
FICA Tax			\$2,914	\$2,914
Health Insurance			\$6,795	\$6,795
Retirement			\$950	\$950
Other Benefits			\$799	\$799
<b>sub-total</b>			<b>\$11,776</b>	<b>\$11,776</b>
<b>Travel</b>				
Local Travel for Outreach			\$3,200	\$3,200
<b>sub-total</b>			<b>\$3,200</b>	<b>\$3,200</b>
<b>Equipment</b>				
Replacement and/or maintenance of existing equipment			\$447	\$447
<b>sub-total</b>			<b>\$447</b>	<b>\$447</b>
<b>Supplies</b>				
Office Supplies			\$633	\$633
Consumer-related items			\$0	\$0
<b>sub-total</b>			<b>\$633</b>	<b>\$633</b>
<b>Other</b>				
Staff training			\$400	\$400
Building and Equip Maintenance			\$1,158	\$1,158
Purchase Services			\$3,474	\$3,474
Protective Payee Services			\$2,201	\$2,201
Communication			\$1,351	\$1,351
Utilities			\$856	\$856
Admin Costs			\$10,026	\$10,026

Office Rent			\$642	\$642
Insurance			\$447	\$447
<b>sub-total</b>			<b>\$20,555</b>	<b>\$20,555</b>
<b>Total Tabor PATH Budget</b>	<b>\$74,391</b>			

Please note: LCBHDS allocates an additional \$13,760 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded services for Lancaster County total \$124,333. Tabor will have \$60,631 in PATH federal and state funding plus \$13,760 from the county.

35. Lancaster County Behavioral Health and Developmental Services

150 Queen Street

Lancaster, PA 17603

Contact: John Stygler

Contact Phone #: 7172998027

Has Sub-IUPs: No

Provider Type: Social service agency

PDX ID: PA-039

State Provider ID: 4239

Geographical Area Served: Central Region

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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h. Other \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:  
 For source of match dollars for state funds: Lancaster County Behavioral Health and Developmental Service will receive \$2,180 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 294      Estimated Number of Persons to be Enrolled: 2  
 Estimated Number of Persons to be Contacted who are Literally Homeless: 2  
 Number Staff trained in SOAR in Grant year ended in 2014: 0      Number of PATH-funded consumers assisted through SOAR: 0

**Lancaster County  
Behavioral Health and Developmental Disabilities  
PATH Intended Use Plan  
FY 2016-17**

**1. Local Provider Description**

Lancaster County Behavioral Health and Developmental Services (LCBHDS) is the local mental health governmental agency that oversees the PATH funds to the community and provides the fiduciary services for the contingency funds and HMIS implementation. LCBHDS will receive \$2,180 to provide security deposits and HMIS oversight.

County of Lancaster  
Behavioral Health and Developmental Services  
150 N Queen St  
Suite 610  
Lancaster, PA 17603  
717-299-8027

PDX Name – PA-039 Lancaster: Lancaster County MH/MR/EI

**2. Collaboration with HUD Continuum of Care (CoC) Program**

Lancaster County and City are within the HUD CoC PA-510. LCBHDS, is part of the Lancaster County Coalition to End Homelessness (herein known as LCCEH) (HUD Continuum of Care. LCBHDS is in one or more of the three subcommittees identified in the Heading Home plan. LCBHDS's Executive Director and Deputy Director of Administration are members of the Leadership Council for LCCEH. LCBHDS provides and/or funds mental health, intellectual disabilities and early intervention 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 \$799,000 to provide this oversight. LCBHDS will continue to meet on a bi-monthly 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 funds.

**3. Collaboration with Local Community Organizations**

LCBHDS separated the LCCEH responsibilities for the Lancaster County's HUD Continuum of Care and is now under Lancaster General Health. LCBHDS will continue to meet on a bi-monthly basis with LCCEH, working on specific needs of the people

experiencing homelessness in Lancaster County. LCBHDS will remain a member of LCCEH up to Leadership Council. Provide and/or funds mental health, intellectual disabilities and early intervention services. Participates in the human services block grant planning as a county agency.

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. Neighborhood Services – housing support, representative payee
18. Arch Street Center – mental health drop-in center
19. ICAN of Lancaster – mental health drop-in center
20. Council of Churches – food bank, emergency winter shelter
21. Philhaven Hospital – mental health treatment services, mental health diversion program
22. Lebanon Veterans Administration – Federal veteran services
23. Lancaster County Veteran Affairs Office – Local government veteran assistance office
24. Various Landlords in the community
25. Community Basics – housing development
26. Housing Development Corp – housing development
27. Holcomb Behavioral Health – crisis diversion
28. Lancaster County Drug and Alcohol Commission – drug and alcohol services

29. Compass Mark – drug and alcohol services
30. Various housing development companies
31. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
32. 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. The PATH HOC meet with the local homeless emergency shelter provider every week to discuss current cases and how they can work together.

#### 4. **Service Provision**

LCBHDS will provide fiduciary oversight of security deposits to roughly 2 individuals in the PATH CTI program or working with the PATH HOCM. In addition, with the implementation of HMIS with Lancaster County's PATH funded programs, LCBHDS will serve as the PATH lead agency to review and aggregate the data and assure the data is correct and timely. The services include: Security Deposits, HMIS oversight.

This is a support to the PATH CTI program and the PATH HOCM in obtaining permanent housing for people with security deposits. HMIS oversight will assure that the data aggregated by LCBHDS is accurate and timely.

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 programs, 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, Master Leasing and supportive housing services 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. 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.

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 outreach 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 and they become homeless for a portion of each month due to using all their financial means. The PATH CTI Grant will support people who fall into one of these gaps to support them in attaining permanent safe and affordable housing. This program will focus on those in the transitional age group who are literally homeless. 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 is those who are homeless or at risk of homelessness that are transitional age, which Lancaster identifies as ages 18-24. In the first year of focusing on this group has in theory significant results. In 2015, this age group represented 10% (2014 PIT 15.1%) of those who were in emergency shelter and 6.4% (2014 PIT 12.8%) were in a homeless transitional housing program were 18-24. This group represent 8.7% (2014 PIT 13.8%) of the total HUD defined homeless population in Lancaster County. This also represents a 52.2% decrease of those 18-24 who are experiencing homelessness from the 2014 PIT count to the 2015 PIT count. The total decrease of those people experiencing homelessness in Lancaster County and City CoC was 24.1%. LCBHDS has worked with the transitional age populations with mental illness through specialized programs to include targeted case management, residential rehabilitation and support groups.

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.

Tabor 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.

Tabor 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.

While the HMIS lead agency separated from LCBHDS, LCBHDS Housing Specialist is still involved in HMIS 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 not drug and alcohol service provider and is not required to follow the 42 CFR Part 2 regulations.

## **5. Data**

LCBHDS transitioned the HMIS lead agency responsibility to another entity, LCCEH. LCBHDS will continue to be 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. There will be on-going training for current staff and training new staff and providers as they enter the system. Each contract with the PATH providers require the entry of data in HMIS as part of the service provision. Lancaster is fully utilizing HMIS as of July 1, 2015, for the PATH data points. LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. June 30, 2016, Lancaster will be fully utilizing HMIS for the PATH programs.

## **6. Alignment with PATH goals**

The PATH HOCM will have access to security deposits that will assist in getting people into permanent housing and out of homelessness.

## **7. Alignment with State Mental Health Services Plan**

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.

LCBHDS has 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.

## **8. Alignment with State Plan to End Homelessness**

Lancaster County has not historically and does not current have a significant number of chronically homeless adults (7, 2015 PIT Count; 10, 2014 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.

## **9. Other Designated Funds**

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. 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 \$13,760 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded services \$124,333. Pennsylvania reduced the state allocation several years ago. Lancaster decided these programs should remain whole and reallocated base funds to cover the decrease. The state and federal allocation is \$110,573.

#### **10. SSI/SSDI Outreach, Access, Recovery (SOAR)**

As March 31, 2016, 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 14 consumers supported by PATH Outreach Case Management and 2 consumers through PATH CTI program with a SOAR application in 2014-15. 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.

#### **11. Housing**

LCBHDS only provide the fiduciary oversight of security deposits to Tabor's CTI program and PATH HOCM. The consumers would have access to all the same housing resources outlined in Tabor's and CSG's Intended Use Plan.

#### **12. Coordinated Entry**

LCBHDS participates 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. 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 2015 PIT count reflects this investment, in that only 14.0% of those counted reported an mental illness, while Pennsylvania is at 23.1% and the United States is at 18.4%. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's mental health case manager or LCBHDS's Housing Specialist.

### **13. Justice Involved**

LCBHDS 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. All three services do not use criminal convictions as a sole reason for PATH services and/or resources to be denied. 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 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. 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.

LCBHDS 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, LCBHDS 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 to.

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.

### **14. Staff Information**

No direct service staff will be utilized in this part of LCBHDS's PATH funded services.

### **15. Client Information**

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 security deposits will be 2 and the projected number of enrolled clients that will receive security deposits for FY 2016-17 is 2. Estimated percent of the clients to be literally homeless is 100%.

## 16. Consumer Involvement

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 Quality Improvement Council, 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 times 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.

## 12. Budget Narrative

### **Personnel:**

Cost associated with a portion of the salaries employee who will provide the direct service provision.

### **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 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.

### **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.

### **Supplies:**

Costs associated with office supplies needed to do day to day business of the PATH program.

### **Other:**

Security deposits will be provided to PATH CTI consumers based on financial need to support acquiring housing. HMIS data entry is to pay for LCBHDS staff to oversee the HMIS data entry for accuracy and timeliness.

**Lancaster County  
2015-16 PATH Budget**

	<b>Annual Salary</b>	<b>PATH- funded FTE</b>	<b>PATH- funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
<b>sub-total</b>	<b>\$0</b>	<b>0%</b>	<b>\$0</b>	<b>\$0</b>
<b>Fringe Benefits</b>				
Payroll tax			\$0	\$0
Other Benefits			\$0	\$0
<b>sub-total</b>			<b>\$0</b>	<b>\$0</b>
<b>Travel</b>				
Local Travel for Outreach			\$0	\$0
<b>sub-total</b>			<b>\$0</b>	<b>\$0</b>
<b>Equipment</b>				
Replacement and/or maintenance of existing equipment			\$0	\$0
<b>sub-total</b>			<b>\$0</b>	<b>\$0</b>
<b>Supplies</b>				
Office Supplies			\$0	\$0
Consumer Related Supplies			\$500	\$500
<b>sub-total</b>			<b>\$0</b>	<b>\$0</b>
<b>Other</b>				
Security deposits			\$1,180	\$1,180
HMIS			\$500	\$500
<b>sub-total</b>			<b>\$2,180</b>	<b>\$2,180</b>
<b>Total LCBHDS PATH Budget</b>			<b>\$2,180</b>	

36. 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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 46,874	\$ 15,625	\$ 62,499	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 46,874	\$ 15,625	\$ 62,499	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 46,874	\$ 15,625	\$ 62,499	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 46,874	\$ 15,625	\$ 62,499	

Source(s) of Match Dollars for State Funds:

Lehigh County MH/ID/D&A/HealthChoices will receive \$62,499 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 125      Estimated Number of Persons to be Enrolled: 35  
 Estimated Number of Persons to be Contacted who are Literally Homeless: 15  
 Number Staff trained in SOAR in Grant year ended in 2014: 0      Number of PATH-funded consumers assisted through SOAR: 1

**Lehigh County  
PATH Intended Use Plan  
FY 2016-2017**

**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/Mental Retardation. 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 \$46,874 and a state match of \$15,625 for a total of \$62,499 for the fiscal year 2016/2017.

**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 Eastern PA 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 consumers 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 consumers. 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 consumers 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. Consumers are referred to the appropriate agency for specific needs identified by the consumer 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 a consumer 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 consumers can access treatment and case management services; The Lehigh Valley D&A Intake Unit – which assesses consumers with co-occurring disorders, makes recommendations regarding D&A treatment or rehabilitation placement, and provides intensive case management services; 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 consumer services. Agencies we connect consumers with include but are not limited to: Goodwill, Office of Vocational Rehabilitation, Recovery Education, D&A intake and 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 consumers 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 PA PATH HMIS Technical Assistance Conferences are free.

Lehigh County follows the Health Insurance Portability & Accountability Act of 1996 (HIPAA). We notify each consumer of what the Act means and their rights under the Act.

### **Data**

Our PATH staff are entering all PATH consumers in the PA HMIS system. Our case managers work with each other on being sure consumers 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 consumers that are most vulnerable risk for homelessness. We currently have a case manager that is stationed at the soup kitchen program to work with consumers 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 consumers 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 consumers 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 consumers after, between and in concert with connecting consumer 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 consumers in the SOAR application process. PATH staff directly assist consumers in reviewing their individual situation in order to help them apply for benefits they may qualify for. Last year our SOAR Case manager helped one person to apply for benefits, while she was working with that consumer to obtain all of the medical records, he applied for SS on his own. This stopped the whole SOAR process. He did obtain SS on his own.

## **Access to 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 consumers in subsidized housing units. The Fountain Street Bridge Program continues to offer a transitional housing program and allows consumers 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 Valley has a Coordinated Entry for Homeless Services Pilot Project. 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, 48% of our enrolled PATH consumers 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 consumers at the county and at the various community organizations are of both sexes, a variety of ethnic backgrounds and between the same age ranges as the consumers 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 2016/17, we project serving around 125 consumers. We project enrolling about 35 consumers. From recent years, we have found that about 12% of the consumers served with PATH funds are "literally" homeless, 73% of consumers enrolled by PATH were Caucasian, 10% were Hispanic or Latino, 13% were Black or African American, with many consumers falling into more than one category.

All individuals served were between the ages of 18 to 64 years, 70% 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. Consumers and/or family members are represented on the Mental Health and HealthChoices Advisory Boards and are well represented on the Mental Health Planning Committee. Consumers 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 25 TAY this year. Last year about 20% of the people serviced were in our Transitional Age Youth group.

The funds expected to be used for them would therefore be around \$2000. 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.

**Lehigh County  
FY 2016-2017 PATH Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Sr. Case Manager 3	\$65,126	.5 FTE	\$21,166	\$21,166
Sr. Case Manager 2	\$61,991	.1 FTE	\$4,029	\$4,029
Sr. Case Manager 2	\$56,277	.2 FTE	\$7,316	\$7,316
Sr. Case Manager 2	\$56,277	.1 FTE	\$3,658	\$3,658
Program Specialist/Supervisor	\$79,269	.1 FTE	\$5,152	\$5,152
<b>sub-total</b>				<b>\$41,321</b>
<b>Fringe Benefits</b>				
Case Mngr Benefits	\$23,784		\$3,568	\$3,568
Case Mngr Benefits	\$22,639		\$679	\$679
Case Mngr Benefits	\$20,552		\$1,233	\$1,233
Case Mngr Benefits	\$20,552		\$617	\$617
Prog Spec Benefits	\$28,949		\$868	\$868
<b>sub-total</b>				<b>\$6,965</b>
<b>Travel</b>				
Travel-train/workshps/mtgs				\$200
<b>sub-total</b>				<b>\$200</b>
<b>PATH Assistance Payments</b>				
Rental Assistance				\$2,000
Security Deposits				\$10,378
Utility Payments				\$1,500
<b>Sub-Total</b>				<b>\$13,878</b>
<b>Other</b>				
Postage				\$35
Trainings				\$100
<b>Sub-total</b>				<b>\$135</b>
<b>Total PATH Budget</b>				<b>\$62,499</b>

**Lehigh County  
PATH Budget Narrative  
FY 2016-2017**

**Personnel:**

A portion of the 4 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 consumers. 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 consumer would have been evicted due to utility non-payment. This would be the case in which a consumer 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 consumers, 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.

37. 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 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				
h. Other	\$ 0	\$ 0	\$ 0	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 0	\$ 0	\$ 0	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
<b>j. Indirect Costs (Administrative Costs)</b>	\$ 46,874	\$ 15,625	\$ 62,499	
<b>k. Grand Total (Sum of i and j)</b>	\$ 46,874	\$ 15,625	\$ 62,499	

Source(s) of Match Dollars for State Funds:

Community Counseling will receive \$62,499 in federal and state PATH funds.

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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 3

**Luzerne/Wyoming Counties  
Community Counseling Services  
2016.2017 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 \$62,499.

**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 has 10 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 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.

## **Alignment with State Plan to End Homelessness**

Community Counseling Services recognizes that case management and outreach are key to engagement with chronically homeless individuals. The Homeless Advocate teams with workers from CEO, AAA, and C&Y to meet consumers where they are. There are times that extended engagement is a necessity to move someone into housing and services.

## **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.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

Since July 2015 4 SOAR applications have been completed with 3 positive results. We have consulted with other agencies on 3 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 2016.

### **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.

## **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**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing Case Manager	\$33000	1.0		\$33000
2 Supervisors	\$88497	.3		\$29499
<b>sub-total</b>				\$62499
<b>Fringe Benefits</b>				
FICA Tax				
Unemployment				
Retirement				
Life Insurance				
<b>sub-total</b>				
<b>Travel</b>				
Local Travel for Outreach				
Travel to training and workshops				
<b>sub-total</b>				
<b>Supplies/Equipment</b>				
Consumer-related items				
<b>sub-total</b>				
<b>Other</b>				
Staff training				
One-time rental assistance				
Security deposits				
<b>sub-total</b>				
<b>Total PATH Budget</b>			<b>\$62499</b>	

38. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

h. Other \$ 46,874 \$ 21,438 \$ 68,312

Office: Other (Describe in Comments) \$ 46,874 \$ 21,438 \$ 68,312 Detailed budgets and narratives are included in individual provider IUPs.

i. Total Direct Charges (Sum of a-h) \$ 46,874 \$ 21,438 \$ 68,312

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 46,874 \$ 21,438 \$ 68,312

Source(s) of Match Dollars for State Funds:  
 Mercer County overall will receive a total of \$68,312 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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Mercer County**  
**Comprehensive PATH Intended Use Plan**  
**FY 2016-2017**

**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. For 37 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. As the initial point of contact for these three programs, the MCBHC provides administrative oversight, centralized program intake functions, case management services, peer support services, mobile psychiatric nursing services, early intervention services, and prevention education programs. 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.

**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"

The MCBHC will receive a federal allocation of \$46,874 and a state allocation of \$21,438 totaling \$68,312. The attached line item budget reflects the detail funding for MCBHC. Within this budget, under the purchase services line item, is the amount of money that the agency subcontracts with one in-county agency. The sub-contracted agency is Community Counseling Center (CCC). CCC will receive an allocation of \$31,690 to support PATH funded services. This is a change from previous years as MCBHC is not contracting with Community Action Partnership of Mercer County (CAPMC) for PATH services, but will continue to financially support CAPMC for housing services and supports utilizing base dollars. The rationale is to reduce the administrative burden for CAPMC related to PATH reporting, documentation, quarterly calls, etc.

Community Counseling Center is a non-profit agency providing comprehensive community behavioral health services since 1957. The Center provides treatment, rehabilitation and support services through a wide range of services for children, adults, and families who are experiencing behavioral health concerns. 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.

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**

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: Community Counseling Center, Behavioral Health Commission, Veterans Services, Community Action Partnership of Mercer County, AWARE, Prince of Peace Center, Adult Probation and Parole, the Self Determination Project, Mercer County Housing Authority, Southwest Legal Services, Primary Health Network, and local Realtors.

The Housing Coordinator within the Mercer County Behavioral Health Commission attends the monthly local Housing Coalition meetings. These meetings provide an opportunity of sharing, collaboration, and communication within local organizations which provide housing services. The Community Integration Services (CIS) Administrator of Community Counseling Center is an active member of the Western Region CoC. During the Mercer County Housing Coalition meetings, the CIS is able to share and update the committee as to the activities of the Western Region CoC. The CIS in turn, keeps the regional entities updated on the activities of the Mercer County Housing Coalition.

### **Collaboration with Local Community Organizations**

#### **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 Medication Assisted Treatment 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, 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.

MCBHC was awarded a 10 person Community Hospital Integration Program Project (CHIPP) for the 2013/2014 fiscal year. Within the grant, CCC opened a 4 person Community Residential Rehabilitation (CRR) program for four of the CHIPP individuals. The CRR program is individualized to meet the needs in efforts to reduce re-admissions to the hospitals and to promote community involvement and inclusion. Another goal at the CRR is to provide independent living skills for individuals who are working towards independent living. CCC also offers a partial care CRR/Fairweather Lodge. The Fairweather Lodge Program is a community support-based program that can assist persons with mental illness reintegrate back into the community. The goal of the program is to provide emotional support, a place to live, and employment for its members. CCC also has a 16 bed Enhanced Personal Care Boarding Home (EPCBH) located in Sharon. In January 2014, CCC and Children and Youth Services (CYS) began a new program, collaborating on a new transition-age housing program, Supportive Housing Services for Youth in Transition. The program is designed for individual's ages 18-21 who are clients within the CYS system and do not necessarily have a mental health diagnosis. A CYS case worker is designated to assist youth aging out of the foster care system and assist in transitioning into adulthood. The case worker will have a maximum of 8 individuals on their case load. CCC also collaborates with other organizations to provide an emergency shelter for homeless individuals and families. In addition to the housing services, CCC provides outpatient mental health and substance abuse treatment, psychiatric rehabilitation, supported employment, certified peer support services, family based mental health, school based, BHRS, and respite care.

Other county programs that offer housing services and supports, which do not receive PATH funds, 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 utilized by the Housing Coalition. The City of Sharon also greatly supports the Coalition's Homeless Awareness Month Activities by blocking off streets, re-routing traffic, and providing police car escorts for the Annual "Walk A Mile In Their Shoes" Awareness walk.

**The Community Action Partnership of Mercer County (CAPMC)** also 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 210 units of senior housing at seven locations. This program is for independent living for income qualified seniors ages 62 and older. Additionally, the agency owns and manages 32 units of special needs housing at 10 locations. Such special needs housing includes: Emergency Shelter, Legacy House, Independence Park, and Permanent Supported Housing for Persons with Serious Mental Illness inclusive of eight units at three 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 nine 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. Another housing project through CAPMC is a program for Veterans who are experiencing a housing crisis.

**The Good Shepherd Center** addresses the physical needs of the economically challenged in the greater Greenville area. 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, the 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. The Housing Authority does have preferences for veterans and individuals who are homeless. Staff from the Housing Authority participates actively on the Mercer County Housing Coalition.

**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. Within the housing supports of FSS, there are two programs. Those programs are Project RUTH (Resources, Understanding, Training, and Homes) which is a service to advocate for the homeless of Mercer County and provides support and training in basic life skills for essential living. In 2014, Project RUTH served 51 individuals: 17 women, 2 men, and 25 children. The second program under FSS is HOPE Advocacy. HOPE (Help and Opportunity for Personal Empowerment) provides long-term support for individuals living independently and need further assistance in learning basic life skills. In 2014, HOPE Advocacy served 77 individuals, 30 women, 1 man, and 46 children. All individuals served in both programs were below the poverty level.

**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.

**Youth Advocate Program (YAP)** is the most recent compliment to the housing services and supports continuum offered in Mercer County. YAP is offering two 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.

A second key employment provider is CCC, a recipient of PATH dollars. 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 to be provided to those deemed literally homeless by the two PATH recipient organizations include: outreach services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, staff training, case management services, supportive and supervisory services in residential settings, referrals for primary health services, job training, educational services, and relevant housing services. Additionally, 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 that 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, 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. Those additional services would be

educational classes provided by a variety of organizations within Mercer County. The staff would assist the individual with applying for those classes.

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. As mentioned above, a sub-committee of the Mercer County Housing Coalition is pursuing a grant to address the family unit issue, with the Mercer County AWARE being the Local Lead Agency on this project, as well as, matching dollars needs for the grant. At this time, the committee is continuing to search for a suitable building and location for this project. Joshua's Haven is an emergency shelter for single men, but Mercer County has no shelter identified for single women or family units. The emergency shelter being proposed would address part of this problem.

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.

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. Consumers experiencing a co-occurring mental illness and substance abuse disorder can access appropriate treatment through the Central Intake Unit of MCBHC. 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. The 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. As previously mentioned, MCBHC does have Certified Recovery Specialist services and Drug and Alcohol Case Coordination. Staff have training for both substance abuse and mental health co-occurring disorders in order to be better prepared to address the specific needs of this population. Additionally, the MCBHC contracts with multiple co-occurring residential treatment providers.

PATH-funded staff 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 will be offered throughout all of the Human Service agencies within Mercer County. One of the goals of having this training would be 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.

Another evidenced-based training that was in Mercer County was Mental Health First Aid. Community Counseling Center had provided this training for many different groups throughout the county in order to educate the general population in how to help an individual in a mental

health crisis or developing a mental illness. Unfortunately, this training opportunity was not able to be financially sustained due to the loss of the Mental Health Matters grant funding.

Staff monitors the website 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.

### **Data**

The MCBHC has been entering data into PA HMIS since December 2011. CCC is also an established user of HMIS. All PATH eligible individuals are entered into the PA HMIS system. DCED is the PA HMIS provider with Brian Miller as the HMIS Director.

### **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 Mental Health Services Plan**

The Mercer County Behavioral Health Commission provides multiple services and supports which are consistent with the state initiatives to prevent or reduce homelessness. The PATH 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 eviction. The 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. Additionally, the United Way of Mercer County has launched a new campaign of "Lifting Families Out of Poverty". The United Way plans to organize training sessions to promote financial stability and independence. By providing ongoing trainings and

educational opportunities, people within the community, both those with mental health conditions, and those without, will be less likely to become homeless.

In regard to PATH integrating with the Mercer County disaster preparedness and emergency planning, the 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, Robyn Kokus.

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 subgroup 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 is trained and actively serves on both CIRT and DCORT.

### **Alignment with State Plan to End Homelessness**

As stated in the previous section, the MCBHC provides services and supports which are in alignment with the state plan to end homelessness. The staff providing the services through MCBHC are providing case management services and are able to identify homeless, or at risk of homeless, 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.

### **Other Designated Funds**

Mercer County is not a Mental Health Block Grant recipient. As stated previously, 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 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, but are not earmarked for PATH services specifically.

MCBHC does receive federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars. Those funds are used for Prevention and Intervention/Treatment of alcohol and drug use. Those funds are not earmarked for PATH services specifically.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

There is currently five known Mercer County staff trained in SOAR. The MCBHC PATH Coordinator received the certification on 12/26/14. Within the current 2015-2016 fiscal year, an additional staff person at the MCBHC has completed the on-line training and is awaiting notification of completing the process successfully. She submitted her application on 4/19/16. To date, there was no PATH funded consumers assisted using SOAR at the MCBHC because all the PATH funded individuals receive SSI or SSDI, and/or are employed.

MCBHC hopes to build the SOAR process. There has been recent contact by inmates within the State Correctional Facilities requesting assistance with SOAR applications. It is hoped that a new process will be able to assist the inmates with facilitating SOAR applications.

### **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**

At the present time, Mercer County is not part of a coordinated entry program. We do utilize "211" as often as possible but our CoC is in the process of piloting a Coordinated Entry Program. If the pilot project works well, during the fiscal year 2016-17, we will implement a Coordinated Entry Program for Mercer County and the entire CoC.

### **Justice Involved**

MCBHC continues to provide co-occurring MH/DA intervention within its County Prison. This intervention is provided through a Forensic Case Manager who works closely with the justice involved mental health and substance abuse consumers. Additionally to the intake, assessment, and evaluation provided within the jail system, the Forensic Case Manager also provides psycho-

educational groups. Within the 2014-2015 service year 250 inmates were assessed. The breakdown of type of assessments provided was: 162 Drug and Alcohol; 20 Driving while Under the Influence; 29 Mental Health, and 38 Dual. In addition to the assessments, psycho educational groups were provided. A total of 4 Drug and Alcohol groups were provided to a total of 31 participants.

The Case Management staff also work closely with Probation and Parole in order to coordinate and monitor services within the community. The MCBHC staff are familiar with the PATH services and will make PATH referrals, as necessary, regardless of criminal backgrounds or history.

Additionally, Mercer County has a Veteran's Court. This service provides a diversion from entering the justice system for individuals who are veteran's and qualify for the specialized court program.

MCBHC supports the efforts being made by the local Criminal Justice Advisory Board (CJAB). MCBHC is a member of the CJAB and supports the housing initiatives that are being discussed, one being a diversion from the justice system for individuals with mental health conditions who are homeless and the other being a plan for re-entry of individuals who are being released from the jails and prisons who have a mental health diagnosis and who are homeless.

The PATH program at MCBHC does not inquire about criminal background, involvement, or history. Therefore, there is no data regarding the percentage of enrolled individuals who may be justice involved.

### **Staff information**

Specific to MCBHC, PATH is administered by one individual housed within the MCBHC. There is a total of 91 part-time and full-time staff employed by the MCBHC. 81% of the workforce is comprised of women and 19% men. Regarding race, 98% of the staff are Caucasian and 2% are Black. Please reference CCC's Intended Use Plans 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

Demographics of PATH individuals served through the BHC from 2014-2015 fiscal year:

Age:		Race:		Ethnicity:		Gender:	
<b>18-23</b>	8%	<b>Black or African American</b>	8%	<b>Non-Hispanic/Non-Latino</b>	92%	<b>Male</b>	25%
<b>24-30</b>	0%	<b>White</b>	83%	<b>Hispanic/Latino</b>	8%	<b>Female</b>	75%
<b>31-50</b>	50%	<b>Refused</b>	8%				
<b>51-61</b>	33%						
<b>62+</b>	8%						

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.

The PATH Coordinator does not provide street outreach. However, the PATH Coordinator works closely with the mental health case management department in regards to homelessness and homeless needs.

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 60. Estimating that of those 60 clients, 55% will be literally homeless. The individual organizational breakdown of the total number is: Behavioral Health Commission- 21; Community Counseling Center- 39.

## 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. The 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. The NFI also reports to the county Administrative Entity any proposals 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 newest 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.

The Housing Coalition is always seeking individuals who have been homeless to serve on the committee. This committee, which has individuals who are homeless and have a mental health illness, is active in planning and implementing the annual "Walk A Mile In Their Shoes". This, along with many speaking engagements throughout Mercer County, promotes awareness of homelessness. The County Commissioners have declared November as Homeless Awareness Month in Mercer County.

The PATH coordinator communicates upcoming trainings, regional meetings, and conference opportunities with the other PATH provider. The PATH providers actively participate in the Western Region Housing Options Coalition where we are exposed to staff development opportunities and networking.

### **Health Disparities Impact Statement**

➤ **The unduplicated number of TAY individuals who are expected to be served using PATH funds**

It is estimated that the number of unduplicated number of TAY individuals served using PATH funds in Mercer County is expected to be 10. The MCBHC estimates the number of individuals served will be 3. Please refer to the individual organizational intended use plan for organizational estimated numbers.

➤ **The total amount of PATH funds expected to be expended on services for the TAY population**

The total estimated budget for Mercer County is \$8000. The Mercer County Behavioral Health Commission (MCBHC) estimates the TAY budget to be \$750.00.

➤ **The types of services funded by PATH that are available for TAY individuals**

The types of services available for TAY individuals are the same as for everyone. Anyone age 18 and above may be eligible to receive PATH funded services and may be eligible for financial assistance for first month's rent, security deposit, or assistance to maintain utility service in order to prevent homelessness. Additionally, referrals can be made to other agencies for other services that may be needed to assist the individual in obtaining and maintaining independent living. Some of those additional services include, but are not limited to: mental health case management, supportive housing services, psychiatric rehabilitation, and additional housing supports. Supports offered through other agencies include supportive housing, housing counseling, outreach services, referrals to community mental health services, staff training, and case management.

➤ **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**

The local Community Support Program, New Freedom Initiative (NFI), formed a Transition-Age Workgroup (TAWG) in effort to identify and address the needs faced by this 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. The TAWG has proposed a couple options to address needs of this population. Some of the suggestions are: Big Brother/Big Sister program, Youth Peer Specialist, or Transition Age Coordinator.

The 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 made to increase the knowledge of the services and supports available to the TAY population.

The most recent effort made by TAWG is to identify the gaps of services within the transition age youth is a Needs Assessment. The Needs Assessment currently is being answered by all schools within Mercer County, which includes public, private, and parochial schools. Additionally, the Prevention Department within the MCBHC is able to complete the Needs Assessment. The hope is that the Assessment will determine the needs that the schools and individuals working with the TAY population are able to identify. The next step within the process of identifying needs of the TAY is to request participation and completion of a Needs Assessment by parents, guardians, and family members of the Transition-Age Youth. The sub-committee will review the responses and develop a recommendation for the Mercer County Mental Health/Developmental Services Administrator.

## **Budget Narrative - 2016-2017**

The money received through the contract with Behavioral Health Commission will be used for salaries and benefits of the case workers who will be assisting the persons referred for services. Within Behavioral Health Commission, 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. Total PATH allocation for Mercer County consists of: \$46,874 federal dollars and \$21,438 state match dollars which equals overall budget submitted.

### 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 54 cents per mile, which is the 2016 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 2016/2017.

*Community Counseling Center* – Supported Housing Services for this population are funded with Path dollars. Community Counseling Center is estimating contacting 110 individuals in the upcoming fiscal year. Of those individuals, estimating that 39 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 2016-2017 PATH Budget**

	<b>Annual Salary</b>	<b>PATH- funded FTE</b>	<b>PATH- funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing Coordinator	42,803	.3 FTE	\$12,841	\$12,841
Case Manager	35,225	.16 FTE	5,636	5,636
<b>sub-total</b>			<b>18,477</b>	<b>18,477</b>
<b>Fringe Benefits</b>				
FICA Tax			1,413	1,413
Health Insurance			8,690	8,690
Retirement			1,109	1,109
Life, Disability & Misc. Benefits			309	309
PA Unemployment			177	177
Workmen's Compensation			126	126
<b>sub-total</b>			<b>11,824</b>	<b>11,824</b>
<b>Travel</b>				
Travel to trainings and meetings			567	567
<b>sub-total</b>			<b>567</b>	<b>567</b>
<b>Contracts/Purchase Services</b>				
Community Counseling Services			31,690	31,690
<b>sub-total</b>			<b>31,690</b>	<b>31,690</b>
<b>Supplies</b>				
Office Supplies			705	705
<b>sub-total</b>			<b>705</b>	<b>705</b>
<b>Other</b>				
One-time rental assistance			3,349	3,349
Occupancy			1,700	1,700
<b>sub-total</b>			<b>5,049</b>	<b>5,049</b>
<b>Total PATH Budget</b>				<b>\$68,312</b>

39. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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b. Fringe Benefits	0.00 %	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)				
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h. Other	\$ 0	\$ 0	\$ 0	
No Data Available				

i. Total Direct Charges (Sum of a-h)	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
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k. Grand Total (Sum of i and j)	\$ 0	\$ 0	\$ 0	
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Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Community Counseling Center will receive \$31,690 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	103	Estimated Number of Persons to be Enrolled:	39
Estimated Number of Persons to be Contacted who are Literally Homeless:	72		
Number Staff trained in SOAR in Grant year ended in 2014:	2	Number of PATH-funded consumers assisted through SOAR:	4

**Mercer County**  
**Community Counseling Center of Mercer County**  
**PATH Grant Intended Use Plan**  
**FY 2016-17**

**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 almost 60 years. Community Integration Services were started in the early 1980's with its Residential Program. All services are available to any resident of Mercer County with housing services provided in the rural areas.

The agency will receive \$31,690 in PATH Funding, this is a \$3,000 increase from the prior year. The amount of funding is dictated by the county administrative agent. 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 local Housing Coalition and other contacts in the county.

Community Counseling Center 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 northern region. The CoC at the present time is working on a coordinated Entry and Assessment Process. A pilot program has been started in 5 counties within the Western CoC and there are plans of initializing it across the entire region by October of 2016.

As a member of the Northwest RHAB board, she attends the monthly meeting either by phone or in person. 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 an as needed basis. As part of her responsibilities, information is relayed from the RHAB and CoC to the local coalition as well as keeping the regional entities updated on the activities of the Mercer County Housing Coalition.

## **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, Community Action Partnership of Mercer County, AWARE, Prince of Peace Center, Adult Probation and Parole, 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

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. Such a referral can be made to Community Counseling Center for Mental Health Services, or Domestic Abuse Victims would be referred for shelter to AWARE, and others were refer Veterans to Community Action Partnership' for their specialized program. This network of agencies coordinates referrals to assist individuals to navigate the multi resources with less frustration.

## **Service Provision**

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. 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. 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 has met with the individual and has determined their eligibility into the program their needs can be assessed and the necessary referrals completed.

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 is 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.

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 Supportive 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.
- 11 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 collaboration with CHAPPS of Crawford County to provide housing for five Chronically Homeless Persons with Mental Illness. This is a master leasing project.

Over the past years, the housing gap in Mercer County has not changed. We continue to struggle with the 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. This year a partnership between Community Counseling Center and AWARE Agency has been formed and AWARE is willing to complete the ESG Grant to secure the funds needed for the project. A site is being sought to house the shelter but no affordable location has been secured.

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 but even several of those provide questionable services. 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.

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.

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.

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.

## **Data**

At the present time we at Community Counseling Center of Mercer County are entering PATH data in the PA HMIS system on individuals who are entered into the PATH program. We are entering all of the outreach contacts that are made into HMIS, but we are not able to enter all of the demographic information into the PATH program because they do not meet eligibility. Due to the resignation of one of our users, we will be training and retraining several new and former PA HMIS users to enter all of the additional information that was presented in the HMIS training in April. The data will include all contact information as well as all referrals made and attained by the program participants. The number of users will give us the capacity to enter all of the data into the HMIS system by June 30, 2016. All of the users will view the needed trainings listed on the PA HMIS website through DCED to begin as well as attend all additional and updated training as needed. The system manager will ensure that all data is being entered into the system by running monthly reports. The DCED PA HMIS Director is Brian Miller.

### **Alignment with PATH goals**

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. 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 has met with the individual and has determined their eligibility into the program their needs can be assessed and the necessary referrals completed.

### **Alignment with State Mental Health Services Plan**

The State Plan to End Homelessness states that counties should develop: A program or project which prevents or reduces Homelessness. 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.

The Supportive Housing Staff as part of the information provided through their life skills training program discuss and review with the participants disaster preparedness and emergency planning. For those in the emergency shelter, the staff discusses the location of the tornado shelter and the fire exits in the building. Similar discussion occurs 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 person could get information regarding where they should go and what is occurring in a natural disaster. This includes phone numbers to the American Red Cross and Mercer County Dept of Public Safety for severe weather conditions.

If a National Defense Disaster should occur the individuals will follow the directives of the local officials and the County Disaster Plan. The phone number to the County Emergency Management agency will be provided to them.

If the individual is homeless, they also will be given similar information such as phone numbers and the location of the nearest building that could provide them shelter.

## **Alignment with State Plan to End Homelessness**

The State Plan to End Homelessness states that counties should develop: A program or project which prevents or reduces Homelessness. In Mercer County with the use of the PATH funding, Community Counseling Center is able to support staff to provide services to the most vulnerable population which includes persons with a Mental Health diagnosis. The staff is able to meet the person where they are and assist them in securing housing and provide referrals for additional resources that they may be eligible for in the area. We have partnered with CHAPPS to secure a HUD Grant to do master leasing for the Chronically Homeless. PATH dollars help to support the caseworker assigned to these individuals.

## **Other Designated Funds**

Through two of the HUD grants for which we are a sub-recipient, 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.

## **SSI/SSDI Outreach, Access, Recovery (SOAR)**

At the end of this fiscal year 2015-16, we have two staff members trained in SOAR. Both of the staff members work directly with those persons eligible for PATH services. During the last fiscal year, we assisted 4 individuals through the process and were successful in securing Social Security Benefits for 2 of the individuals. One individual left the program before completing the process and the other is still working on the application.

## **Housing**

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, they 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, Joshua's Haven being one of the three, 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 PATH Caseworker to discuss their needs and what services are appropriate for them. If there is an opening in one of the HUD projects, they will be referred to those. In our area, there are several regional HUD projects for the chronically homeless. If they meet the criteria for these projects they again will

be referred. If all of the projects are filled, then the caseworker will work with the individual to find a private landlord or the 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**

At the present time, we are not part of a coordinated entry program. We do utilize "211" as often as possible but our CoC is in the process of piloting a Coordinated Entry Program. If the pilot project works well, during the fiscal year 2016-17, we will implement a Coordinated Entry Program for Mercer County and the entire CoC.

### **Justice Involved**

In Mercer County, during the past year, there has been a great deal of movement toward coordinating services between the Mental Health System and the Justice System. The Community Integration Services Administrator is now part of the CJAB in the county. She also is part of the sub-committee to help to develop a plan to divert individuals with Mental Health issues that are homeless out of the Justice System. On the other end of the process, the sub-committee is working on placement for individuals being released that are homeless and have a mental Health diagnosis. Last June, a two day Mapping and Planning session was held with the assistance of PCCD to address the gaps in services and the needs of the individuals. At the present time, 20% of the PATH individuals have a criminal history.

### **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. At the present time, all of the Supportive Housing workers are white females between the ages of 25-40. 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 services provided through the PATH Grant through the Community Counseling Center will be to persons with Mental Illness who are homeless throughout Mercer County. We are projecting to contact or be contacted by 103 individuals. Of those individuals, 39 will be enrolled in the program and 70% of those will be literally homeless. The majority of those we will be serving are single males under the age of 50. Many of the men will have either a Drug and Alcohol history or have at some point been incarcerated.

## **Consumer Involvement**

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. Satisfaction surveys are given to participants every 6 months in all Community Integration Services to obtain feedback regarding the programs.

As part of the intake packet given to every individual entering services, there is consent for treatment, a copy of their rights and a grievance procedure if needed. When a referral is made to another agency, a list of providers is given to the person so that they have a choice in which they are referred to for additional services.

The Mercer County Housing Coalition has at least one member who has experienced homelessness. The coalition is always looking to expand their membership to include those individuals who have been homeless to help better serve those in the county. 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.

## **Health Disparities Impact Statement**

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 permanent 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.

- 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
- Within this population of Transition Age Youth, we would need to implement a plan that would address issues such as the usage of drugs and alcohol, education and employment and the knowledge of basic life skills. We would also deal with peer pressure within the

independent living situation as we have experienced multi- persons living with the individual on the lease. Also, there is the failure to follow through on action plans to benefit the person due to lack of motivation or entitlement.

One strategy that we would attempt to utilize would be group activities for individuals in this age range. The group would focus on the topics listed above. The groups could also be used as a peer to peer support group. On many occasions those who have faced a similar issue can better relate to those experiencing the same issue. When assigning a staff member to the TAY, a younger staff member may be easier to relate to and the individuals may feel more comfortable with them as opposed to an older person. In each case, the strategies are going to vary because each individual is going to have different needs and barriers to face. Once a person has been assessed then a plan can be put into place to address those disparities.

### **Budget Narrative**

The PATH funds will be used to support a portion of a Supportive Housing caseworker's salary and 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.

**Personnel:** The funding amount of \$20,542 is being requested to provide for 60% of a full time Supportive Housing Caseworker, and, \$3,000 to cover a small portion of their Health Care Cost. The Health Care Coverage is dependent on the type of coverage needed either individual or family.

**Fringe Benefits:** The funding requested in the amount of \$3,315 is the total needed to cover the set costs. The amount for each category is determined by a standard set percentage based on the salary amount.

**Travel:** Funding is requested to pay for the cost associated with usage of an agency vehicle. The amount of \$3,745 will be used to pay for gas and maintenance of the vehicle. The vehicle will be used by staff to travel to meet the individual through the county, to transport the individual to services and to find appropriate housing.

**Supplies:** The funding requested in the amount of \$1,088 covers general office supplies and the cost of any electronic device used by the caseworker to document services provided.

**Mercer County  
Community Counseling Center  
FY 2016-2017 PATH Budget**

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
Housing Case Manager		.6 FTE Salary and Health Care	23,542	23,542
Outreach Liaison (Certified Peer Specialists)				
<b>sub-total</b>			23,542	23,542
<b>Fringe Benefits</b>				
FICA Tax			1569	1569
Unemployment			308	308
Retirement			1,027	1027
Life Insurance			411	411
<b>sub-total</b>			3,315	3,315
<b>Travel</b>				
Local Travel for Outreach			3,745	3,745
Travel to training and workshops				
<b>sub-total</b>			3,745	3,745
<b>Supplies/Equipment</b>				
Consumer-related items			1,088	1,088
<b>sub-total</b>				
<b>Other</b>				
Staff training				
One-time rental assistance				
Security deposits				
<b>sub-total</b>				
<b>Total PATH Budget</b>			<b>\$31,690</b>	

40. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 0 \$ 0 \$ 0

j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 25 Estimated Number of Persons to be Enrolled: 21

Estimated Number of Persons to be Contacted who are Literally Homeless: 14

Number Staff trained in SOAR in Grant year ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Mercer County**  
**Comprehensive PATH Intended Use Plan**  
**FY 2016-2017**

**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. For 37 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. As the initial point of contact for these three programs, the MCBHC provides administrative oversight, centralized program intake functions, case management services, peer support services, mobile psychiatric nursing services, early intervention services, and prevention education programs. 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.

**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"

The MCBHC will receive a federal allocation of \$46,874 and a state allocation of \$21,438 totaling \$68,312. The attached line item budget reflects the detail funding for MCBHC. Within this budget, under the purchase services line item, is the amount of money that the agency subcontracts with one in-county agency. The sub-contracted agency is Community Counseling Center (CCC). CCC will receive an allocation of \$31,690 to support PATH funded services. This is a change from previous years as MCBHC is not contracting with Community Action Partnership of Mercer County (CAPMC) for PATH services, but will continue to financially support CAPMC for housing services and supports utilizing base dollars. The rationale is to reduce the administrative burden for CAPMC related to PATH reporting, documentation, quarterly calls, etc.

Community Counseling Center is a non-profit agency providing comprehensive community behavioral health services since 1957. The Center provides treatment, rehabilitation and support services through a wide range of services for children, adults, and families who are experiencing behavioral health concerns. 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.

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**

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: Community Counseling Center, Behavioral Health Commission, Veterans Services, Community Action Partnership of Mercer County, AWARE, Prince of Peace Center, Adult Probation and Parole, the Self Determination Project, Mercer County Housing Authority, Southwest Legal Services, Primary Health Network, and local Realtors.

The Housing Coordinator within the Mercer County Behavioral Health Commission attends the monthly local Housing Coalition meetings. These meetings provide an opportunity of sharing, collaboration, and communication within local organizations which provide housing services. The Community Integration Services (CIS) Administrator of Community Counseling Center is an active member of the Western Region CoC. During the Mercer County Housing Coalition meetings, the CIS is able to share and update the committee as to the activities of the Western Region CoC. The CIS in turn, keeps the regional entities updated on the activities of the Mercer County Housing Coalition.

### **Collaboration with Local Community Organizations**

#### **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 Medication Assisted Treatment 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, 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.

MCBHC was awarded a 10 person Community Hospital Integration Program Project (CHIPP) for the 2013/2014 fiscal year. Within the grant, CCC opened a 4 person Community Residential Rehabilitation (CRR) program for four of the CHIPP individuals. The CRR program is individualized to meet the needs in efforts to reduce re-admissions to the hospitals and to promote community involvement and inclusion. Another goal at the CRR is to provide independent living skills for individuals who are working towards independent living. CCC also offers a partial care CRR/Fairweather Lodge. The Fairweather Lodge Program is a community support-based program that can assist persons with mental illness reintegrate back into the community. The goal of the program is to provide emotional support, a place to live, and employment for its members. CCC also has a 16 bed Enhanced Personal Care Boarding Home (EPCBH) located in Sharon. In January 2014, CCC and Children and Youth Services (CYS) began a new program, collaborating on a new transition-age housing program, Supportive Housing Services for Youth in Transition. The program is designed for individual's ages 18-21 who are clients within the CYS system and do not necessarily have a mental health diagnosis. A CYS case worker is designated to assist youth aging out of the foster care system and assist in transitioning into adulthood. The case worker will have a maximum of 8 individuals on their case load. CCC also collaborates with other organizations to provide an emergency shelter for homeless individuals and families. In addition to the housing services, CCC provides outpatient mental health and substance abuse treatment, psychiatric rehabilitation, supported employment, certified peer support services, family based mental health, school based, BHRS, and respite care.

Other county programs that offer housing services and supports, which do not receive PATH funds, 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 utilized by the Housing Coalition. The City of Sharon also greatly supports the Coalition's Homeless Awareness Month Activities by blocking off streets, re-routing traffic, and providing police car escorts for the Annual "Walk A Mile In Their Shoes" Awareness walk.

**The Community Action Partnership of Mercer County (CAPMC)** also 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 210 units of senior housing at seven locations. This program is for independent living for income qualified seniors ages 62 and older. Additionally, the agency owns and manages 32 units of special needs housing at 10 locations. Such special needs housing includes: Emergency Shelter, Legacy House, Independence Park, and Permanent Supported Housing for Persons with Serious Mental Illness inclusive of eight units at three 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 nine 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. Another housing project through CAPMC is a program for Veterans who are experiencing a housing crisis.

**The Good Shepherd Center** addresses the physical needs of the economically challenged in the greater Greenville area. 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, the 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. The Housing Authority does have preferences for veterans and individuals who are homeless. Staff from the Housing Authority participates actively on the Mercer County Housing Coalition.

**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. Within the housing supports of FSS, there are two programs. Those programs are Project RUTH (Resources, Understanding, Training, and Homes) which is a service to advocate for the homeless of Mercer County and provides support and training in basic life skills for essential living. In 2014, Project RUTH served 51 individuals: 17 women, 2 men, and 25 children. The second program under FSS is HOPE Advocacy. HOPE (Help and Opportunity for Personal Empowerment) provides long-term support for individuals living independently and need further assistance in learning basic life skills. In 2014, HOPE Advocacy served 77 individuals, 30 women, 1 man, and 46 children. All individuals served in both programs were below the poverty level.

**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.

**Youth Advocate Program (YAP)** is the most recent compliment to the housing services and supports continuum offered in Mercer County. YAP is offering two 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.

A second key employment provider is CCC, a recipient of PATH dollars. 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 to be provided to those deemed literally homeless by the two PATH recipient organizations include: outreach services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, staff training, case management services, supportive and supervisory services in residential settings, referrals for primary health services, job training, educational services, and relevant housing services. Additionally, 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 that 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, 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. Those additional services would be

educational classes provided by a variety of organizations within Mercer County. The staff would assist the individual with applying for those classes.

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. As mentioned above, a sub-committee of the Mercer County Housing Coalition is pursuing a grant to address the family unit issue, with the Mercer County AWARE being the Local Lead Agency on this project, as well as, matching dollars needs for the grant. At this time, the committee is continuing to search for a suitable building and location for this project. Joshua's Haven is an emergency shelter for single men, but Mercer County has no shelter identified for single women or family units. The emergency shelter being proposed would address part of this problem.

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.

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. Consumers experiencing a co-occurring mental illness and substance abuse disorder can access appropriate treatment through the Central Intake Unit of MCBHC. 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. The 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. As previously mentioned, MCBHC does have Certified Recovery Specialist services and Drug and Alcohol Case Coordination. Staff have training for both substance abuse and mental health co-occurring disorders in order to be better prepared to address the specific needs of this population. Additionally, the MCBHC contracts with multiple co-occurring residential treatment providers.

PATH-funded staff 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 will be offered throughout all of the Human Service agencies within Mercer County. One of the goals of having this training would be 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.

Another evidenced-based training that was in Mercer County was Mental Health First Aid. Community Counseling Center had provided this training for many different groups throughout the county in order to educate the general population in how to help an individual in a mental

health crisis or developing a mental illness. Unfortunately, this training opportunity was not able to be financially sustained due to the loss of the Mental Health Matters grant funding.

Staff monitors the website 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.

### **Data**

The MCBHC has been entering data into PA HMIS since December 2011. CCC is also an established user of HMIS. All PATH eligible individuals are entered into the PA HMIS system. DCED is the PA HMIS provider with Brian Miller as the HMIS Director.

### **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 Mental Health Services Plan**

The Mercer County Behavioral Health Commission provides multiple services and supports which are consistent with the state initiatives to prevent or reduce homelessness. The PATH 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 eviction. The 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. Additionally, the United Way of Mercer County has launched a new campaign of "Lifting Families Out of Poverty". The United Way plans to organize training sessions to promote financial stability and independence. By providing ongoing trainings and

educational opportunities, people within the community, both those with mental health conditions, and those without, will be less likely to become homeless.

In regard to PATH integrating with the Mercer County disaster preparedness and emergency planning, the 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, Robyn Kokus.

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 subgroup 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 is trained and actively serves on both CIRT and DCORT.

### **Alignment with State Plan to End Homelessness**

As stated in the previous section, the MCBHC provides services and supports which are in alignment with the state plan to end homelessness. The staff providing the services through MCBHC are providing case management services and are able to identify homeless, or at risk of homeless, 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.

### **Other Designated Funds**

Mercer County is not a Mental Health Block Grant recipient. As stated previously, 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 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, but are not earmarked for PATH services specifically.

MCBHC does receive federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars. Those funds are used for Prevention and Intervention/Treatment of alcohol and drug use. Those funds are not earmarked for PATH services specifically.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

There is currently five known Mercer County staff trained in SOAR. The MCBHC PATH Coordinator received the certification on 12/26/14. Within the current 2015-2016 fiscal year, an additional staff person at the MCBHC has completed the on-line training and is awaiting notification of completing the process successfully. She submitted her application on 4/19/16. To date, there was no PATH funded consumers assisted using SOAR at the MCBHC because all the PATH funded individuals receive SSI or SSDI, and/or are employed.

MCBHC hopes to build the SOAR process. There has been recent contact by inmates within the State Correctional Facilities requesting assistance with SOAR applications. It is hoped that a new process will be able to assist the inmates with facilitating SOAR applications.

### **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**

At the present time, Mercer County is not part of a coordinated entry program. We do utilize "211" as often as possible but our CoC is in the process of piloting a Coordinated Entry Program. If the pilot project works well, during the fiscal year 2016-17, we will implement a Coordinated Entry Program for Mercer County and the entire CoC.

### **Justice Involved**

MCBHC continues to provide co-occurring MH/DA intervention within its County Prison. This intervention is provided through a Forensic Case Manager who works closely with the justice involved mental health and substance abuse consumers. Additionally to the intake, assessment, and evaluation provided within the jail system, the Forensic Case Manager also provides psycho-

educational groups. Within the 2014-2015 service year 250 inmates were assessed. The breakdown of type of assessments provided was: 162 Drug and Alcohol; 20 Driving while Under the Influence; 29 Mental Health, and 38 Dual. In addition to the assessments, psycho educational groups were provided. A total of 4 Drug and Alcohol groups were provided to a total of 31 participants.

The Case Management staff also work closely with Probation and Parole in order to coordinate and monitor services within the community. The MCBHC staff are familiar with the PATH services and will make PATH referrals, as necessary, regardless of criminal backgrounds or history.

Additionally, Mercer County has a Veteran's Court. This service provides a diversion from entering the justice system for individuals who are veteran's and qualify for the specialized court program.

MCBHC supports the efforts being made by the local Criminal Justice Advisory Board (CJAB). MCBHC is a member of the CJAB and supports the housing initiatives that are being discussed, one being a diversion from the justice system for individuals with mental health conditions who are homeless and the other being a plan for re-entry of individuals who are being released from the jails and prisons who have a mental health diagnosis and who are homeless.

The PATH program at MCBHC does not inquire about criminal background, involvement, or history. Therefore, there is no data regarding the percentage of enrolled individuals who may be justice involved.

### **Staff information**

Specific to MCBHC, PATH is administered by one individual housed within the MCBHC. There is a total of 91 part-time and full-time staff employed by the MCBHC. 81% of the workforce is comprised of women and 19% men. Regarding race, 98% of the staff are Caucasian and 2% are Black. Please reference CCC's Intended Use Plans 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

Demographics of PATH individuals served through the BHC from 2014-2015 fiscal year:

Age:		Race:		Ethnicity:		Gender:	
<b>18-23</b>	8%	<b>Black or African American</b>	8%	<b>Non-Hispanic/Non-Latino</b>	92%	<b>Male</b>	25%
<b>24-30</b>	0%	<b>White</b>	83%	<b>Hispanic/Latino</b>	8%	<b>Female</b>	75%
<b>31-50</b>	50%	<b>Refused</b>	8%				
<b>51-61</b>	33%						
<b>62+</b>	8%						

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.

The PATH Coordinator does not provide street outreach. However, the PATH Coordinator works closely with the mental health case management department in regards to homelessness and homeless needs.

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 60. Estimating that of those 60 clients, 55% will be literally homeless. The individual organizational breakdown of the total number is: Behavioral Health Commission- 21; Community Counseling Center- 39.

## 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. The 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. The NFI also reports to the county Administrative Entity any proposals 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 newest 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.

The Housing Coalition is always seeking individuals who have been homeless to serve on the committee. This committee, which has individuals who are homeless and have a mental health illness, is active in planning and implementing the annual "Walk A Mile In Their Shoes". This, along with many speaking engagements throughout Mercer County, promotes awareness of homelessness. The County Commissioners have declared November as Homeless Awareness Month in Mercer County.

The PATH coordinator communicates upcoming trainings, regional meetings, and conference opportunities with the other PATH provider. The PATH providers actively participate in the Western Region Housing Options Coalition where we are exposed to staff development opportunities and networking.

### **Health Disparities Impact Statement**

➤ **The unduplicated number of TAY individuals who are expected to be served using PATH funds**

It is estimated that the number of unduplicated number of TAY individuals served using PATH funds in Mercer County is expected to be 10. The MCBHC estimates the number of individuals served will be 3. Please refer to the individual organizational intended use plan for organizational estimated numbers.

➤ **The total amount of PATH funds expected to be expended on services for the TAY population**

The total estimated budget for Mercer County is \$8000. The Mercer County Behavioral Health Commission (MCBHC) estimates the TAY budget to be \$750.00.

➤ **The types of services funded by PATH that are available for TAY individuals**

The types of services available for TAY individuals are the same as for everyone. Anyone age 18 and above may be eligible to receive PATH funded services and may be eligible for financial assistance for first month's rent, security deposit, or assistance to maintain utility service in order to prevent homelessness. Additionally, referrals can be made to other agencies for other services that may be needed to assist the individual in obtaining and maintaining independent living. Some of those additional services include, but are not limited to: mental health case management, supportive housing services, psychiatric rehabilitation, and additional housing supports. Supports offered through other agencies include supportive housing, housing counseling, outreach services, referrals to community mental health services, staff training, and case management.

➤ **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**

The local Community Support Program, New Freedom Initiative (NFI), formed a Transition-Age Workgroup (TAWG) in effort to identify and address the needs faced by this 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. The TAWG has proposed a couple options to address needs of this population. Some of the suggestions are: Big Brother/Big Sister program, Youth Peer Specialist, or Transition Age Coordinator.

The 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 made to increase the knowledge of the services and supports available to the TAY population.

The most recent effort made by TAWG is to identify the gaps of services within the transition age youth is a Needs Assessment. The Needs Assessment currently is being answered by all schools within Mercer County, which includes public, private, and parochial schools. Additionally, the Prevention Department within the MCBHC is able to complete the Needs Assessment. The hope is that the Assessment will determine the needs that the schools and individuals working with the TAY population are able to identify. The next step within the process of identifying needs of the TAY is to request participation and completion of a Needs Assessment by parents, guardians, and family members of the Transition-Age Youth. The sub-committee will review the responses and develop a recommendation for the Mercer County Mental Health/Developmental Services Administrator.

## **Budget Narrative - 2016-2017**

The money received through the contract with Behavioral Health Commission will be used for salaries and benefits of the case workers who will be assisting the persons referred for services. Within Behavioral Health Commission, 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. Total PATH allocation for Mercer County consists of: \$46,874 federal dollars and \$21,438 state match dollars which equals overall budget submitted.

### 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 54 cents per mile, which is the 2016 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 2016/2017.

*Community Counseling Center* – Supported Housing Services for this population are funded with Path dollars. Community Counseling Center is estimating contacting 110 individuals in the upcoming fiscal year. Of those individuals, estimating that 39 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 2016-2017 PATH Budget**

	<b>Annual Salary</b>	<b>PATH- funded FTE</b>	<b>PATH- funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Housing Coordinator	42,803	.3 FTE	\$12,841	\$12,841
Case Manager	35,225	.16 FTE	5,636	5,636
<b>sub-total</b>			<b>18,477</b>	<b>18,477</b>
<b>Fringe Benefits</b>				
FICA Tax			1,413	1,413
Health Insurance			8,690	8,690
Retirement			1,109	1,109
Life, Disability & Misc. Benefits			309	309
PA Unemployment			177	177
Workmen's Compensation			126	126
<b>sub-total</b>			<b>11,824</b>	<b>11,824</b>
<b>Travel</b>				
Travel to trainings and meetings			567	567
<b>sub-total</b>			<b>567</b>	<b>567</b>
<b>Contracts/Purchase Services</b>				
Community Counseling Services			31,690	31,690
<b>sub-total</b>			<b>31,690</b>	<b>31,690</b>
<b>Supplies</b>				
Office Supplies			705	705
<b>sub-total</b>			<b>705</b>	<b>705</b>
<b>Other</b>				
One-time rental assistance			3,349	3,349
Occupancy			1,700	1,700
<b>sub-total</b>			<b>5,049</b>	<b>5,049</b>
<b>Total PATH Budget</b>				<b>\$68,312</b>

50 Beech Drive  
Norristown, PA 19403

Provider Type: Community mental health center

Contact: Bill Myers

PDX ID: PA-071

Contact Phone #: 6102796100

State Provider ID: 4271

Geographical Area Served: Southeast Region

Planning Period From 7/1/2016 to 6/30/2017

\* 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				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Construction (non-allowable)				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
h. Other	\$ 70,371	\$ 23,457	\$ 93,828	
<b>Line Item Detail *</b>	<b>Federal Dollars *</b>	<b>Matched Dollars *</b>	<b>Total Dollars</b>	<b>Comments</b>
Office: Other (Describe in Comments)	\$ 70,371	\$ 23,457	\$ 93,828	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 70,371	\$ 23,457	\$ 93,828	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Indirect Costs (Administrative Costs)	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 70,371	\$ 23,457	\$ 93,828	

Source(s) of Match Dollars for State Funds:

Montgomery County Emergency Service will receive \$93,828 in federal and state PATH funds.

Estimated Number of Persons to be Contacted: 60      Estimated Number of Persons to be Enrolled: 32  
 Estimated Number of Persons to be Contacted who are Literally Homeless: 2  
 Number Staff trained in SOAR in Grant year ended in 2014: 0      Number of PATH-funded consumers assisted through SOAR: 0

**Montgomery County**  
**Montgomery County Emergency Services, Inc**  
**PATH Intended Use Plan**  
**FY 2016-2017**

**Local Provider Description**

PA-071 Montgomery County Emergency Service, Inc. (MCES)  
50 Beech Drive, Norristown, 19403-5421  
Phone: 610-279-6100  
Fax: 610-278-0978

2016/2017 Total PATH Allocation: \$93,828

The provider name listed in the PATH Data Exchange is PA-071 Montgomery County Emergency Service. MCES was established in 1974 with the intent to prevent the criminalization of the mentally ill. At that time, MCES was a 24-bed inpatient hospital. Today, MCES is a full-scale, comprehensive crisis response center, offering a diverse array of services to the community including:

- **Inpatient Psychiatric Services:** Providing voluntary and involuntary hospitalization for individuals experiencing a psychiatric emergency. Individuals are provided with crisis stabilization, comprehensive assessment, short-term intensive psychiatric/co-occurring treatment and medical evaluation, as well as aftercare planning services.
- **Crisis Center and Hot Line:** The Crisis Department assists with psychiatric and/or co-occurring emergencies, as well as telephone support, referral information and comprehensive assessments. MCES is a participating member of the National Suicide Prevention Lifeline Network.
- **Justice Related Services:** MCES aids persons with serious mental illness in contact with the criminal justice system. Services prevent unnecessary hospitalization and/or avoidable involvement in the criminal justice system. MCES also provides Crisis Intervention Specialist (CIS) training to law enforcement officers. This assists officers in becoming more sensitive, informed, and competent in their interactions with individuals with mental illness.
- **MCES provides a psychiatric EMS Squad 305, a Basic Life Support (BLS) ambulance** staffed with Emergency Medical Technicians (EMTs) who respond to behavioral emergencies in the community, and assist law enforcement in serving involuntary psychiatric warrants (“302s”).
- **Crisis Residential Program (CRP):** MCES operates an 8-bed freestanding facility offering professional mental health services and support to individuals experiencing mental health crises that may put them at risk of hospitalization.

MCES is licensed by the Department of Human Services (DHS) and the Department of Health, as well as accredited by The Joint Commission (TJC).

### **Collaboration with HUD Continuum of Care**

The Montgomery County Department of Behavioral Health and Developmental Disabilities (BH/DD) has a long history of participation in and collaboration with the Montgomery County Continuum of Care (CoC). The Department administers a number of HUD CoC Program grants which provide Permanent Supportive Housing and a day shelter for homeless persons. Over the past decade, Department staff have participated in and/or chaired numerous CoC committees and action teams, including the current Montgomery County CoC Governance Board.

Over the last few years, a new initiative around housing and homelessness has emerged. It is the Montgomery County Your Way Home program. Your Way Home includes the CoC process and expands its efforts to end homelessness in the County.

The existence of the Your Way Home Call Center and the Your Way Home Housing Resource Centers has allowed our homeless Continuum of Care to move toward the preferred models of Centralized Intake, Coordinated Assessment, Prioritization based upon level of vulnerability, Rapid Re-Housing, and Homeless Diversion. The current Chair of the Montgomery County Commissioners, as well as Your Way Home, has expressed interest in more housing for those re-entering the community from the county jail. The BH/DD supports this work and keeps MCES PATH staff connected to Your Way Home and the CoC.

### **Collaboration with Local Community Organizations**

The PATH program supports participants in accessing the following services through partnerships with community providers. Staff maintain existing relationships with existing providers, incorporate any new services for program participants as appropriate, and seek to identify and arrange service compacts with new providers offering services salient to the needs of program clients.

- Primary Health Care/Community Health Services – Program participants have a high incidence of undiagnosed, undertreated, or untreated medical issues, both chronic and acute. These individuals need access to health care providers that can identify and treat these conditions in order to prevent physical decompensation and avoidable medical hospital re-admissions. The effective treatment and management of these conditions and their symptoms is an essential component to increasing the prospects for successful community integration and the ability to obtain and maintain a stable residence.

- Mental Health Services – Participants are connected with resources that assess the type, scope, and severity of psychiatric issues, as well as a range of community-based treatment, crisis intervention, and inpatient care if needed. These services are critical in increasing the prospect for successful community re-integration, stability, and self-efficacy of the individual, as well as decreasing unnecessary psychiatric hospital recidivism and symptom exacerbation.
- Substance Abuse Services – Co-occurring drug and alcohol problems may limit participants’ housing options and affect the continued availability of adequate housing. The program partners with providers of assessment, detox, rehabilitation, treatment, and support services for participants.
- Peer Support – The program promotes peer support as a vehicle for increased social inclusion in the community of individuals in recovery from mental and substance use challenges. This is achieved by engaging participants with providers who offer certified peer specialists as well as peer-led services.
- Income and Health Insurance Maintenance – Returning offenders incarcerated for more than a month who had been receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) need help restoring these benefits, which may take several weeks. This program assists participants in re-establishing those benefits, applying for healthcare benefits, Supplemental Nutrition Assistance Program (SNAP), Veterans benefits, and other sources of income maintenance, if eligible. The program staff are connected to SSI/SSD Outreach Access and Recovery (SOAR) resources in the community.
- Education & Training – The program partners with community organizations that can assist participants in meeting educational and vocational training objectives to enhance their long-term economic self-sufficiency.
- Employment –The program encourages individuals to explore full or part-time employment. Montgomery County has Career Centers located at several of the mental health care provider agencies, and the PATH program encourages participants to use services there.

Coordination and collaboration with other community outreach resources is achieved through:

- Participation in coordinative entities such the Montgomery County Community Support Program (CSP), Moving Agencies toward Excellence (MAX), Intercommunity Council of Norristown (ICN), the Montgomery County Joint Providers Group, the Montgomery County Forensic Coalition, the Norristown Hub, and the Lower Merion Mental Health Alliance.
- Close working relationships are also maintained with the four base service units serving Montgomery County: Community Behavioral Health, Creative Health, Northwestern Human Services, and the Penn Foundation.

- MCES JRS staff also liaise with other behavioral health providers serving program eligible individuals (e.g., Ron Lewis Associates).

## **Service Provision**

The Department complies with all State and Federal regulations governing the confidentiality of Substance Abuse and Mental Health records. The PATH program maintains confidentiality of the individuals records via a secured Electronic Medical Records system or EMR. Physical charts and documents are housed in a locked and secured area of the department. PATH/MCES has confidential releases for Behavioral Health, Substance Abuse and HIV. All releases are available upon request. MCES will adhere to all state and federal provisions regarding client privacy and confidentiality. As a covered program PATH 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. MCES policy incorporates these provisions and provides procedures and documentation for information clients of their rights, securing their consent, and recording when consent is withheld or unavailable. All MCES personnel receive re-education on confidentiality and privacy policies annually.

The population served by this program are PATH eligible individuals who are involved with the Criminal Justice System. The lack of adequate housing can delay an individual's discharge from incarceration, increase the length of incarceration, or deny a person bail (for individuals at the Magisterial District Court Level). During a recent study in Montgomery County the average length of stay in number of jail days for people who experience Serious Mental Illness (SMI) totaled 230 days verses the general population which averaged 72 days. On average, people with SMI are likely to remain in jail nearly 3.2 times longer than people without SMI. Individuals who are incarcerated and facing the increased stress of homelessness upon release are at a high risk for an increase in challenging symptoms, hospitalization, or re-incarceration. Without stable housing, individuals cannot be approved for a "home plan" by Probation/Parole and "max out" their entire sentence with little chance for parole regardless of good behavior, or positive strides the individual may have made toward their recovery while incarcerated.

PATH participants are challenged with serious mental illness, co-occurring substance abuse, and are homeless or at imminent risk of homelessness. People who are homeless or close to becoming homeless have serious multiple challenges and unmet service needs that must be addressed to ameliorate the deleterious impact of their situation.

The behavioral health system in Montgomery County is strong in terms of a variety of resources. However, a gap in services does exist for the criminal justice population. Understanding and navigating the criminal justice system requires expertise and, because many provider staff strive to be well-trained generalists, their staff do not have the time to dedicate to becoming experts at serving individuals in the criminal justice system. This expertise, when developed, is requisite to creating a path that diverts individuals from the criminal system. The PATH Forensic Case Management service is a key service in filling that gap in Montgomery County. MCES JRS

prioritizes PATH eligible individuals who are involved with the criminal justice system for case management services.

Both the BH/DD and MCES have a strong commitment to the provision of training opportunities for the mental health community. The program makes full use of free training offered by the BH/DD and fee-based trainings offered by Eagleville Hospital (substance abuse) and Horsham Clinic (mental illness).

PATH staff benefit from the Trauma Informed Services initiative, which has been underway at MCES for the past four years. MCES employs an individual-oriented, trauma-aware recovery model, and provides frequent educational opportunities for staff to engage in meaningful dialogue about best practices. This enables PATH staff to provide trauma sensitive best practices to individuals who have a serious mental illness and are experiencing homelessness.

The Department helps to connect individuals with Medicaid using COMPASS in coordination with MCCF to get individual's benefits prior to release at MCCF. These efforts also include connecting individuals with the traditional community-based services and non-specialized case management services once their legal status is resolved or stabilized.

## **Data**

Relative to participation in the CoC, BH/DD has been a participant in the County's HMIS system from its beginning over a decade ago. The system is coordinated by the County's Dept. of Housing and Community Development (HCD) using software from Clarity Human Services. BH/DD and HCD have collaborated to establish the PATH program as a user in the HMIS system. PATH data is captured in HMIS. HCD provides ongoing training for MCES staff in the use of the HMIS system. MCES staff also utilizes training offered by the Commonwealth of Pennsylvania. The PATH HMIS Director is Emma Hertz who is a HCD staff person.

## **Alignment with PATH Goals**

Program services provided using PATH funds will target those incarcerated in the county prison, street outreach and case management as a priority service and maximize serving the most vulnerable adults who are literally and chronically homeless. Prison and street outreach includes working with homeless shelters, missions, and other organizations potentially serving program eligible.

## **Alignment with State Mental Health Services Plan**

MCES works with BH/DD to assure that all the 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.

MCES works with the DCORT coordinator at the BH/DD office in preparation to utilize the existing Disaster Behavioral Health Plan for any potential disasters or emergency situations. MCES integrates disaster preparedness and emergency planning into our continuity of care planning and facilitates updating and testing of emergency response plans.

### **Alignment with State Plan to End Homelessness**

MCES JRS utilizes PATH funds to provide case management services for the most vulnerable adults who are literally and chronically homeless and who are involved with the criminal justice system. The service targets and prioritizes individuals who meet these criteria and are in jails, prisons, hospitals, shelters or any community setting in which they are located.

### **Other Designated Funds**

MCES JRS receives some block grant funding to help support the administrative, overhead and some operational costs of the PATH program.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

The Montgomery County Housing and Community Development Department is currently contracted with a service provider for a Your Way Home Public Benefits Specialist. The Public Benefits Specialist is currently completing their SOAR training and will be working with homeless individuals helping them connect to mainstream benefits and resources. The Public Benefits Specialist will provide personal navigation services to clients assisting them in applying for benefits for which they are eligible, including those available through SOAR. MCES –JRS has not had any clients receive these SOAR services as of this date due in part to the start status of this program.

### **Housing**

Returning prisoners face many barriers in the private rental market. These include affordability, poor credit backgrounds, and criminal history, among other issues. The program partners with providers to assist participants in overcoming these obstacles by locating and securing decent, affordable housing. The program develops relationships with landlords to facilitate better access to open units and to identify landlords willing to rent, on a permanent basis, to individuals who may have criminal justice involvement. Additionally the PATH staff work with the BH/DD in accessing any and all new housing initiatives that are developed for the mental health population through Medicaid reinvestment funds or other County resources.

Transitional housing provides an intensive, structured living arrangement for adults receiving assistance in developing and utilizing daily living skills such as grocery shopping, meal planning and preparation, personal hygiene habits, cleaning, laundry, budgeting and medication

management 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 the result of family conflict, the reluctance of family members to welcome an offender back into their lives, or the lack of an immediate family, participants need immediate housing upon release as well as access to shelter on an emergency basis if their ongoing residential arrangements are disrupted. This program assists individuals connect with resources that may be available relating to emergency/short-term housing.

Homeless veterans continue to be actively sought out in staff outreaching and engaging them into participation in PATH services. Homeless Veterans are disproportionately represented in both the homeless and incarcerated populations and are given specific focus by the program. The program continues to attempt to make full use of the extensive resources and support that the Veterans Administration (VA) has for Veterans through community partners and directly to Veterans facing homelessness.

The program informs any Veteran who is homeless or at imminent risk of becoming homeless of the VA's "Make the Call to 877-4AID-VET (424-3838)" initiative connects callers 24/7 with VA's services to overcome or prevent homelessness for Veterans. Program staff identify homeless Veterans eligible for VA Health Care Services, who require case management services in order to obtain and sustain independent community housing, and who meet the VA definition of homelessness by either:

- Lacking a fixed, regular, adequate night-time residence or
- Identifying his or her primary residence as a shelter, welfare hotel, transitional or temporary housing facility, or public or private place not designed for, or ordinarily used as, a regular sleeping accommodation

PATH staff assists eligible homeless Veterans to apply for HUD-VASH (Housing and Urban Development – VA Supportive Housing) vouchers which targets vulnerable Veterans with medical, mental health, and/or substance use disorders. Special focus is given to 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 a Coordinated Entry program for homeless individuals. MCES JRS collaborates with the Your Way Home program on a routine basis to help homeless individuals secure housing through this program.

## **Justice Involved**

MCES has a long history in jail diversion efforts in regard to individuals with serious mental illness who have criminal justice contact as a result of their illness. MCES has incorporated the Sequential Intercept Model into its JRS planning and programming. This background provides the foundation for the current program. MCES gives operational priority to preventing initial involvement of eligible individuals with the criminal justice system and deterring re-involvement of eligible individuals.

## **Staff Information**

The PATH program provides case management that engages individuals and prepares them to achieve the goals of increased sufficiency, stability, and greater self-determination which supports the participants to obtain and maintain permanent housing. Barriers to housing are identified and addressed by the individual and their PATH Case Manager as they work together in securing appropriate housing opportunities as well as ongoing supports that assists PATH participants in maintaining wellness and retaining housing.

The PATH Program is managed by the MCES Forensic Case Management Department and provides a wide range of outreach and engagement services in a person-centered, trauma-informed manner to any PATH eligible individuals who are involved with the criminal justice system. Services are geared to individuals who are incarcerated, but may also be provided to individuals who are in the community, inpatient hospital environment, and outpatient settings who are homeless or near homeless and involved with the criminal justice system. The program provides flexible, consumer-directed and recovery-oriented services to meet participants where they are in their recovery. Motivational Interviewing techniques are used in both the outreach/engagement and ongoing case management services provided to participants in order to connect and then maintain ongoing engagement. Also included in the service are elements of Critical Time Intervention (CTI) to ensure that both housing and future support needs are met.

MCES JRS personnel take advantage of all county and state level training and educational opportunities to augment their familiarity with and sensitivity to pertinent age, gender, racial/ethnic, disability, lesbian, gay, bisexual, transgender and differences of participants. This includes MCES mandated training in cultural competence and health disparities.

Staff have been trained by the following agencies to assist the Department in Cultural Competence:

- Mazzone Center Training on LGBTQ “knowledge to empower the individuals we serve, as well as to help providers and professionals of all kinds to better understand and advocate for the needs of LGBTQ people.”
- Center for Urban Community Services – Housing Based Case Management
- “Just Culture” Training
- MCES Annual Requirements – staff must demonstrate cultural competence
- Aging and Adult Protective Service Agents - Pennsylvania Department of Aging
- Participated in PATH and SOAR webinars

- Case Management Training
- Other trainings include: Forensic, Behavioral Health, Mental Health Law, Criminal Law, Substance Use & Abuse, etc.

The PATH Case Managers and Team Leader works with the law enforcement and criminal justice community (i.e. bail, Probation/Parole, Court Orders, etc.). The following is a description of the case manager and team leader:

**Case Manager:** A forensic mental health specialist who conducts outreach within the Montgomery County Correctional Facility (MCCF) to identify, assess and advocate for any PATH eligible individuals who are incarcerated and is facing homelessness upon release, especially those who are “maxing out” because of the lack of adequate housing.

**Team Leader:** A behavioral health specialist who supervises forensic case managers. In addition the Team Leader serves as the Montgomery County Behavioral Health Court (BHC) Liaison to advocate in the diversion of individuals from incarceration through treatment and support. The Team Leader ensures that all PATH eligible individuals who are involved with the Criminal Justice System receive the appropriate treatment and service coordination.

**Departmental/Staff Demographic Information:**

Female:	3
Male:	4
African American:	1
Caucasian:	6

MCES is committed to hiring qualified individuals who have lived experience of mental health challenges and/or people who have experienced homelessness for the purpose of those staff members sharing their personal stories as a means of inspiration for the service participants. Currently one staff member in the PATH program has homelessness experience.

**Client Information**

The population served by this program includes individuals who are homeless or who are at imminent risk of homelessness, and who have involvement in the criminal justice system. Individuals who are currently incarcerated and who have no permanent address are especially at risk for homelessness upon their release from corrections, and would be served through this program by receiving case management services to connect them with housing, as well as to ensure that their level of functioning in the community is sufficient to maintain their housing. Assessments are conducted to determine barriers that may impede the acquisition or retention of housing. The PATH Forensic Case Management staff continue to support participants in overcoming those barriers.

Statistics identifying potential PATH participants who are incarcerated can be gleaned by examination of individuals who are currently being held at the Montgomery County Correctional Facility (MCCF) who have been diagnosed with a mental illness and who are serving a maximum sentence for no reason other than that they have no permanent address.

The lack of adequate housing can delay an individual's discharge from incarceration, increase the length of incarceration, or, for individuals at the Magisterial District Court level or preliminary arraignment, deny a person bail. Incarcerated individuals are facing increased stressors and stigmatization of incarceration. This stigma, coupled with the challenges of their mental health issues, becomes overwhelming for many individuals.

Those currently incarcerated and with no permanent address are at a higher risk for an increase in challenging symptoms, hospitalization, or re-incarceration. Without stable housing, the individual cannot be approved for a "home plan" by Probation/Parole and "maxes out" serving their entire sentence with little chance for parole. This may occur regardless of good behavior, mitigating circumstances, or any positive strides they may have made toward their recovery while incarcerated.

The program tracks and reports client data in terms of race/ethnicity, gender, and sexual orientation. As available, data are gathered from MCCF records. As appropriate, program clients are asked to voluntarily self-report any information not otherwise available. Subpopulation data is only reported in the aggregate.

In the course of a year the PATH program will serve approximately 60 individuals.

From July 1, 2015 to April 1, 2016 we have 32 individuals enrolled in PATH services, with one individuals being "Homeless" and thirty-one individuals being "At Risk of Homelessness." Outreach efforts include; fourteen individuals on a targeted priority list, and over twenty inmates per month that could potentially be "homeless or at risk of homelessness."

## **Consumer Involvement**

A Certified Peer Specialist (CPS) who works with the BH/DD was involved in the planning and development of the proposed PATH services program at MCES. This CPS brought the perspective of a family member and that of a person with lived experience as well as knowledge of PATH services to the planning process.

The program has benefited the constant engagement of a Case Manager who was a Certified Peer Specialist (CPS). This Case Manager had direct experience with personally being at imminent risk for homelessness in the past. This position is presently vacant and MCES plans to fill it in the coming program year.

The BH/DD contracts with the Montgomery County Consumer Satisfaction Team (CST), a provider organization which employs individuals in recovery to evaluate the satisfaction of the PATH participants in terms of the services they receive from the PATH program.

The success of this program is contingent on many factors, one of which being an effective evaluation and meaningful integration of consumers and family members in the execution of this program and its activities. MCES values the role of consumers in its overall mission implementation and governance. A member of MCES's Board of Directors is a consumer, and her input is vital to the programmatic process. Representatives from MCES are regularly in attendance at monthly meetings held by the Montgomery County Community Support Program (CSP), an organization that fosters positive dialogue and collaboration between consumers and providers.

### **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.

The program promotes clients' use of health care services through information-sharing, referral, and advocacy by developing a plan to decrease disparities in access, service use, and outcomes in comparison to the general population. It identifies sources of health care, eligibility requirements, and potential obstacles related to disability, language, and transportation.

Since the program's inception, MCES Case Managers served PATH-eligible individuals between the ages of 18-24, and others whose ages ranged anywhere from 25-34. MCES will continue, in the coming year, to provide PATH-related services to an equivalent if not increasing number of individuals in this age group. MCES coordinates care for this population with Central Behavioral Health's (CBH) Transition-Age Case Management program once any pending criminal charges are resolved/abated. Central's Transition-Age Case Management program seeks to equip and empower young adults and help them balance desired independence with any necessary support services. The YALE (Young Adult Learning Environment) program also has a residential option that may be appropriate for certain PATH-eligible individuals who are transition-age.

As stated above: Staff have been trained by the following agencies to assist the Department in Cultural Competence:

- Mazzoni Center Training on LGBTQ "knowledge to empower the individuals we serve, as well as to help providers and professionals of all kinds to better understand and advocate for the needs of LGBTQ people."
- Center for Urban Community Services – Housing Based Case Management
- "Just Culture" Training
- MCES Annual Requirements – staff must demonstrate cultural competence
- Aging and Adult Protective Service Agents - Pennsylvania Department of Aging
- Participated in PATH and SOAR webinars
- Case Management Training



Montgomery County  
Montgomery County Emergency Service, Inc.  
Justice Related Services Department  
FY 2016-2017 PATH Budget

	<b>Annual Salary</b>	<b>PATH-funded FTE (hours/week)</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Staff / Positions</b>				
Case Manager	36,590	1.5 FTE	54,852	54,852
Team Leader	64,979	.08 FTE	4,971	4,971
Clerk	25,209	.08 FTE	1,891	1,891
<b>Sub-Total</b>			61,714	61,714
<b>Fringe Benefits</b>				
Employer Match Taxes			4,752	4,752
Insurance and Other			14,935	14,935
Retirement			1,790	1,790
<b>Sub-Total</b>			21,477	21,477
<b>Other</b>				
Staff Development			1266	1266
Advertising and office			395	395
Communications			1346	1346
Accounting and Legal			300	300
Engagement Supplies			500	500
<b>Sub-Total</b>			3807	3807
<b>Travel</b>				
Client Transportation			800	800
Automobile Leased/Purchased			315	315
Automobile Insurance			1083	1083
Automotive Repairs & Maintenance			240	240
Staff Travel			784	784
<b>Sub-Total</b>			3,222	3,222
<b>Indirect Costs</b>				
Administrative costs 4%			3608	3608
<b>Sub-Total</b>			3,608	3,608
<b>Total PATH Budget</b>			93,828	93,828

42. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>a. Personnel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>c. Travel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>d. Equipment</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>e. Supplies</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>f. Contractual</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>g. Construction (non-allowable)</b>				
<b>h. Other</b>	\$ 847,468	\$ 289,639	\$ 1,137,107	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 847,468	\$ 289,639	\$ 1,137,107	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 847,468	\$ 289,639	\$ 1,137,107	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
<b>j. Indirect Costs (Administrative Costs)</b>	\$ 0	\$ 0	\$ 0	
<b>k. Grand Total (Sum of i and j)</b>	\$ 847,468	\$ 289,639	\$ 1,137,107	

Source(s) of Match Dollars for State Funds:

Philadelphia Co overall 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 ended in 2014:	0	Number of PATH-funded consumers assisted through SOAR:	0

**PHILADELPHIA COUNTY**  
**1101 Market Street**  
**7th Floor**  
**Philadelphia, PA 19109**

FY 2016-2017 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:

<b>Project</b>	<b>Federal Allocation</b>	<b>State Allocation</b>	<b>Total Allocation</b>
Project Home - Outreach	\$ 123,506	\$ 0	\$ 123,506
RHD - Kailo Haven	\$ 385,827	\$ 0	\$ 385,827
RHD - La Casa	\$ 338,135	\$ 0	\$ 338,135
RHD - Cedar Park	\$ 0	\$ 289,639	\$ 289,639
<b>Total</b>	<b>\$ 847,468</b>	<b>\$ 289,639</b>	<b>\$ 1,137,107</b>

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 and Supervisory 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 \$50 million 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 homeless mentally ill 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 are co-chairs of the local 100K Homes efforts to prioritize resources for the most vulnerable persons living on our streets. 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 2015 and 2016, 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. 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. 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 (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 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.

- 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. 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 Boarding Homes, Safe Havens 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 Supportive Housing, the Mayor's Point of contact regarding the planning, implementation, and oversight of homeless service initiatives.

- Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with five social service agencies for the provision of 234 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. 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 234 existing 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. This number is decreased from last year due to the VA Safe Haven closure. The larger residential system and continuum of resources have maintained an average occupancy level of 91% during CY 2015.

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 OMH/MR 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 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.

The county program does provide input to the Consolidated Plan, and its PATH activities are consistent with the plan goals. Other agencies of the city government have point responsibility for development and updates related to this plan.

### 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 27<sup>th</sup>, 2016 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 528 persons were sleeping on the streets of Philadelphia, while another 177 persons were in overnight drop in centers. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but nevertheless a gap still remains. Increase in persons sleeping on the streets is in part due to Outreach teams covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments in 2015 were \$733/month and Fair Market Rates are at \$1,103. 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 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 are also involved in the planning and beginning stages of receiving Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose.

### 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 a robust system and 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** - Our Outreach Staff currently uses a handheld computer devices for '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. New and upgraded technologies are being identified at this time to enhance real time data for when the new HMIS system is ready this year.

Philadelphia County is currently in transition to a new HMIS system. When this system is ready and available, outreach data will be migrated into the new system. Safe Haven and Outreach staff will use the new system to capture real time data. The new system is expected to be finalized in 2016 giving us greater access to data within the Philadelphia County. Outreach will be fully utilizing HMIS by July 1, 2016 and Safe Havens by January 1, 2017. The PATH HMIS Lead and Systems Administrator for these programs is Nancy Guarino, of the Office of Supportive Housing.

**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 create a Priority List of people who are then able to access Housing First Services and housing, Safe Havens or any other housing options available through PHA or DBH reinvestment dollars. We have targeted

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 are starting to work together using a "Boot Camp" 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.

**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 when the Pope visited Philadelphia September 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: PHA vouchers, 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 Outreach Team to provide more support to people who need it and are not in typically seen locations of Center City.

Upon opening a Safe Haven for 10 male Transition Age Youth (TAY), and as we are in the process of transitioning another Female Transition Age Youth Safe Haven, we are seeing

approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs. Staff are working on training and supports for Outreach and Safe Havens to address needs of this population.

**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 all 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.

**SSI/SSDI Outreach, Access, Recovery (SOAR)** - Since December 2007, the Homeless Advocacy Project (HAP) in partnership with DBHIDS, has secured federal Supplemental Security Income (SSI) disability benefits for more than 1,200 homeless individuals on an expedited basis through its SOAR (SSI/SSDI Outreach, Access, Recovery) Project. With an approval rate of 96% and an average processing time of just over one month, HAP's project is the most successful SOAR initiative in the country. The Outreach teams partner with HAP and Case Managers on SOAR applications and all Case Managers have been trained on the SOAR process.

Through RHD's three PATH Funded programs, we were able to enroll 5 new SOAR participants, with an eligibility result of 60%. Project Home's Outreach workers are not able to directly enroll an individual in SOAR, and therefore had no new enrollees. However, Project Home is able to refer an individual to a secondary program to become enrolled in SOAR, but there is no current mechanism for tracking that specific flow of referrals. No additional PATH personnel were trained last year.

**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 allocates 200 Housing Choice Vouchers a year to address issues of homelessness in the community. The MOU between the City and the Housing Authority remains in effect though PHA is struggling to make this commitment due to decreased funding.
- Exclusive access to openings in the city's inventory of 545 Housing First options, operated by Horizon House and Pathways to Housing PA.
- 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.

**Coordinated Entry** - Project Home 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 Subsidies 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.

**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.

**Client Information** - The projected number of adults clients to be contacted using PATH funds is 700 persons. The majority of those will be through outreach services, while 300 will be through the residential programs. The projected number of adult clients to be enrolled using PATH funds will be 350 persons. All persons admitted to residential services (approximately 300), will be considered PATH enrolled clients and another 50 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:

- 80.1% had both co-occurring substance abuse and behavioral health issues
- 6.1% veterans
- 63.4% black/African-American
- 29.2% white
- 73% male
- 14.9% between the ages of 18-29
- 19.2% between the ages of 30-39
- 23.1% between the ages of 40-49
- 29.8% between the ages of 50-59
- 13.1% 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.

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 73.3% male and 63.4% 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. In 2011, DBHIDS outreach services added 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

14.9% of the street population are between the ages of 18-29, and in July 2015 the RHD La Casa Safe Haven was transitioned to serve the TAY population to better meet the needs of males within this age group and to create a bridge to Permanent Supported Housing. In the summer of 2016 a new Safe Haven will be opened for transition age women. Currently, the

funding received from PATH is expected to serve 20 transition age youth in the La Casa setting as well as up to 10 PATH enrolled clients within this age group. The total amount of PATH funds expected to be expended on services for the TAY population is \$338,135. This money goes towards efforts to create a Safe Haven for TAY Males, to provide them a place to reside, develop important life skills and act as a stepping stone to permanent supportive housing.

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.

**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 34 direct care staff in three residential programs and 5 outreach staff. All of the staff listed on the PATH 2016-2017 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

<b>Project Home Outreach</b>	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
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
<b>Subtotal</b>	<b>\$139,213</b>			<b>\$123,506</b>

<b>RHD - Kailo Haven</b>	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
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
Resident Advisor	\$21,840	100%	\$21,840	\$21,840
<b>Subtotal</b>	<b>\$385,827</b>			<b>\$385,827</b>

<b>RHD - Cedar Park</b>	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
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
<b>Subtotal</b>	<b>\$289,639</b>			<b>\$289,639</b>

<b>RHD - La Casa</b>	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
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
<b>Subtotal</b>	<b>\$338,135</b>			<b>\$338,135</b>

<b>Fringe Benefits</b>				
RHD Employees (30%)	\$301,980	0%	\$0	\$0
Project Home Employees (25%)	\$22,419	0%	\$0	\$0
<b>Subtotal</b>	<b>\$324,399</b>			<b>\$0</b>

<b>Grand Total</b>				<b>\$1,137,107</b>
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43. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

For source of match dollars for state funds: Project HOME will receive \$123,506 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	350	Estimated Number of Persons to be Enrolled:	350
Estimated Number of Persons to be Contacted who are Literally Homeless:	350		
Number Staff trained in SOAR in Grant year ended in 2014:	0	Number of PATH-funded consumers assisted through SOAR:	0

**Project HOME: Street Outreach**  
**1515 Fairmount Avenue**  
**Philadelphia, PA 19130**  
**2016-2017 PATH Intended Use Plan**  
**Philadelphia County**

**Local Provider Description** - The mission of the 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.

More detailed information regarding Project Home can be found at their Web site, [www.projecthome.org](http://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.

<b>Project</b>	<b>Federal Allocation</b>	<b>State Allocation</b>	<b>Total Allocation</b>
Project Home - Outreach	\$ 123,506	\$ 0	\$ 123,506
<b>Total</b>	<b>\$ 123,506</b>	<b>\$ 0</b>	<b>\$ 123,506</b>

**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 Home executive 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 will also be working with the CoC around a new collaborative "Boot Camp" to end homelessness.

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 or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinators are co-chairs of the local 100K Homes efforts to prioritize resources for the most vulnerable persons living on our streets. 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 2015-2016 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. 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 Home also 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.

- 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.

*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.

- Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with five social service agencies for the provision of 234 entry level beds designated specifically for homeless persons with mental illness or co-occurring disorders. 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:* The DBHIDS – Office of Mental Health continues to centrally gate-keep virtually all of the current mental health residential slots. This includes the 234 existing 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. This number is decreased from last year due to the VA Safe Haven closure. The larger residential system and continuum of resources have maintained an average occupancy level of 91% during CY 2015.

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). 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.

### 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 27<sup>th</sup>, 2016 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 528 persons were sleeping on the streets of Philadelphia, while another 177 persons were in overnight drop in centers. There has been a partnership with the Philadelphia Housing Authority to address the gap, but a gap still remains. Increase in persons sleeping on the streets is in part due to Outreach teams covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments in 2015 were \$733/month and Fair Market Rates are at \$1,103. 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 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 are also involved in the planning and beginning stages of receiving Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose.

### 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. With a robust system and 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** - Our Outreach Staff currently uses a handheld computer devices for '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. New and upgraded technologies are being identified at this time to enhance real time data for when the new HMIS system is ready this year.

Philadelphia County is currently in transition to a new HMIS system. When this system is ready and available, outreach data will be migrated into the new system. Safe Haven and Outreach staff will use the new system for real time data. The new system is expected to be finalized in 2016 giving us greater access to data within the Philadelphia County. Outreach will be fully utilizing HMIS by July 1, 2016. The PATH HMIS Lead and Systems Administrator for these programs is Nancy Guarino, of the Office of Supportive Housing.

**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 create a Priority List of people who are then able to access Housing First Services and housing, Safe Havens or any other housing options available through PHA or DBH reinvestment dollars. We have targeted 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 its various stakeholders are starting to work together using a "Boot Camp" 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.

**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 when the Pope visited Philadelphia September 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: PHA vouchers, 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 Outreach Team to provide more support to people who need it and are not in typically seen locations of Center City.

Upon opening a Safe Haven for 10 male Transition Age Youth (TAY), and as we are in the process of transitioning another Female Transition Age Youth Safe Haven, we are seeing approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs. Staff are working on training and supports for Outreach and Safe Havens to address needs of this population.

**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.

**SSI/SSDI Outreach, Access, Recovery (SOAR)** - Since December 2007, the Homeless Advocacy Project (HAP) in partnership with DBHIDS, has secured federal Supplemental Security Income (SSI) disability benefits for more than 1,200 homeless individuals on an expedited basis through its SOAR (SSI/SSDI Outreach, Access, Recovery) Project. With an approval rate of 96% and an average processing time of just over one month, HAP's project is the most successful SOAR initiative in the country. The Outreach teams partner with HAP and Case Managers on SOAR applications and all Case Managers have been trained on the SOAR process. Project Home's Outreach workers are not able to directly enroll an individual in SOAR, and therefore had no new enrollees. However, Project Home is able to refer an individual to a secondary program to become enrolled in SOAR, but there is no current mechanism for tracking that specific flow of referrals. No additional PATH personnel were trained last year.

**Access to Housing** - Outreach participants have exclusive access to the DBH safe haven system that includes all 3 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 allocates 200 Housing Choice Vouchers a year to address issues of homelessness in the community. The MOU between the City and the Housing Authority remains in effect though PHA is struggling to make this commitment due to decreased funding.
- Exclusive access to openings in the city's inventory of 545 Housing First options, operated by Horizon House and Pathways to Housing PA.
- 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.

**Coordinated Entry** - Project Home 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 Subsidies 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.

**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.

**Client Information** - The projected number of adult clients to be contacted by Project Home using PATH funds will be 350 persons. The projected number of adult clients to be enrolled using PATH funds will be 350 persons. Fifty of the 300 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:

- 80.1% had both co-occurring substance abuse and behavioral health issues
- 6.1% veterans
- 63.4% black/African-American
- 29.2% white
- 73% male
- 14.9% between the ages of 18-29
- 19.2% between the ages of 30-39
- 23.1% between the ages of 40-49
- 29.8% between the ages of 50-59
- 13.1% 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.

### **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 73.3% male and 63.4% 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. In 2011, DBHIDS outreach services added 2 categories to the

gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

14.9% of the street population is between the ages of 18-29, and in July 2015 Outreach teams were able to access a newly transitioned Safe Haven to for Transition Aged Males. There is present planning for a Safe Haven for Transition Aged Females for summer 2016.

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.

**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 2016-2017 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

<b>Project Home Outreach</b>	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
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
<b>Total</b>	<b>\$139,213</b>			<b>\$123,506</b>
<b>Fringe Benefits</b>				
RHD Employees (30%)	\$301,980	0%	\$0	\$0
<b>Subtotal</b>	<b>\$301,980</b>			<b>\$0</b>
<b>Grand Total</b>				<b>\$123,506</b>

44. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

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

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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g. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Resources for Human Development: Cedar Park**  
**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. 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 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.

Cedar Park will receive \$289,639 from PATH funding; all of which is allocated from the state.

<b>Project</b>	<b>Federal Allocation</b>	<b>State Allocation</b>	<b>Total Allocation</b>
RHD - Cedar Park	\$ 0	\$ 289,639	\$ 289,639
<b>Total</b>	<b>\$ 0</b>	<b>\$ 289,639</b>	<b>\$ 289,639</b>

**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. RHD is a key participant in the city’s plans to end homelessness including serving on the 10 year Plan committee, participating and supporting the 100K Homes efforts and working closely with DBH to expand their inventory of PSH.

In addition, RHD and Cedar Park work very closely with Philadelphia’s Department of Behavioral Health and Intellectual disAbilities (DBHIDS). DBHIDS allocates \$50 million 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 RHD sit on the local CoC Board or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinators are co-chairs of the local 100K Homes efforts to prioritize resources for the most vulnerable persons living on our streets. Persons who receive PATH funded services are a high priority for CoC resources.

**Collaboration with Local Community Organizations** - The designated PATH providers and Cedar Park 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 managed 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 a significant inventory of Permanent Supportive Housing and is recipients of numerous McKinney/COC grants. RHD also works with Horizon House and Pathways to Housing to identify people with the highest need for housing services through their programs.

**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.

- Street & Shelter Outreach

PATH funded outreach services are afforded referral access to Boarding Home, Safe haven, café, 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.

*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.

- Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with five social service agencies for the provision of 234 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. 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 234 existing 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. This number is decreased from last year due to the VA Safe Haven closure. The larger residential system and continuum of resources have maintained an average occupancy level of 91% during CY 2015.

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, OSH, DBHIDS and Housing First Providers to secure Permanent Supported Housing for all eligible residents.

### 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 27<sup>th</sup>, 2016 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 528 persons were sleeping on the streets of Philadelphia, while another 177 persons were in overnight drop in centers. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but nevertheless a gap still remains. Increase in persons sleeping on the streets is in part due to Outreach teams covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments in 2015 were \$733/month and Fair Market Rates are at \$1,103. 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 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 are also involved in the planning and beginning stages of receiving Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose.

### Evidenced Based Practices

In 2010, DBHIDS began supporting 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 a robust system and 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.

**Data** - The plan for FY16 is to begin to plan to migrate Safe Haven data (including Cedar Park) into the HMIS system once it is available and implemented through the Office of Supportive Housing. This is expected to be finalized in 2016. The city is changing vendors and when the new system is in place we will be able to capture and share outreach data.

Philadelphia County is currently in transition to a new HMIS system. When this new system is ready and available, Safe Havens will migrate the outreach data. Outreach teams already use handheld computers to be able to enter data at the time of an encounter

making real time data available and technology is being identified for better and timelier data entry. The Safe Havens do use real time data and are in the midst of transitioning to an all electronic process, ending the reliance of paper. Due to the local behavioral health managed care organization we have integrated data and outcomes and operational processes, with the local behavioral Medicaid managed care system. Safe Havens plan on fully integrating and using the new PATH HMIS system by January 1, 2017. The PATH HMIS Lead and Systems Administrator for these programs is Nancy Guarino, of the Office of Supportive Housing.

**Alignment with PATH Goals** - The City uses Outreach data to determine create a priority list based on chronicity and vulnerability. Those seen to be highest on the priority list are able to access Housing First Services, Cedar Park or any other housing options available through PHA or DBH reinvestment dollars. We have targeted people with the most need and chronicity to access valuable resources for housing and to end homelessness.

Data that is gathered by Project Home goes into the main Mental Health Residential data system, which is accessed when determining whether to place a client into Cedar Park, a different Safe haven or an alternative location, to ensure that those with the highest needs are not only being served but that their specific needs are catered to and met through their housing options. At DBHIDS we continually work together with different programs and organizations to ensure that our efforts are not in a vacuum but instead are brought together to work in a systematic manner. The City, Outreach and its various stakeholders are starting to work together using a “Boot Camp” 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.

Additionally, it should be noted that DBHIDS has a Safe Haven reporting process that is shared with providers at a monthly meeting. While not all Safe Havens are PATH funded, all Safe Havens collaborate together through the County Homeless Coordinator, two county Program Analysts and a county Supervisor to coordinate care for their residents with the treatment and supportive housing systems.

**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 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 when the Pope visited Philadelphia September 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 of DBHIDS’ reinvestment funds are earmarked for our housing programs which includes tenant based

rental assistance for persons 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: PHA vouchers, 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.

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 Outreach Team to provide more support to people who need it and are not in typically seen locations of Center City.

### **Other Designated Funds**

DBHIDS spends \$50 million 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.

**SSI/SSDI Outreach, Access, Recovery (SOAR)** - Since December 2007, the Homeless Advocacy Project (HAP) in partnership with DBHIDS, has secured federal Supplemental Security Income (SSI) disability benefits for more than 1,200 homeless individuals on an expedited basis through its SOAR (SSI/SSDI Outreach, Access, Recovery) Project. With an approval rate of 96% and an average processing time of just over one month, HAP's project is the most successful SOAR initiative in the country. The Outreach teams partner with HAP and Case Managers on SOAR applications and all Case Managers have been trained on the SOAR process.

Through RHD's three PATH Funded programs, we were able to enroll 5 new SOAR participants, with an eligibility result of 60%. One of those clients was enrolled in Cedar Park. No additional PATH personnel were trained last year.

**Access to Housing** - Outreach participants have exclusive access to the DBH Safe Haven system that include, Cedar Park and RHD's two other PATH funded residential programs.

Outreach participants and Cedar Park's residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which allocates 200 Housing Choice Vouchers a year to address issues of homelessness in the community. The MOU between the City and the Housing Authority remains in effect though PHA is struggling to make this commitment due to decreased funding.
- Exclusive access to openings in the city's inventory of 545 Housing First options, operated by Horizon House and Pathways to Housing PA.
- 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.

**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 Subsidies 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.

**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.

**Client Information** - The projected number of adult clients to be contacted using PATH funds is 700 persons. The majority of those will be through outreach services, while 300 will be through the residential programs. The projected number of adult clients to be enrolled using PATH funds will be 350 persons. All persons admitted to residential services (approximately 300), will be considered PATH enrolled clients and another 50

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, which are similar to the demographics of our RHD Safe Havens, as those in the Safe Havens are referred by Outreach contacts.

- 80.1% had both co-occurring substance abuse and behavioral health issues
- 6.1% veterans
- 63.4% black/African-American
- 29.2% white
- 73% male
- 14.9% between the ages of 18-29
- 19.2% between the ages of 30-39
- 23.1% between the ages of 40-49
- 29.8% between the ages of 50-59
- 13.1% 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.

Finally, The DBHIDS’ Office of Mental Health prepares an Annual Plan for Mental Health Services. On an annual basis, this plan is distributed to the public, the Community Support Program (CSP), and to 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. All DBHIDS services operated by RHD participate in the CST process, including Cedar Park. Safe Havens have access to Peer Specialists that come to the setting and participate with residents in a variety of ways and are based in interest and need. RHD 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.

### **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 73.3% male and 63.4% 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. In 2011, DBHIDS outreach services added 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

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.

**Budget Narrative** - The PATH Funds received are allocated for the salaries and benefits for 34 direct care staff in three residential programs. All of the staff listed on the PATH 2016-2017 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

<b>RHD - Cedar Park</b>	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
Program Manager	\$67,000	100%	\$67,000	\$67,000
Case Mgr	\$39,599	100%	\$39,585	\$39,599
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
<b>Subtotal</b>	<b>\$289,639</b>			<b>\$289,639</b>

<b>Fringe Benefits</b>				
Cedar Park Employees (30%)	\$115,748	0%	\$0	\$0
<b>Subtotal</b>	<b>\$115,748</b>			<b>\$0</b>

<b>Grand Total</b>				<b>\$385,827</b>
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2107 Tioga St  
Philadelphia, PA 19140

Provider Type: Community mental health center

Contact: Jim McPhail

PDX ID: PA-061

Contact Phone #: 2152258645

State Provider ID: 4261

Geographical Area Served: Southeast Region

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>a. Personnel</b>	\$ 0	\$ 0	\$ 0	
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No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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<b>b. Fringe Benefits</b>	0.00 %	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>c. Travel</b>	\$ 0	\$ 0	\$ 0	
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No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>d. Equipment</b>	\$ 0	\$ 0	\$ 0	
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No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>e. Supplies</b>	\$ 0	\$ 0	\$ 0	
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No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>f. Contractual</b>	\$ 0	\$ 0	\$ 0	
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No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>g. Construction (non-allowable)</b>	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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<b>h. Other</b>	\$ 0	\$ 0	\$ 0	
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No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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<b>j. Indirect Costs (Administrative Costs)</b>	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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<b>k. Grand Total (Sum of i and j)</b>	\$ 0	\$ 0	\$ 0	
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Source(s) of Match Dollars for State Funds:

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 ended in 2014:	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 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.

<b>Project</b>	<b>Federal Allocation</b>	<b>State Allocation</b>	<b>Total Allocation</b>
RHD - Kailo Haven	\$ 385,827	\$ 0	\$ 385,827
<b>Total</b>	<b>\$ 385,827</b>	<b>\$ 0</b>	<b>\$ 385,827</b>

**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. RHD is a key participant in the city’s plans to end homelessness including serving on the 10 year Plan committee, participating and supporting the 100K Homes efforts and working closely with DBH to expand their inventory of PSH.

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 representatives RHD sit on the local CoC Board or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinators are co-chairs of the local 100K Homes efforts to prioritize resources for the most vulnerable persons living on our streets. Persons who receive PATH funded services are a high priority for CoC resources.

**Collaboration with 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 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 a significant inventory of Permanent Supportive Housing and is recipients of numerous McKinney/COC grants. RHD also works with Horizon House and Pathways to Housing to identify people with the highest need for housing services through their programs.

**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.

- Street & Shelter Outreach

PATH funded outreach services are afforded referral access to Boarding Home, Safe haven, café, 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.

*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.

- Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with five social service agencies for the provision of 234 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. 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 234 existing 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. This number is decreased from last year due to the VA Safe Haven closure. The larger residential system and continuum of resources have maintained an average occupancy level of 91% during CY 2015.

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, OSH, DBHIDS and Housing First Providers to secure Permanent Supported Housing for all eligible residents.

### 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 27<sup>th</sup>, 2016 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 528 persons were sleeping on the streets of Philadelphia, while another 177 persons were in overnight drop in centers. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but nevertheless a gap still remains. Increase in persons sleeping on the streets is in part due to Outreach teams covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms.

There is also a severe gap in affordable housing in Philadelphia County. SSI payments in 2015 were \$733/month and Fair Market Rates are at \$1,103. 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 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 are also involved in the planning and beginning stages of receiving Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose.

#### Evidenced Based Practices

In 2010, DBHIDS began supporting 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 a robust system and 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.

**Data** - The plan for FY16 is to begin to plan to migrate Safe Haven data (including Kailo Haven) into the HMIS system once it is available and implemented through the Office of Supportive Housing. This is expected to be finalized in 2016. The city is changing vendors and when the new system is in place we will be able to capture and share outreach data.

Philadelphia County is currently in transition to a new HMIS system. When this new system is ready and available, Safe Havens will migrate the outreach data. Outreach teams already use handheld computers to be able to enter data at the time of an encounter making real time data available and technology is being identified for better and timelier

data entry. The Safe Havens do use real time data and are in the midst of transitioning to an all electronic process, ending the reliance of paper. Due to the local behavioral health managed care organization we have integrated data and outcomes and operational processes, with the local behavioral Medicaid managed care system. Safe Havens plan on fully integrating and using the new PATH HMIS system by January 1, 2017. The PATH HMIS Lead and Systems Administrator for these programs is Nancy Guarino, of the Office of Supportive Housing.

**Alignment with PATH Goals** - The City uses Outreach data to determine create a priority list based on chronicity and vulnerability. Those seen to be highest on the priority list are able to access Housing First Services, Kailo Haven or any other housing options available through PHA or DBH reinvestment dollars. We have targeted people with the most need and chronicity to access valuable resources for housing and to end homelessness.

Data that is gathered by Project Home goes into the main Mental Health Residential data system, which is accessed when determining whether to place a client into Kailo Haven, a different Safe haven or an alternative location, to ensure that those with the highest needs are not only being served but that their specific needs are catered to and met through their housing options. At DBHIDS we continually work together with different programs and organizations to ensure that our efforts are not in a vacuum but instead are brought together to work in a systematic manner. The City, Outreach and its various stakeholders are starting to work together using a “Boot Camp” 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.

Additionally, it should be noted that DBHIDS has a Safe Haven reporting process that is shared with providers at a monthly meeting. While not all Safe Havens are PATH funded, all Safe Havens collaborate together through the County Homeless Coordinator, two county Program Analysts and a county Supervisor to coordinate care for their residents with the treatment and supportive housing systems.

**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 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 when the Pope visited Philadelphia September 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: PHA vouchers, 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.

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 Outreach Team to provide more support to people who need it and are not in typically seen locations of Center City.

### **Other Designated Funds**

DBHIDS spends \$50 million 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.

**SSI/SSDI Outreach, Access, Recovery (SOAR)** - Since December 2007, the Homeless Advocacy Project (HAP) in partnership with DBHIDS, has secured federal Supplemental Security Income (SSI) disability benefits for more than 1,200 homeless individuals on an expedited basis through its SOAR (SSI/SSDI Outreach, Access, Recovery) Project. With an approval rate of 96% and an average processing time of just over one month, HAP's project is the most successful SOAR initiative in the country. The Outreach teams partner with HAP and Case Managers on SOAR applications and all Case Managers have been trained on the SOAR process.

Through RHD's three PATH Funded programs, we were able to enroll 5 new SOAR participants, with an eligibility result of 60%. One of those clients was enrolled in Kailo Haven. No additional PATH personnel were trained last year.

**Access to Housing** - Outreach participants have exclusive access to the DBH Safe Haven system that include, Kailo Haven and RHD's two other PATH funded residential programs.

Outreach participants and Kailo Haven's residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which allocates 200 Housing Choice Vouchers a year to address issues of homelessness in the community. The MOU between the City and the Housing Authority remains in effect though PHA is struggling to make this commitment due to decreased funding.
- Exclusive access to openings in the city's inventory of 545 Housing First options, operated by Horizon House and Pathways to Housing PA.
- 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.

**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 Subsidies 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.

**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.

**Client Information** - The projected number of adult clients to be contacted using PATH funds is 700 persons. The majority of those will be through outreach services, while 300 will be through the residential programs. The projected number of adult clients to be enrolled using PATH funds will be 350 persons. All persons admitted to residential services (approximately 300), will be considered PATH enrolled clients and another 50 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, which are similar to the demographics of our RHD Safe Havens, as those in the Safe Havens are referred by Outreach contacts.

- 80.1% had both co-occurring substance abuse and behavioral health issues
- 6.1% veterans
- 63.4% black/African-American
- 29.2% white
- 73% male
- 14.9% between the ages of 18-29
- 19.2% between the ages of 30-39
- 23.1% between the ages of 40-49
- 29.8% between the ages of 50-59
- 13.1% 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.

Finally, The DBHIDS’ Office of Mental Health prepares an Annual Plan for Mental Health Services. On an annual basis, this plan is distributed to the public, the Community Support Program (CSP), and to 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. All DBHIDS services operated by RHD participate in the CST process, including Kailo Haven. Safe Havens have access to Peer Specialists that come to the setting and participate with residents in a variety of ways and are based in interest and need. RHD 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.

### **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 73.3% male and 63.4% 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. In 2011, DBHIDS outreach services added 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

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.

**Budget Narrative** - The PATH Funds received are allocated for the salaries and benefits for 34 direct care staff in three residential programs. All of the staff listed on the PATH 2016-2017 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**

### Comprehensive Budget

<b>RHD - Kailo Haven</b>	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
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
Resident Advisor	\$21,840	100%	\$21,840	\$21,840
<b>Subtotal</b>	<b>\$385,827</b>			<b>\$385,827</b>

<b>Fringe Benefits</b>				
Kailo Haven Employees (30%)	\$115,748	0%	\$0	\$0
<b>Subtotal</b>	<b>\$115,748</b>			<b>\$0</b>

<b>Grand Total</b>				<b>\$385,827</b>
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Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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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. Construction (non-allowable)

h. Other \$ 0 \$ 0 \$ 0

No Data Available

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

k. Grand Total (Sum of i and j) \$ 0 \$ 0 \$ 0

Source(s) of Match Dollars for State Funds:

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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Resources for Human Development: La Casa**  
**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. 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.

<b>Project</b>	<b>Federal Allocation</b>	<b>State Allocation</b>	<b>Total Allocation</b>
RHD - La Casa	\$ 338,135	\$ 0	\$ 338,135
<b>Total</b>	<b>\$ 338,135</b>	<b>\$ 0</b>	<b>\$ 338,135</b>

**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. RHD is a key participant in the city’s plans to end homelessness including serving on the 10 year Plan committee, participating and supporting the 100K Homes efforts and working closely with DBH to expand their inventory of PSH.

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 representatives RHD sit on the local CoC Board or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinators are co-chairs of the local 100K Homes efforts to prioritize resources for the most vulnerable persons living on our streets. Persons who receive PATH funded services are a high priority for CoC resources.

**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 a significant inventory of Permanent Supportive Housing and is recipients of numerous McKinney/COC grants. RHD also works with Horizon House and Pathways to Housing to identify people with the highest need for housing services through their programs.

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There is also a severe gap in affordable housing in Philadelphia County. SSI payments in 2015 were \$733/month and Fair Market Rates are at \$1,103. 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 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 are also involved in the planning and beginning stages of receiving Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose.

#### Evidenced Based Practices

In 2010, DBHIDS began supporting 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 a robust system and 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.

**Data** - The plan for FY16 is to begin to plan to migrate Safe Haven data (including La Casa) into the HMIS system once it is available and implemented through the Office of Supportive Housing. This is expected to be finalized in 2016. The city is changing vendors and when the new system is in place we will be able to capture and share outreach data.

Philadelphia County is currently in transition to a new HMIS system. When this new system is ready and available, Safe Havens will migrate the outreach data. Outreach teams already use handheld computers to be able to enter data at the time of an encounter making real time data available and technology is being identified for better and timelier data entry. The Safe Havens do use real time data and are in the midst of transitioning to

an all electronic process, ending the reliance of paper. Due to the local behavioral health managed care organization we have integrated data and outcomes and operational processes, with the local behavioral Medicaid managed care system. Safe Havens plan on fully integrating and using the new PATH HMIS system by January 1, 2017. The PATH HMIS Lead and Systems Administrator for these programs is Nancy Guarino, of the Office of Supportive Housing.

**Alignment with PATH Goals** - The City uses Outreach data to determine create a priority list based on chronicity and vulnerability. Those seen to be highest on the priority list are able to access Housing First Services, La Casa or any other housing options available through PHA or DBH reinvestment dollars. We have targeted people with the most need and chronicity to access valuable resources for housing and to end homelessness.

Data that is gathered by Project Home goes into the main Mental Health Residential data system, which is accessed when determining whether to place a client into La Casa, a different Safe haven or an alternative location, to ensure that those with the highest needs are not only being served but that their specific needs are catered to and met through their housing options. At DBHIDS we continually work together with different programs and organizations to ensure that our efforts are not in a vacuum but instead are brought together to work in a systematic manner. The City, Outreach and its various stakeholders are starting to work together using a “Boot Camp” 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.

Additionally, it should be noted that DBHIDS has a Safe Haven reporting process that is shared with providers at a monthly meeting. While not all Safe Havens are PATH funded, all Safe Havens collaborate together through the County Homeless Coordinator, two county Program Analysts and a county Supervisor to coordinate care for their residents with the treatment and supportive housing systems.

**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 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 when the Pope visited Philadelphia September 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: PHA vouchers, 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.

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 Outreach Team to provide more support to people who need it and are not in typically seen locations of Center City.

Upon opening a Safe Haven for 10 male Transition Age Youth (TAY), and as we are in the process of transitioning another Female Transition Age Youth Safe Haven, we are seeing approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs. Staff are working on training and supports for Outreach and Safe Havens to address needs of this population. \$338,135 of the PATH Funds will be used to continue our efforts to serve transition aged males in the La Casa Safe Haven. In the coming months we will also be opening a Safe Haven for transition aged females. We continually strive to use the funds designated to meet the needs of those who are currently being underserved.

### **Other Designated Funds**

DBHIDS spends \$50 million 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.

**SSI/SSDI Outreach, Access, Recovery (SOAR)** - Since December 2007, the Homeless Advocacy Project (HAP) in partnership with DBHIDS, has secured federal Supplemental Security Income (SSI) disability benefits for more than 1,200 homeless individuals on an expedited basis through its SOAR (SSI/SSDI Outreach, Access, Recovery) Project. With an approval rate of 96% and an average processing time of just over one month, HAP's project is the most successful SOAR initiative in the country. The Outreach teams partner with HAP and Case Managers on SOAR applications and all Case Managers have been trained on the SOAR process.

Through RHD's three PATH Funded programs, we were able to enroll 5 new SOAR participants, with an eligibility result of 60%. One of those clients was enrolled in La Casa. No additional PATH personnel were trained last year.

**Access to Housing** - Outreach participants have exclusive access to the DBH Safe Haven system that include, La Casa and RHD's two other PATH funded residential programs.

Outreach participants and La Casa's residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which allocates 200 Housing Choice Vouchers a year to address issues of homelessness in the community. The MOU between the City and the Housing Authority remains in effect though PHA is struggling to make this commitment due to decreased funding.
- Exclusive access to openings in the city's inventory of 545 Housing First options, operated by Horizon House and Pathways to Housing PA.
- 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.

**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 Subsidies 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.

**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.

**Client Information** - The projected number of adult clients to be contacted using PATH funds is 700 persons. The majority of those will be through outreach services, while 300 will be through the residential programs. The projected number of adult clients to be enrolled using PATH funds will be 350 persons. All persons admitted to residential services (approximately 300), will be considered PATH enrolled clients and another 50 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, which are similar to the demographics of our RHD Safe Havens, as those in the Safe Havens are referred by Outreach contacts.

- 80.1% had both co-occurring substance abuse and behavioral health issues
- 6.1% veterans
- 63.4% black/African-American
- 29.2% white
- 73% male
- 14.9% between the ages of 18-29
- 19.2% between the ages of 30-39
- 23.1% between the ages of 40-49
- 29.8% between the ages of 50-59
- 13.1% 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.

Finally, The DBHIDS’ Office of Mental Health prepares an Annual Plan for Mental Health Services. On an annual basis, this plan is distributed to the public, the Community Support Program (CSP), and to 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. All DBHIDS services operated by RHD participate in the CST process, including La Casa. Safe Havens have access to Peer Specialists that come to the setting and participate with residents in a variety of ways and are based in interest and need. RHD 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.

### **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 73.3% male and 63.4% 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. In 2011, DBHIDS outreach services added 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH funded staff are included in this data system.

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.

**Budget Narrative** - The PATH Funds received are allocated for the salaries and benefits for 34 direct care staff in three residential programs. All of the staff listed on the PATH 2016-2017 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

<b>RHD - La Casa</b>	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
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
<b>Subtotal</b>	<b>\$338,149</b>			<b>\$338,135</b>

<b>Fringe Benefits</b>				
RHD Employees (30%)	\$101,440	0%	\$0	\$0
<b>Subtotal</b>	<b>\$101,440</b>			<b>\$0</b>

<b>Grand Total</b>				<b>\$439,575</b>
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590 Terry Reiley Way

Provider Type: Social service agency

Pottsville, PA 17901

PDX ID: PA-064

Contact: Gerald Achenbach

State Provider ID: 4264

Contact Phone #: 5706212700

Geographical Area Served: Northeast Region

Planning Period From 7/1/2016 to 6/30/2017

\* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>a. Personnel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>c. Travel</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>d. Equipment</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>e. Supplies</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
<b>f. Contractual</b>	\$ 0	\$ 0	\$ 0	
No Data Available				

<b>g. Construction (non-allowable)</b>				
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Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	\$ 0	\$ 0	\$ 0	Detailed budgets and narratives are included in individual provider IUPs.

<b>i. Total Direct Charges (Sum of a-h)</b>	\$ 0	\$ 0	\$ 0	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
<b>j. Indirect Costs (Administrative Costs)</b>	\$ 31,578	\$ 10,526	\$ 42,104	
<b>k. Grand Total (Sum of i and j)</b>	\$ 31,578	\$ 10,526	\$ 42,104	

Source(s) of Match Dollars for State Funds:

Service Access and Management, Inc. will receive \$42,104 in federal and state PATH funds.

Estimated Number of Persons to be Contacted:	210	Estimated Number of Persons to be Enrolled:	80
Estimated Number of Persons to be Contacted who are Literally Homeless:	42		
Number Staff trained in SOAR in Grant year ended in 2014:	2	Number of PATH-funded consumers assisted through SOAR:	0

**Schuylkill County  
PATH Intended Use Plan  
FY 2016-1017**

Agency Providing Services:

Service Access and Management, Inc.  
590 Terry Reiley Way  
Pottsville, PA 17901

PDX: PA-064 Schuylkill: Service Access and Management, Inc.

### **1. Local Provider Description**

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.

The sole provider for PATH (Projects for Assistance in Transition from Homelessness) services for the 2016 – 2017 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.

This Intended Use Plan will serve consumers in Schuylkill County. Although Service Access and Management, Inc. operates in twenty-six (26) Pennsylvania counties and six (6) 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.

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 \$42,104 in PATH funding for the 2016 – 2017 fiscal year. Of this amount, \$10,526 is the State (Block Grant) Match and \$31,578 is the Federal Allocation. The local contribution is \$16,242, plus additional funds are used for rental subsidies, security deposits, furniture, household items, motel vouchers and emergency food needs.

## **2. Collaboration with HUD Continuum of Care (CoC) Program**

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.

The planning, coordinating and assessment of housing matters regarding persons who have a mental illness is 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 2015, December 2015 and January 2016 to plan for the January 2016, Point-in-Time Count.

Other local planning activities and program coordination provide for persons with mental health illnesses having the opportunity to reside in one of five permanent supportive housing options 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. In addition to Barefield Plaza and the Mt. Hope apartments, two additional apartments at 719 North Second Street, Pottsville, Pennsylvania, have been completed and the two units are currently occupied. 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, two additional 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 June of 2016, three additional Permanent Supportive Housing units will be 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. 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 Case Manager.

### **3. Collaboration with Local Community Organizations**

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.

Coordination of outreach activities is achieved in a number of ways. Because we have a very active Local Housing Options Team 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.

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**

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 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 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.

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 Case Manager by name. Monica Kissinger's (PATH 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 Case Manager's networking and reputation, persons who are literally homeless have found us. From July 1, 2014, through June 30, 2015, there were 226 potential PATH consumers who either walked into the Service Access and Management, Inc. office or called the PATH Case Manager to seek assistance.

One full-time PATH 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 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.

The leveraging of other available funds for PATH client services is a real strength of the PATH program.

One constant source of leverage is through 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 makes this support available for PATH consumers.

Our greatest gap has been the absence of an emergency shelter. There was a temporary homeless shelter in Schuylkill County. It opened in February, 2014, and closed during April, 2014. There is no current emergency shelter operating in Schuylkill County for the general population. (Our only shelter in the county is a shelter that specializing in addressing issues of women affected by domestic violence.) However, Servants to All is actively engaged with the United Presbyterian Church in developing an overnight shelter.

Schuylkill County lacked a residential housing program to assist transition age youth from 2012 until July of 2015. On August 1, 2015, a Transition Age Youth program was implemented in Schuylkill County. The program seeks to house sixteen (16) transition age youth over a two year period. The project will assist this population with subsidized rent, security deposits, furniture, household supplies and professionals will assist transition age youth with accessing housing and being 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.

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.

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.

Besides on-going training through our Learning Management System (LMS) Network of Care, the PATH 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 Case Manager join him in meetings where the PATH 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 Case manager attended the meetings and contributed to the presentations.

These training options will continue in 2016 – 2017.

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.

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 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.

## 5. Data

Service Access and Management, Inc. is already a registered user of HMIS and 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 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 data 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 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 plan to participate on the next call which will be on 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 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 Case Manager and Housing Coordinator intend to participate in future PATH trainings, webinars, and conference calls that will benefit Service Access and Management's PATH program.

2016-2017 Currently, consumer information is placed on forms and those forms are placed in individual consumer PATH binders. Those binders will be replaced with more detailed data input into HMIS. HMIS will also 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 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.

PA DCED serves as the Administrator/HMIS Lead Agency for Service Access and Management's PATH program. PA DCED utilizes Eccovia Solutions, Inc. (ClientTrack, Inc.) as the software vendor who provides the hosting services of the web-based case management system that Service Access and Management's PATH program uses. The specific HMIS PATH director is Dave Weathington of PA DCED.

## **6. Alignment with PATH goals**

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 Case Manager. The County contributes monies to support this position. The PATH Case Manager benefits not only from state level PATH technical assistance, but the PATH 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 Case Manager.

Recently, our PATH Case Manager attended the PATH two day technical assistance conference in State College on April 20, 2016, and April 21, 2016.

In addition to the history of the position, along with the everyday Service Access and Management, Inc. support of the position, our current PATH Case Manager is also enrolled in a 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, 2014 through June 30, 2015, there were 226 potential PATH consumers who either walked into the Service Access and Management, Inc. office or called the PATH Case Manager to seek assistance.

The PATH 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 (called My Father's House) on November 4, 2015, all individuals who are homeless, or at imminent risk of homelessness often times visit My Father's House before visiting 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 Case Manager.

## **7. Alignment with State Mental Health Services Plan**

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 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*.

The Service Access and Management, Inc. PATH program focuses on case management. Upon identifying individuals who are qualified to receive PATH services, our PATH 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.

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 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. 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.

## **8. Alignment with State Plan to End Homelessness**

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 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 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.

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 Case Manager by name. Monica Kissinger's (PATH Case Manager) name has become synonymous with homelessness throughout Schuylkill County based on her successful reputation for assisting those who are homeless. We have learned that through our PATH Case Manager's networking and reputation, persons who are literally homeless have found us. From July 1, 2014, through June 30, 2015, there were 226 potential PATH consumers who either walked into the Service Access and Management, Inc. office or called the PATH Case Manager to seek assistance.

One full-time PATH 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 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.

## **9. Other Designated Funds**

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

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. SSI/SSDI Outreach, Access, Recovery (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.)

There were no PATH funded consumers assisted directly through SOAR during the 2015 – 2016 grant year. 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. Housing**

Because Service Access and Management, Inc. has a well-funded Housing staff and program, 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 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 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.

During 2013-2014 and 2014-2015, additional monies were available to assist with security deposits and first month's rent for PATH consumers. These monies have become available through Reinvestment Contingency funds.

- (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 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 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 now in progress and will provide three more beds.

Permanent supportive housing beds first became available in June, 2011. By the summer of 2015, eighteen permanent supportive housing beds will be available in the City of Pottsville.

- (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 Homeless Shelter. From February, 2014 until April, 2014, local churches in Pottsville, Pennsylvania, came together to address the need of the homeless by providing temporary shelter. Initially, churches rotated from week to week and then one specific church agreed to remain open 24/7. The initial length of stay for an individual was 14 days with an emphasis on residents receiving supports and services in the community. While residing at the shelter, the PATH Case Manager conducted outreach and worked with the individuals in order to assist them with their housing needs.
- (j) 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 Case Manager coordinates with My Father's House to screen for PATH eligibility. My Father's House assists with temporary housing, food, job searches, clothing, spiritual needs and referrals to other services.

- (k) Transition Age Youth Program. Beginning August 1, 2015, Service Access and Management, Inc. implemented program dedicated to assisting 16 transition age youth through June 30, 2017. 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.

## **12. Coordinated Entry**

Currently, there is no formal Coordinated Entry process available in the area served by Service Access and Management Inc.'s. PATH program. 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. 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.

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.

## **13. Justice Involved**

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 Case Manager works with consumers at all points of the criminal justice system process. Often, our PATH Case Manager will attend hearings with consumers who have been charged with crimes or who are facing eviction. The PATH Case Manager at this point may plan for the consumers' housing needs and help prevent them becoming homeless. The PATH Case Manager can work with individuals in prison as well as those who are about to be discharged. The PATH Case Manager can help consumers access resources and act as a point-of-contact for probation and parole officials.

While in the community, consumers with a criminal history often have trouble accessing public housing and other affordable housing due to their previous charges. Service Access and Management, Inc.'s PATH Case Manager has established a close

relationship with our two public housing authorities, and is very well versed on what information is needed to get consumers “exceptions” and to address previous charges. This would include letter of rehabilitation from treatment facilities, letters of completion from probation and parole officials, confirmations or diagnosis and other information that makes their applications more likely to be approved. If the application is denied, the PATH 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.

#### **14. Staff Information**

The Service Access and Management, Inc. Schuylkill County staff, including all management, professional and administrative support staff, totals seventy (70). Of this total, fifty-six (56) are females and fourteen (14) are males. The age range is twenty-three (23) years of age to sixty-six (66) years of age. The staff consists of sixty-eight (68) Caucasians, one (1) African American and one (1) Hispanic/Latino.

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.

Our staff is required to complete the following trainings:

- 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.

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.

## 15. Client Information

The demographics of the client population during the most recent annual report (2014-2015) follow:

### AGE

0	17 and Under
15	18 – 23 years
11	24 – 30 years
63	31 – 50 years
21	51 – 61 years
0	62 and over
0	Don’t know
0	Refused

### GENDER

57	male
53	female
0	Don’t Know
0	Refused

RACE/ETHNICITY

- 0 American Indian or Alaskan Native
- 0 Asian
- 7 Black or African American
- 1 Native Hawaiian or other Pacific Islander
- 99 White
- 3 Two or More Races
- 0 Don't Know
- 0 Refused

HOUSING STATUS (AT FIRST CONTACT)

- 14 Outdoors (e.g. street, abandoned or public building, automobile)
- 31 Short term shelter
  - 0 Long term shelter
- 49 Own or someone else's apartment, room or house
  - Hotel, SRO, boarding house
- 4 Halfway house, residential treatment program
  - Institution (psychiatric or other hospital, nursing home, etc.)
- 3 Jail or correctional facility
- 9 Other
- 0 Unknown

LENGTH OF TIME LIVING OUTDOORS OR IN SHORT TERM SHELTER AT FIRST CONTACT

- 3 Less than 2 days
- 15 2 to 30 days
- 9 31 to 90 days
- 11 91days to one year
- 7 Over one year
- 0 Unknown

The projected number of adult clients to be contacted during the 2016-2017 year using PATH funds by the PATH Case Manager will be approximately two hundred ten (210). Because Service Access and Management, Inc. either provides or oversees all mental health services contracted through Schuylkill County's MH/DS Program, our PATH 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.

The projected number of adult clients to be enrolled using PATH funds who have a mental health illness and who are homeless or at imminent risk of homelessness that are contacted and enrolled by the PATH Case Manager will be approximately eighty (80).

The percentage of adult clients to be served with PATH funds and who are projected to be "literally" homeless will be approximately twenty percent (20%) of clients served with PATH funds.

## **16. Consumer Involvement**

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 is 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.

## 17. Health Disparities Impact Statement

Service Access and Management (SAM) expects to serve thirty-seven (37) Transitional Age Youth (TAY) during the 2016-2017 PATH fiscal year.

SAM, Inc. expects to expend \$13,475 on services for the TAY population in the PATH program.

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:

- 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.
- 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.
- 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.

- Outpatient Services. Five providers within the county provide specialized services including, but not limited to, medication management, psychotherapy and intensive outpatient services.
- 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.
- Community Employment. Provides for work experiences, job training and job coaching in preparation for gainful employment.
- Vocational Rehabilitation. Provides services in preparation for the return to gainful employment.
- Peer Support Services. Certified Peer Specialists provide mentoring and support to individuals with serious mental illnesses to increase coping skills and resilience.
- Psychiatric Rehabilitation. This is a site based psychiatric rehabilitation program.
- Clubhouse Program. The Clubhouse Program is structured around a work-day model.
- 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.
- Mobile Psychiatric Rehabilitation. Mobile Psychiatric Rehabilitation is available to individuals who are not able to access traditional services due to transportation issues.

Service Access and Management, Inc. received a Transition Age Youth grant effective August 1, 2015. Our goal is 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.

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

## 18. Budget Narrative

The budget narrative follows:

- a. Case management services costs include health, dental, vision, life insurance, FICA, Worker's Compensation. (\$51,564) The PATH 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 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 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 Case Manager will visit food banks, soup kitchens, the Salvation Army and other areas that are frequented by persons who are homeless.

Our PATH 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 Case Manager will assist in referring these individuals to supported living programs offered by two local providers.

The PATH 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. (\$450) The PATH Case Manager will incur travel expenses while working directly with PATH clients and while conducting outreach activities.

- c. Supplies and cell phone costs. (\$1,028) We want the PATH 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. (\$5,304) This is the allowable block grant rate and includes costs for services such as accounting, insurance and human resources.

**Schuylkill County  
Service Access and Management, Inc.  
FY 2016 – 2017 PATH Budget**

- Federal Funds: 31,578
- State (Block Grant) Funds: 10,526
- Additional Local Funds: 16,242

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)	33,490	1.0 FTE	18,125	15,365	33,490
Fringe benefits and costs (health, dental, vision, life insurance, FICA, workers' compensation)	18,074	1.0 FTE	9,782	8,292	18,074
Travel	450		244	206	450
Supplies and cell phone costs	1,028		556	472	1,028
Total direct	53,042		28,707	24,335	53,042
Indirect (as allowed by Block Grant guidelines)	5,304		2,871	2,433	5,304
TOTAL	58,346		31,578	26,768	58,346
Minimum Block Grant required (PATH State)	10,526	Match in Block Grant 14,843			
Additional Block Grant Funds	16,242	Match in Block Grant 11,925			

48. 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 7/1/2016 to 6/30/2017

\* Indicates a required field

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

c. Travel \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

d. Equipment \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

e. Supplies \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

f. Contractual \$ 0 \$ 0 \$ 0

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
----------	-----------------	-----------------	---------------	----------

g. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
----------	-------------------	-------------------	---------------	----------

h. Other \$ 46,874 \$ 21,438 \$ 68,312

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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Office: Other (Describe in Comments) \$ 46,874 \$ 21,438 \$ 68,312

Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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i. Total Direct Charges (Sum of a-h) \$ 46,874 \$ 21,438 \$ 68,312

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
----------	-------------------	-------------------	---------------	----------

j. Indirect Costs (Administrative Costs) \$ 0 \$ 0 \$ 0

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
----------	-------------------	-------------------	---------------	----------

k. Grand Total (Sum of i and j) \$ 46,874 \$ 21,438 \$ 68,312

Source(s) of Match Dollars for State Funds:  
York Co will receive a total of \$68,312 in federal and state PATH funds.

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 ended in 2014: 0 Number of PATH-funded consumers assisted through SOAR: 0

**Bell Socialization Services – PATH Intended Use Plan**  
**2016-2017**  
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.

\$46,874 is the federal PATH allocation  
\$21,438 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**

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.

**Outreach:** includes any face-to-face contact with consumers that link them to services. The Program Coordinator and the caseworkers outreach at local shelters, soup kitchens and other organization that service the homeless population. 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

In the Supported Housing Program we operate on a case by case status when referring individuals to certain programs. Once a need is established 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 established 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.

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 and 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 Director: 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 from 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**

The SHP works closely with the York County MH/IDD and many mental health organizations to better service our homeless population. Bell Socializations Services is a non profit organization that services individuals with Intellectual disabilities and Mental Health diagnosis. SHP caseworkers provide linkage to mental health providers for services such as therapy, medication management and psychiatrist appointments. 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.

### **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.

### **SSI/SSDI Outreach, Access, Recovery (SOAR)**

The SHP Program plans to have SOAR training offered to PATH staff within the next year. The SHP Program Coordinator has expressed interest and given a head count to the Human Services Program Specialist. PATH staff is currently waiting for a training to be organized and directed. To date, there are no SHP staff that

are SOAR trained. For grant year 2013, it is anticipated that two staff will be SOAR trained. Subsequently, no PATH funded consumers have been assisted through SOAR. As of 2015/2016, no SOAR training has been conducted for PATH staff.

### **Access to 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.

### **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 35 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.

To date we currently services 40 individuals and continue to strive to reach our goals to service more individuals who meet PATH requirements. It is anticipated that 40% of the individuals that will be served in 2016-2017 will be literally homeless i.e. staying in shelters or in uninhabitable conditions. Our goal continues to grow the program and service 59 individuals by 2016-2017.

### **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**

Describe the provider's plan to track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age.

Behavioral Health Disparities are currently being tracked in the current HMIS System. Assessments are done upon enrollment in the PATH program and updated on an ongoing basis. 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.

Describe the provider's plan to identify, address and track the language needs of disparity-vulnerable subpopulations.

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.

Describe the provider's plan to address and eventually reduce disparities in access, service use, and outcomes for the identified disparity-vulnerable subpopulations  
Bell Socialization Services along with the PATH staff continue to foster relationships with community partners and other service providers. By improving communication between providers we can better understand who is being served within our community and provide care that will yield positive outcomes. By linking services, we can systematically improve obstacles that have historically caused discrimination or exclusion.

How PATH funds will be utilized to measure, track and respond to these disparities.

Several times a year, Bell Socialization Services provides trainings and speakers on various topics relevant to serving adults with mental health diagnoses. These trainings are attended by PATH funded Supported Housing Caseworkers. These trainings have included the healthcare disparities experienced by the population they serve, the long term effects of this issue, and strategies and local resources to improve this situation. Caseworkers attempt to identify and advocate for the best healthcare available for the consumer.

In most recent history our PATH program serviced 71% of consumers who are between the ages of 18-30. Currently we service 40 PATH individuals, 14 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.

## Budget Narrative

All PATH funds are used for case manager salaries.

### SAMPLE BUDGET TABLE

County  
 Provider Name  
 PATH Program  
 FY 2016-2017 Budget

\*Please add additional rows as necessary

	<b>Annual Salary</b>	<b>PATH-funded FTE</b>	<b>PATH-funded salary</b>	<b>TOTAL</b>
<b>Position</b>				
Case Manager	22,000	2.5	55,000	55,000
<b>sub-total</b>				<b>55,000.00</b>
<b>Fringe Benefits</b>				
FICA Tax	4207.00			4207.00
Health Insurance	7150.00			7150.00
Retirement	1949.00			1949.00
Life Insurance	6.00			6.00
<b>sub-total</b>				<b>13,312.00</b>
<b>Travel</b>				
Local Travel for Outreach				
Travel to training and workshops				
<b>sub-total</b>				<b>0.00</b>
<b>Equipment</b>				
(list individually)				
<b>sub-total</b>				
<b>Supplies</b>				
Office Supplies				

Consumer-related items				
<b>sub-total</b>				
<b>Other</b>				
Staff training				
One-time rental assistance				
Security deposits				
Postage				
<b>sub-total</b>				<b>0.00</b>
<b>Total PATH Budget</b>				<b>68,312.00</b>



### III. State Level Information

#### A. Operational Definitions

Term	Definition
Homeless Individual:	<p>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:</p> <p>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.”</p>
Imminent Risk of Becoming Homeless:	<p>Pennsylvania's definition for “imminent risk of becoming homeless” has not changed since last year and is defined as follows:</p> <p>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 includes persons facing eviction 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.</p>
Serious Mental Illness:	<p>Pennsylvania's definition of “serious mental illness” has not changed since the previous year and is as follows:</p> <p>Serious Mental Illness (SMI) – Pennsylvania adopted the Federal definition of “serious mental illness” re: Section 1912(c) of the Public Health Services Act, as amended by PL 102-321, as follows: “an adult with a serious mental illness is a person aged 18 and older who, at any time in the past year, was diagnosed with a mental, behavioral, or emotional disorder meeting the diagnostic criteria specified in DSM-IV-R or revisions thereafter, which resulted in functional impairment, substantially interfering with or limiting one or more major life activities.”</p> <p>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-IV 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:</p> <p>A. (Treatment History), B. (Functioning Level) or C. (Coexisting Condition or Circumstance). A. Treatment History</p> <ol style="list-style-type: none"> <li>1. Current residence in or discharge from a state mental hospital within the past two years; or</li> <li>2. Two admissions to community or correctional inpatient psychiatric units or crisis residential services totaling 20 or more days within the past two years; or –</li> <li>3. Five or more face-to-face contacts with walk-in or mobile crisis or emergency services within the past two years; or</li> <li>4. 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</li> <li>5. 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</li> <li>6. 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.</li> </ol> <p>B. Functioning Level Global Assessment of Functioning Scale (DSM-III-R, pages 12 and 20) rating of 50 or below.</p> <p>C. Coexisting Condition or Circumstance:</p> <ol style="list-style-type: none"> <li>1. Coexisting diagnosis:             <ol style="list-style-type: none"> <li>a. Psychoactive Substance Use Disorder; or</li> <li>b. Mental Retardation; or</li> <li>c. HIV/AIDS; or</li> <li>d. Sensory, Developmental and/or Physical Disability; or</li> </ol> </li> <li>2. Homelessness”; or</li> <li>3. Release from criminal detention.</li> </ol> <p>** 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.</p>

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, the State PATH coordinator strongly encourages all PATH providers to continue to make special efforts to reach veterans who are among unsheltered homeless.

Additionally, counties have been establishing partnerships with their local VA and other agencies that serve homeless veterans and their families in to better serve this population within the community.

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 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 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:

In November 2006, A Plan for Promoting Housing and Recovery-Oriented Services, hereafter referred to as The Plan, 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:

In 2007/08, Pennsylvania was awarded a Technical Assistance (TA) grant by the federal PATH program. As part of this TA grant, a 2-day mandatory training was conducted in Harrisburg. Each county PATH coordinator (or designee) and at least one representative from each provider agency attended this training. The State provided additional funds to help offset the expenses that were incurred by the providers in order to attend. The focus of this TA was on outreach, which was chosen to better equip PATH providers and their staff to reach out to and enroll more literally homeless individuals. As a result, all PATH programs are required to conduct outreach and provide case management services as a standard part of their PATH programs.

During site visits and at other forums where PATH providers congregate, the PA State PATH Contact, SPC, emphasizes the importance of targeting the PATH resources toward the literally homeless population.

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 we issue 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:

## 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 Coordinator 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 Consolidated Plan and the Homeless Continuum of Care planning processes. This includes the Agenda for Ending Homelessness in Pennsylvania, which is a 10-year plan that was written and released in November 2005. A revision to this plan is in review stage at this time.

### 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 CoCs, 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 meets monthly and includes 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 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.

#### Homeless Continuum of Care Steering Committee

The statewide CoC Homelessness Steering Committee 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/OMHASAS continue to chair this committee.

The State PATH coordinator also serves on this committee. This Committee works with and through the four rural Regional Homeless Advisory Boards (RHABs) which develop and maintain a Continuum in each region. Together, the RHABs represent 54 of the state's 67 counties. The HUD direct entitlement communities' Continuums of Care are also represented on the Steering Committee, thus making it a statewide vehicle to end homelessness. The Continuum of Care Homelessness Steering Committee defines and addresses those barriers which could ultimately result in homelessness for individuals and their families.

#### Local Housing Option Teams

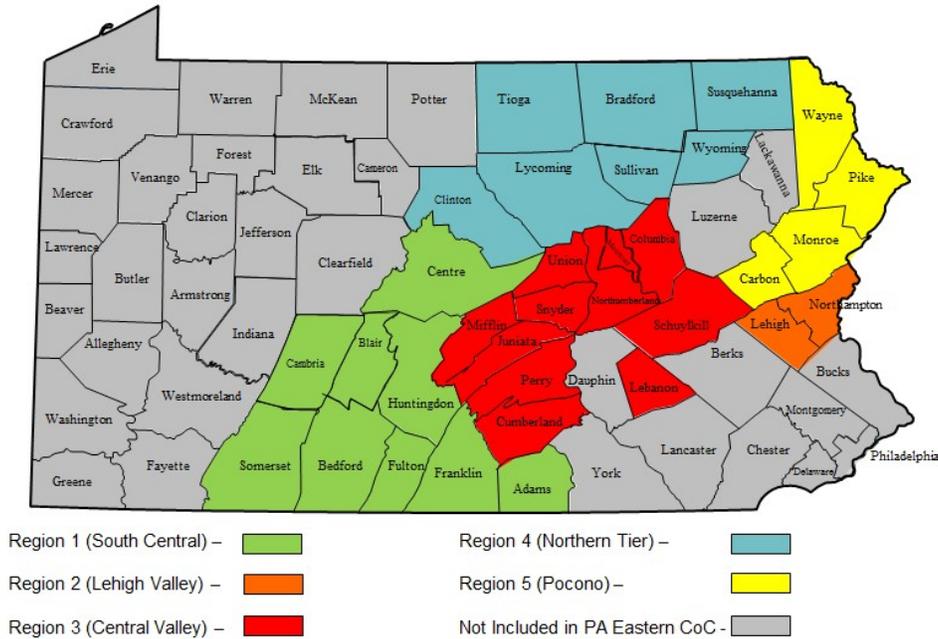
The PA Office of Mental Health and Substance Abuse Services provides technical assistance in formation of Local Housing Option Teams (LHOTS). Currently, there are 44 LHOTS operating in 54 counties (out of a total of 67 counties in the state). County team membership includes representatives from the County 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.

# Eastern PA CoC

**Eastern PA CoC (PA-509):** The Eastern PA CoC is composed of 33 counties. For planning purposes, the CoC is divided into 5 regions and managed by a Regional Homeless Advisory Board (RHAB).

Regional County Distribution for PA Eastern CoC



**South Central RHAB (9 counties):** Adams, Bedford, Blair, Cambria, Centre, Franklin, Fulton, Huntingdon, Somerset

RHAB Co-Chairs:

- Bill Hunter, [bill.hunter@blaircap.org](mailto:bill.hunter@blaircap.org), (814) 946-3651
- Jen Johnson, [jmjohnson@franklincountypa.gov](mailto:jmjohnson@franklincountypa.gov), (717) 264-5387

**Lehigh Valley RHAB (2 counties):** Lehigh, Northampton

RHAB Co-Chairs:

- Kathi Krablin, [kkrablin@valleyyouthhouse.org](mailto:kkrablin@valleyyouthhouse.org), (610) 820-0166
- Lori Sywensky, [LSywensky@northamptoncounty.org](mailto:LSywensky@northamptoncounty.org), (610) 559-3200 x 2

**Central Valley RHAB (11 counties):** Columbia, Cumberland, Juniata, Lebanon, Mifflin, Montour, Northumberland, Perry, Schuylkill, Snyder, Union

RHAB Co-Chairs:

- Ben Laudermilch, [blaudermilch@cchra.com](mailto:blaudermilch@cchra.com), (717) 249-7873
- Shawn Frankenstein, [sfrankenstein@sam-inc.org](mailto:sfrankenstein@sam-inc.org), (570) 516-6567

**Northern Tier RHAB (7 counties):** Bradford, Clinton, Lycoming, Sullivan, Susquehanna, Tioga, Wyoming

RHAB Co-Chairs:

- Mae-Ling Kranz, [mkranz@ywcawilliamsport.org](mailto:mkranz@ywcawilliamsport.org), (570) 322-4637
- Jeff Rich, [Jeff@clintoncountyhousing.com](mailto:Jeff@clintoncountyhousing.com), (570) 748-2954 x 12

**Pocono RHAB (4 counties):** Carbon, Monroe, Pike Wayne

RHAB Co-Chairs:

- Andy White, [AWhyte@co.wayne.pa.us](mailto:AWhyte@co.wayne.pa.us), (570) 253-4262
- Leslie Perryman, [leslie.perryman@rhd.org](mailto:leslie.perryman@rhd.org), (570) 476-9228 x225

Historically, the Eastern PA CoC operated as two separate CoCs, the Central/Harrisburg RHAB and Northeast RHAB. In February 2015, HUD formally approved the merger of these two CoCs into a single Continuum of Care.

This single CoC is formally recognized by HUD as **PA-509 Eastern Pennsylvania CoC**.

Note: Previous funding applications and homeless data for each RHAB can be accessed via the following links: [Central RHAB](#), [Northeast RHAB](#).

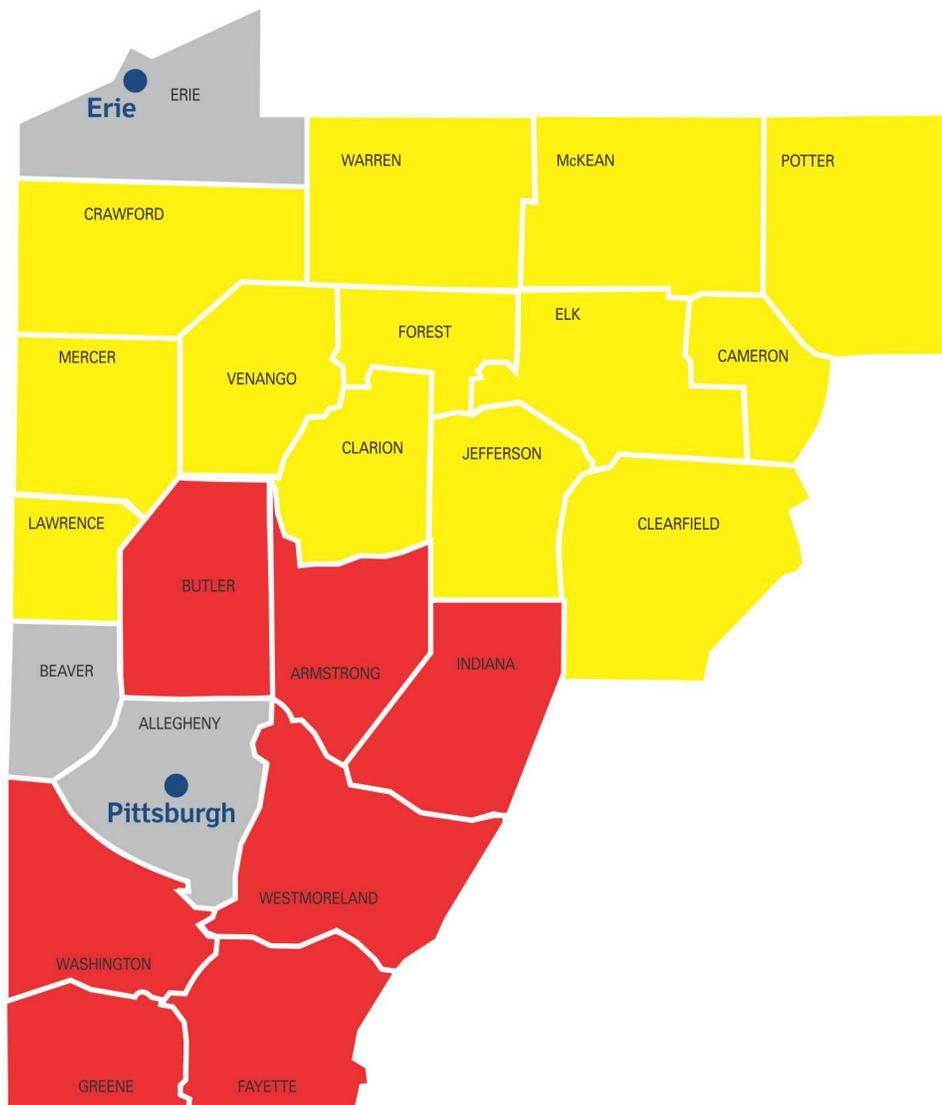
**Continuum of Care Documents — click on the link to view**

- [Governance Charter for the PA Eastern Continuum of Care Collaborative](#)

## Western PA CoC

**Western PA CoC (PA-601):** The Western PA CoC is composed of 2 subareas for planning purposes. Each of these is managed by a Regional Homeless Advisory Board (RHAB):

- **Northwest PA RHAB** (13 counties shown below in yellow): Cameron, Clarion, Clearfield, Crawford, Elk, Forest, Jefferson, Lawrence, McKean, Mercer, Potter, Venango, Warren
- **Southwest PA RHAB** (7 counties shown below in red): Armstrong, Butler, Fayette, Greene, Indiana, Westmoreland, Washington



Historically, the Northwest RHAB and Southwest RHAB operated as two separate CoCs. In February 2015, HUD formally approved the merger of these two CoCs into a single Continuum of Care.

This single CoC is formally recognized by HUD as **PA-601 Western Pennsylvania CoC**.

Note: Previous funding applications and homeless data for each RHAB can be accessed via the following links: [Northwest RHAB](#), [Southwest RHAB](#).

## **The Executive Committee of the Western PA CoC**

The Executive Committee includes the Co-Chairs of CoC Board and two Secretaries. This includes:

### **Co-Chairs**

- Representing the Northwest RHAB: Linda Thompson, (814) 887-5563, lathompson@mckeancountypa.org
- Representing the Southwest RHAB: Tammy Knouse, (724) 430-3013, tknouse@fcaa.org

### **Secretaries**

- Representing the Northwest RHAB: Kim Stucke, (814) 878-2170, kmstucke@stairwaysbh.org
- Representing the Southwest RHAB: Amanda Feltenberger, (724) 284-5114, afeltenb@co.butler.pa.us

### **Continuum of Care Documents — click on the link to view**

- [Governance Charter of the Pennsylvania Western Region Continuum of Care, updated 3-26-15](#)

### 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:

In November 2005, The Commonwealth developed the “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. Pennsylvania’s Agenda for Ending Homelessness is based upon three state-driven strategies. These strategies serve as the backbone for the implementation of the Plan’s Action Steps, which will occur at both the state and local levels. Those strategies include:

- 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.

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:

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 Mental Health Plans 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 are also included in County MH 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:

There are essentially two primary methods used to provide programmatic and financial oversight of the PATH providers:

#### State PATH Coordinator (SPC)

Since 2001, Pennsylvania has employed a full time PATH Coordinator. The PATH Coordinator 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 contact, 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 Coordinator, representatives from the fiscal office and representatives 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.

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.

Pennsylvania has developed a unified PATH-specific format for consumer charts that is being utilized by all PATH providers in the state. This revised charting system continues to include all necessary information for PATH services.

### 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:

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 PATH contact, county PATH contacts 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 - 2016

1. Southeast PA

Philadelphia County	1762
Delaware County	140
Montgomery County	76
Bucks County	110
Chester County	63
Total Southeast PA	2151

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 395

Berks County	109
Dauphin County	112
Lackawanna County	72
Lancaster County	.58
Luzerne County	28
York County	45
Total Eastern PA	819

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) 268

Allegheny County	495
Beaver County	35
Erie County	90
Total Western PA	888

PA TOTAL HOMELESS WITH SERIOUS MENTAL ILLNESS 3858

Note: See Attachment 1 for map of PATH providers

The data presented above was collected on a single night during the last week in January 2016, in most cases, the night of January 27, 2016. Each CoC in Pennsylvania provided the data that they assembled for submission to HUD on the 2016 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 2016 Point-in-Time count.

The data collected shows an increase from 2015 to 2016 of 336 homeless individuals with serious mental illness from 3522 in 2015 to 3858 in 2016, a 9.5% increase.

At the individual CoC level the CoC's that contributed most to this increase are:  
Philadelphia: 1370 in 2015 and 1762 in 2016 – increase of 392 people (29%)

Berks County: 52 in 2015 and 109 in 2016 – increase of 52 people (91%)  
(however this is still below 2014: 117 people)

Bucks County : 78 in 2015 and 110 in 2016 – increase of 32 people (41%)

Lancaster County: 27 in 2015 and 48 in 2016 – increase of 21 people (78%)

Note: While the percentage increase 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.

Counties that experienced the most significant decreases are:

Allegheny County: 553 in 2015 and 495 in 2016 – decrease of 58 people (10%)

Montgomery County 155 in 2015 and 76 in 2016 -- decrease of 79 people (51%)

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. This can result in inaccuracies and varying assumptions about what constitutes serious mental illness. However, this year, the Allegheny County CoC used data from HMIS which uses actual assessments rather than self-reporting to determine the number of individuals with Serious Mental Illness in the CoC. In the FY2017 data analysis, we will specifically ask each CoC what their data source was for this element of the Point in Time count.

The two CoCs with the largest reduction in individuals with serious mental illness, Allegheny and Montgomery, both operate a Coordinated Entry system that prioritizes access to Permanent Supportive Housing and other resources according to vulnerability, as identified through the VI SPDAT, a tool to determine the chronicity and medical vulnerability of homeless individuals. Through this mechanism, they are able to target resources to those with the greatest need, which are often individuals with Serious Mental Illness. In addition, Allegheny County reduced the number of Transitional Housing beds (occupants of which are counted as homeless) and increased the number of Permanent Supportive Housing beds (occupants are counted as housed), also contributing to the decrease in the number of homeless individuals with serious mental illness.

### 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:

Commonwealth general revenues are made available to match the PATH Federal Grant amount. Please see State Match Attachment for confirmation that matching state funds will be provided.

In addition to the state match, some counties also voluntarily provide matching dollars to their PATH programs (please see Table 1 in the Executive Summary). Additionally, some of the services provided with the state match portion of the PATH allocations require a 10% county match (one dollar in county funds for every nine dollars in state funds), depending on the cost center(s) in which the state match funds are expended.

## Baxter, Michelle

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**From:** Polcyn, Kent  
**Sent:** Friday, May 06, 2016 9:21 AM  
**To:** Baxter, Michelle  
**Cc:** Sworen, Joseph; Polcyn, Kent  
**Subject:** Matching Funds Confirmation

**Follow Up Flag:** Follow up  
**Flag Status:** Completed

Hi Michelle,

This is to confirm that in state fiscal year 2016-2017 (July 1, 2016 - June 30, 2017) 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 \$2,352,724 we will allocate a minimum of \$784,241 in state matching funds.

Kent Polcyn  
Bureau of Financial Management & Administration  
Office of Mental Health and Substance Abuse Services  
DGS Annex Complex  
Bldge #11 Administration  
20 Azalea Drive  
Harrisburg PA 17110  
Phone: 717-787-3697  
Fax: 717-787-2866  
[www.dhs.pa.gov](http://www.dhs.pa.gov)

### 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:

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 coordinator 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 by FY 2017. 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:

The Pennsylvania Department of Community and Economic Development (DCED) has established a Homeless Management Information System, HMIS, for the 54 Counties included in the two rural regions of Pennsylvania. In addition, all of the urban counties either use the system administered by DCED or have established their own 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. As of October 1, 2014, all PATH providers operating with PA HMIS system are fully compliant with the new 2014 HMIS data standards released by HUD and the other federal partners. In addition, PA plans to have representatives from DCED to speak about HMIS integration at the 2015 Fall PATH Conference.

Currently, 16 of the 24 PATH-funded counties (and their provider agencies) are utilizing an HMIS for PATH services. Of these 16 counties, 13 utilize the PA HMIS established by DCED and 3 utilize their own HMIS. OMHSAS will fully utilize HMIS for collecting PATH data by the end of FY15/16. In order to accomplish this goal, 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.

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.

### 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:

Through a 2007/2008 TA opportunity from SAMHSA, the PA PATH counties/providers received a 2-day training on "Outreach." This was a mandatory training and the County PATH Coordinator (or designee) and at least one representative from each provider agency attended this training. The state provided additional funds to help offset the expenses (lodging, food, travel etc) that were incurred by the providers in order to attend this training.

In FY 2010/2011, again through a TA opportunity from SAMHSA, the PATH counties/providers in the state received a 2-day training in the areas of data reporting and performance monitoring. Again, the state provided additional monies to support the participation of PATH providers in the training. OMHSAS has full-time staff person to oversee evidence-based practices (EBPs), who is available to support the PATH providers on EBP-related issues. The State PATH Coordinator encourages all PATH contacts to take advantage of the training opportunities provided by PATH as well as other trainings and conferences sponsored by the state. In addition, the SPC is creating a complete database of statewide PATH and SOAR contact information for more efficient distribution of materials.

SOAR is a national project that is designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are homeless or at risk of homelessness and have a physical or mental illness and/or a co-occurring substance use disorder. In September 2014, the new State PATH Coordinator and another OMHSAS staff member attended the SSI/SSDI Outreach, Access and Recovery (SOAR) Leadership Academy. This training certifies staff as trainers in the new Fundamentals SOAR curriculum. PA is transitioning all new SOAR providers to the Fundamentals model.

With the growth of SOAR in PA, the State SOAR Team Lead has started a new SOAR steering committee to implement the Fundamentals format and other updates. To date, thirteen (13) of the 24 PATH MH/ID counties and 1 non-PATH county have received SOAR 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 15/16.

In August 2013, OMHSAS sponsored a statewide PATH conference. The conference focused on cross-systems collaboration, program improvement and HMIS. Our HMIS system developers were on hand to discuss the changes that have been made to the existing PA HMIS system and provide additional training on system usage. SPC also provided additional statewide updates and provided networking and information sharing opportunities for attendees.

A statewide PATH conference is being scheduled for Fall 2015. Focus for this training will be HMIS implementation, disaster preparedness, disparity population programming and the use/growth of SOAR. The SPC will provide additional statewide updates and encourage networking and information sharing among attendees. In addition, 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:

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, thirteen (13) of the 24 PATH MH/ID counties and 1 non-PATH county have received SOAR 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 15/16.

In collaborating with the SAMHSA SOAR TA Center's Liaison, PA has increased enrollment in the SOAR online training program approximately 115% since 8-1-14. A total of 161 people have enrolled since 8-19-2013. 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 is creating a complete database of statewide PATH and SOAR contact information for more efficient distribution of materials and updates to procedures. Quarterly SOAR conference calls will also be implemented to ensure statewide cohesion of SOAR process.

### III. State Level Information

#### P. Coordinated Entry

Narrative Question:

Describe the state's coordinated entry program and role of key partners.

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Footnotes:

In place of a statewide coordinated entry 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 October 2016.

By coordinating entry we can prioritize housing and services for families and individuals based on vulnerability and severity of need. The most needy individuals are considered for housing 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 County 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, one CoC is in the process of expanding the current CE System adding additional Coordinated Entry locations and staff, providing 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.

The CoC uses a phased-assessment process with a series of situational assessments 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 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 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 and other state programs, policies and laws. Indicate the percent of PATH clients with a criminal history.

Footnotes:

PA 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 maxed 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 Coordinator, 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 also attended a statewide Crisis Intervention Team, CIT, training in State College, PA. The CIT meeting focused on verbal de-escalation techniques and coordination with law enforcement to curb recidivism.

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:

<b>Forensic ACT (FACT) Team</b>	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.
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<b>MH Court</b>	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.
<b>Forensic Peer Support</b>	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.
<b>OBH Forensic Specialist</b>	In FY 13-14, OBH hired a dedicated Forensic Specialist to help oversee the myriad of forensic initiatives targeted to the justice-involved population.
<b>Behavioral Health Liaisons</b>	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.
<b>DOC Max-out Tracking</b>	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.

In 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, 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).