I. State Information

State Information

Plan Year

Federal Fiscal Year 2019

State Identification Numbers

DUNS Number 796567790

EIN/TIN 26-0600313

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

Agency Name Pennsylvania Department of Human Services

Organizational Unit Office of Mental Health and Substance Abuse Services

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

City Harrisburg

Zip Code 17105

II. Authorized Representative for the PATH Grant

First Name Valerie

Last Name Vicari

Agency Name Office of Mental Health and Substance Abuse Services

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

City Harrisburg

Zip Code 17105

Telephone 717-705-3879

Fax 717-787-5394

Email Address vavicari@pa.gov

III. State Expenditure Period

From 7/1/2019

To 6/30/2020

IV. Date Submitted

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

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

Title Human Services Program Specialist

Organizational Unit Name PA OMHSAS

First Name Michelle

Last Name Baxter

Telephone 717-346-0752

NOT FINAL

Fax 717-772-7964

Email Address mibaxter@pa.gov

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

I. State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.
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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 Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C.

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

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT
The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR ?? 75.351-75.352, Subrecipient monitoring and management.

Name

Valerie Vicari

Title

Acting Deputy Secretary

Organization

PA DHS, Office of Mental Health and Substance Abuse Services

Signature: Date:

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

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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).
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Name

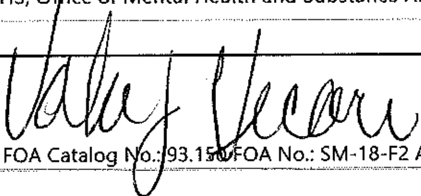
Valerie Vicari

Title

Acting Deputy Secretary

Organization

PA DHS, Office of Mental Health and Substance Abuse Services

Signature:  Date: 6.18.19

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 2 CFR Part 182by:

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).

3. Certifications Regarding Lobbying

Per 45 CFR ?75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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. 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) (31 U.S.C ? 3801- 3812)

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

Valerie Vicari

Title

Acting Deputy Secretary

Organization

PA DHS, Office of Mental Health and Substance Abuse Services

Signature: Date:

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 2 CFR Part 182by:

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).

3. Certifications Regarding Lobbying

Per 45 CFR ?75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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. 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) (31 U.S.C ? 3801- 3812)

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.

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Name

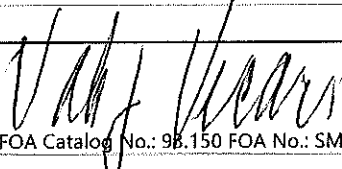
Valerie Vicari

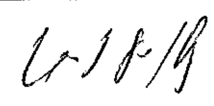
Title

Acting Deputy Secretary

Organization

PA DHS, Office of Mental Health and Substance Abuse Services

Signature: 

Date: 

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

I. State Information

Funding Agreement

FISCAL YEAR 2019
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 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.

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 use disorder, 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 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 2018 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	Valerie Vicari
Title	Acting Deputy Secretary
Organization	PA DHS, Office of Mental Health and Substance Abuse Services

Signature: Date:

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

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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

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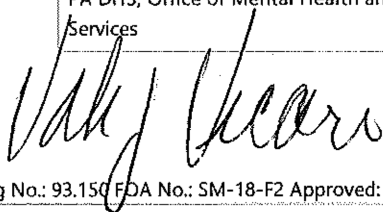
Name	Valerie Vicari
Title	Acting Deputy Secretary
Organization	PA DHS, Office of Mental Health and Substance Abuse Services

Signature:  Date: 6-18-19

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

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 View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name:	Valerie Vicari
Title:	Acting Deputy Secretary
Organization:	PA DHS, Office of Mental Health and Substance Abuse Services

---

Signature: ______________________ Date Signed: ______________________

mm/dd/yyyy

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

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Standard Form LLL (click here)

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Title:	Acting Deputy Secretary
Organization:	PA DHS, Office of Mental Health and Substance Abuse Services

Signature: Valerie Vicari Date Signed: 6-18-19
mm/dd/yyyy

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

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

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

II. Executive Summary

1. State Summary Narrative

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to provide an overview of the state's PATH program with key points that are expanded upon in the State Level Sections of WebBGAS.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes (selected) No

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

II. Executive Summary

2. State Budget

Planning Period From **7/1/2019** to **6/30/2020**

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**$ 51,210**	**$ 3,929**	**$ 55,139**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 55,139	100.00 %	0.93	$ 51,210	$ 3,929	$ 55,139	State PATH Contact

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**77.60 %**	**$ 42,790**	**$ 3,283**	**$ 46,073**	**Overage of Administrative 4% allowed is covered by State funds. In this case, $3283 of my benefits package is paid by the State.**

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
d. Equipment	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
e. Supplies	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
f1. Contractual (IUPs)	**$ 2,273,227**	**$ 783,663**	**$ 3,056,890**	
f2. Contractual (State)	**$ 0**	**$ 0**	**$ 0**	
No Data Available				

Category	Percentage	Federal Dollars	Matched Dollars	Total Dollars	Comments
g1. Housing (IUPs)	**0.00 %**	**$ 0**	**$ 0**	**$ 0**	
g2. Housing (State)		**$ 0**	**$ 0**	**$ 0**	
No Data Available					

PATH housing costs are limited to 20% and can only be PATH allowable costs. Personnel who are considered to be a housing cost should be entered here and not included in the Personnel line item. For questions, call your Program Officer.

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i minus g1)	$ 2,367,227	$ 790,875	$ 3,158,102	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 2,367,227	$ 790,875	$ 3,158,102	
Allocation of Federal PATH Funds	**$ 2,367,227**	**$ 789,075**	**$ 3,156,302**	

Source(s) of Match Dollars for State Funds:

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

NOT FINAL

II. Executive Summary

3. Intended Use Plans

Expenditure Period Start Date: **07/01/2019** Expenditure Period End Date: **06/30/2020**

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

Primary IUP Provider	Provider Type	Geographic Service Area	Allocations	Matching Funds	Estimated # to Contact	Estimated # to Enroll	# Trained in SOAR	# Assisted through SOAR
Allegheny County	Social service agency	Western Region	$461,734	$153,911	120	120	2	550
Allegheny County - Community Human Services Corporation	Social service agency	Western Region	$0	$0	100	75	0	0
Allegheny County - Operation Safety Net	Social service agency	Western Region	$0	$0	900	600	0	0
Armstrong-Indiana County	Social service agency	Western Region	$45,258	$15,086	0	0	0	0
Armstrong-Indiana County - Family Counseling Center of Armstrong County	Community mental health center	Western Region	$0	$0	40	28	0	0
Armstrong-Indiana County - Indiana County Community Action Agency	Social service agency	Western Region	$0	$0	100	25	0	0
Blair County - Home Nursing Agency	Community mental health center	Central Region	$47,087	$15,696	100	80	0	0
Bucks County - Penndel Mental Health Center	Other mental health agency	Southeast Region	$51,680	$17,227	250	175	3	1
Butler County - Catholic Charities	Social service agency	Western Region	$81,903	$27,301	180	140	1	5
Cameron-Elk Behavioral and Developmental Programs	Social service agency	Western Region	$64,421	$21,474	80	50	0	0
Clarion County - Center for Community Resources	Social service agency	Western Region	$34,814	$11,605	105	20	0	0
Crawford County - CHAPS	Consumer-run mental health agency	Western Region	$47,087	$15,696	80	50	1	0
Dauphin County	Social service agency	Central Region	$83,480	$27,827	0	0	0	0
Dauphin County - Case Management Unit	Social service agency	Central Region	$0	$0	20	20	1	7
Dauphin County - Downtown Daily Bread	Shelter or other temporary housing resource	Central Region	$0	$0	250	155	0	0
Dauphin County MH/ID Crisis Intervention	Social service agency	Central Region	$0	$0	150	125	0	0
Delaware County	Social service agency	Southeast Region	$131,919	$43,973	0	0	0	0
Delaware County - Horizon House	Social service agency	Southeast Region	$0	$0	175	85	0	0
Delaware County - Mental Health Partnerships	Community mental health center	Southeast Region	$0	$0	120	50	0	0
Erie County - Erie County Care Management	Social service agency	Western Region	$90,821	$30,274	100	80	3	0
Fayette County - City Mission - Living Stones, Inc.	Other housing agency	Western Region	$58,392	$19,464	450	55	4	3
Forest-Warren - Warren Forest Economic Opportunity Council	Social service agency	Western Region	$34,816	$11,605	75	39	6	1
Franklin-Fulton County Mental Health/Intellectual Disabilities/Early Intervention	Social service agency	Central Region	$54,558	$18,186	90	45	18	0
Greene County Department of Human Services	Social service agency	Western Region	$31,802	$10,601	60	30	1	8
Huntingdon/Mifflin/Juniata County - Service Access and Management, Inc.	Social service agency	Central Region	$31,859	$10,620	75	25	0	0
Lancaster County	Social service agency	Central Region	$91,098	$30,366	0	0	0	0
Lancaster County - Community Services Group	Community mental health center	Central Region	$0	$0	220	140	0	0
Lancaster County - Tabor Community Services	Social service agency	Central Region	$0	$0	40	35	0	0
Lehigh County - Lehigh County MH/ID/D&A/HealthChoices Program	Social service agency	Central Region	$51,680	$17,227	100	40	0	0
Luzerne-Wyoming County - Community Counseling Services	Community mental health center	Northeast Region	$51,680	$17,227	350	210	3	2
Mercer County	Social service agency	Western Region	$56,180	$18,727	0	0	0	0

NOT FINAL

Mercer County - Community Counseling Center	Community mental health center	Western Region	$0	$0	55	45	0	0
Mercer County Behavioral Health Commission	Social service agency	Western Region	$0	$0	23	23	0	0
Montgomery County - Access Services, Inc.	Social service agency	Southeast Region	$79,998	$26,666	170	132	4	4
Philadelphia County	Social service agency	Southeast Region	$438,674	$194,221	0	0	2	73
Philadelphia County - Project HOME	Social service agency	Southeast Region	$0	$0	3,000	870	4	0
Philadelphia County - RHD (Cedar Park)	Community mental health center	Southeast Region	$0	$0	55	50	4	1
Philadelphia County - RHD (Kailo Haven)	Community mental health center	Southeast Region	$0	$0	73	58	4	2
Philadelphia County - RHD (La Casa)	Community mental health center	Southeast Region	$0	$0	21	18	4	4
Schuylkill County - Service Access and Management, Inc.	Social service agency	Northeast Region	$34,816	$11,605	310	84	0	0
York County - Bell Socialization Services	Social service agency	Central Region	$117,470	$17,078	170	80	2	62
		Grand Total	$2,273,227	$783,663	8,207	3,857	67	723

** IUP with sub-IUPs*

Footnotes:

Allegheny County
1 Smithfield St.
Pittsburgh, PA 15222
Contact: James Turner

Provider Type: Social service agency
PDX ID: 001
State Provider ID: 4201
Contact Phone #: 4123505164

NOT FINAL

- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.
  Budgets and budget Narratives are required for every Intended Use Plan
- Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP
- **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.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds 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;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **SSI/SSDI Outreach, Access, Recovery (SOAR)** – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
d. Equipment	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
e. Supplies	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
f. Contractual	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
g. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 461,734**	**$ 153,911**	**$ 615,645**	

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

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**none**
l. Grand Total (Sum of j and k)	$ 461,734	$ 153,911	$ 615,645	

Source(s) of Match Dollars for State Funds:

Allegheny County will receive a total of $615,645 in federal and state PATH funds.
Allegheny County Dept of Human Services will receive $10,000 in federal funds and $3303 in matching state funds.

Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 120
Estimated Number of Persons to be Enrolled: 120

Estimated Number of Persons to be Contacted who are Literally Homeless: 25

Number staff trained in SOAR in grant year ending in 2018: 2
Number of PATH-funded consumers assisted through SOAR: 550

NOT FINAL

ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES
OFFICE OF BEHAVIORAL HEALTH

ALLEGHENY COUNTY PATH COMPREHENSIVE INTENDED USE PLAN
FY 2019-2020

Local Provider Description
Allegheny County's Office of Behavioral Health, located at One Smithfield Street, Pittsburgh PA, 15222, is a county entity and is an office within the Allegheny County Department of Human Services (ACDHS). It is responsible primarily for administering different funding streams to county provider agencies. In turn, these agencies provide mental health services, intellectual or developmental disability services; drug and alcohol services; homeless outreach, prevention and housing services; children, youth and family services; justice related services, etc., to any eligible resident in Allegheny County.

Specifically, the ACDHS PATH program, is administered through the ACDHS, Office of Behavioral Health (OBH) by the County PATH Coordinator. The coordinator oversees and monitors the two PATH provider agencies (listed below) and manages the PATH Contingency Fund Program.

More specifically, the County PATH Coordinator coordinates conference calls with PATH provider agencies, is the liaison between the State PATH Coordinator and County PATH agencies, coordinates site visits, completes the annual Intended Use Plan and generates PATH annual reports, etc.

Effective July 1, 2019, Three Rivers Youth (TRY) will no longer be providing PATH services. Their PATH allocation of $41,317 (Federal $30,988 and State match of $10,329) will be allocated to an existing PATH provider, Community Human Services (CHS).

The additional PATH allocation to CHS will be used to enhance their psychiatric/clinical services to the target population and will allow for additional outreach and case management for people who are street homeless who have a serious mental illness. CHS has demonstrated their commitment and effectiveness in serving the target population through their efforts with the Healthy Housing Outreach Project where they effectively engaged and linked individuals with SMI, including TAY, who are street homeless to shelter, housing, benefits, and behavioral health supports aligning with PATH and the Continuum of Care's strategic plan to end chronic homelessness by serving the most vulnerable adults who are literally and chronically homeless.

Listed below are the three County PATH Recipient Agencies:

Operation Safety Net

NOT FINAL

Operation Safety Net, more specifically, Pittsburgh Mercy Operation Safety Net, (a program through Mercy Life Center Corporation) is a community mental health organization and is a large provider of mental health, behavioral health, and homeless services within the Allegheny County Continuum of Care.

Community Human Services Corporation (CHS)

CHS is a private non-profit, human service provider that offers an array of services to the homeless/at risk homeless population. CHS uses a multi-service approach to provide holistic supportive services throughout Allegheny County. For fiscal year 2019/2020, and as mentioned above, CHS PATH allocation will be increased by $41,317 (Federal $30,988 and State match of $10,329).

Three Rivers Youth (T.R.Y.)

As mentioned above, Three Rivers Youth will no longer be receiving a PATH allocation effective July 1, 2019.

Each Allegheny County PATH provider will provide a more detailed description of their services within their Individual Intended Use Plans.

Allegheny County DHS

As mentioned above, Allegheny DHS manages the PATH Contingency Fund Program, with funds housed in Operation Safety Net.

Each Allegheny County PATH provider will provide a more detailed description of their services within their Individual Intended Use Plans.

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

	Allocations	Federal	+	State Match
A. Operation Safety Net	$534,350	($400,740	+	$133,610)
B. Community Human Services	$ 67,992	($ 50,994	+	$ 16,998)
C. Allegheny County DHS	$ 13,303	($ 10,000	+	$ 3,303)
TOTAL	**$615,645**	**($461,734**	**+**	**$153,911)**

Included in Operation Safety Net's allocation is the PATH Contingency Fund. The amount for FY 2019/2020 will be $29,936. These funds are used to provide monetary assistance for individuals who are homeless or at risk homeless and have SMI or COD. The funds can be applied towards rent/security deposits or utility bills. Each applicant is entitled to a maximum of $300.00, a $100.00 increase from previous years, and can be eligible for the funds every two (2) years.

NOT FINAL

During the fiscal year 2017/2018, 125 eligible PATH individuals benefitted from utilization of PATH funds.

PATH Providers Name and Addresses

Jill Petanovich
Allegheny: Allegheny County Office of Behavioral Health – **PA: 001**
One Smithfield Street, Human Services Building, 3rd Floor
Pittsburgh, PA 15222
Telephone: 412.350.4950
Fax: 412.350.4245
E-mail: jill.petanovich@alleghenycounty.us

Colin McWhertor
Allegheny: Community Human Services – **PA: 035**
2525 Liberty Avenue
Pittsburgh, PA 15222
Telephone: 412.246.1639
Fax: 412.697.2049
E-mail: cmcwhertor@chscorp.org

Marriles Maga
Allegheny: Operation Safety Net – **PA: 040**
903 Watson Street
Pittsburgh, PA 15219
Telephone: 412.263.2545
Fax: 412.689.0925
E-mail: mmaga@pittsburghmercy.org

NOT FINAL

Collaboration with HUD Continuum of Care Program

PATH Provider agencies continue to participate in Allegheny County's Continuum of Care (CoC), PA-600. Each provider will elaborate on their involvement with the CoC through their individual IUPs. Diane Johnson, who works in OBH, provides administrative oversight and support to the PATH program and is an active participant in the CoC; serves on the Homeless Outreach Coordinating Committee (HOCC), a subcommittee of the Homeless Advisory Board (HAB); serves as a liaison between the Office of Behavioral Health and the Office of Community Services/Homeless services; and attends various county/provider/client meetings to identify barriers and find solutions at provider and system levels of care. The OSN PATH provider co-chairs the HOCC committee and is a voting member of the Homeless Advisory Board. Both OSN and CHS are large housing providers within the CoC.

Collaboration with Local Community Organizations
All PATH Provider agencies continue to maintain a collaborative relationship with surrounding community organizations/services. Specifically, the DHS County PATH Coordinator is responsible for overseeing the PATH Contingency Funds. This responsibility allows the coordinator to establish a collaborative relationship with landlords, utility companies, etc.; in providing financial assistance for PATH eligible consumers. Oftentimes, this relationship has resulted in preventing utility shut-off and evictions.

Service Provision

- PATH eligibility determination: PATH eligibility is usually determined upon initial contact through outreach. However, there are situations where initial contact isn't enough to determine eligibility; and subsequent visits are necessary before eligibility is determined. Eligibility is determined by screening potential PATH participants for homelessness or at risk for homelessness and the presence of a serious mental illness or serious mental illness and substance use disorder. Eligibility criteria is documented in HMIS and in individual provider records. PATH eligible individuals are invited to participate in PATH services and are enrolled after they agree to participate.

- Prioritizing services: To maximize serving the most vulnerable adults who are literally and chronically homeless, the bulk of PATH funds are used to fund street outreach and case management services. Outreach/case management services targeting those who are literally homeless are being increased and added to the existing clinical services offered by CHS to help the most vulnerable access the PATH funded behavioral health services. In addition, efforts are underway to ensure those serving people who are street homeless are aware of the PATH contingency funds to help support people who are literally homeless to obtain and maintain housing. Individualize service plans are developed for PATH participants and PATH providers may support participants in obtaining goals related to mental health and drug and alcohol; housing; SOAR and health benefits; employment; rehabilitation, etc. These are just a few of the services that are aligned with PATH goals.

- Leveraging other funds: In conjunction to the PATH Contingency Funds, agencies such as Urban League; Catholic Charities; LIHEAP; Dollar Energy Funds, etc., are utilized for rental utilities assistance. PATH eligible consumers can be connected to SOAR to apply for SSI/SSDI and health benefits, so they can access mainstream health services. Referrals for housing vouchers and transportation assistance is also a way that other funds are leveraged to help PATH participants. As an added note during the Thanksgiving Holiday, a local news station has a Turkey Drive Fund to help needy families, especially those families that are struggling between paying rent or buying groceries.

- Gaps: Needless to say, services gaps continue to be ongoing issues as in previous years:

  A. Lack of affordable housing

NOT FINAL

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

- Services available to clients who have SMI and SUD: Allegheny County's Bureau of Drug and Alcohol is housed within the Office of Behavioral Health and serves as the Single County Authority (SCA). The SCA contracts with several providers, covering all levels of care, who serve people with cooccurring disorders. In addition, Allegheny County has six Centers of Excellence (COEs) which target individuals with Opioid Use Disorder (OUD). PATH participants who are suffering from co-occurring disorders (Mental Health/Drug and Alcohol) can access all of the above-mentioned services if needed. Ongoing efforts are in place to address the opioid crisis including various training/seminars and the dissemination of naloxone and the use of medication assisted treatment to help combat death from OUD.

- 42 CFR Part 2 regulations: DHS's D/A Program supervisor and staff are aware of the regulations involved with 42CFR Part 2. Any questions related to 42CFR Part 2 will be referred to the SCA for clarification.

- Criminal Justice concerns: Allegheny County DHS continues to have a Justice Related Service (JRS) Program designed to assist PATH eligible consumers that are involved with the legal system. Specific components to JRS include, but not limited to:

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

  JRS Specialists will assist the consumer in connecting to a variety of services needed. The main concern upon discharged from jail, is to obtain housing. Reconnecting that person to resources such as Housing Vouchers, HUD (depending on their criminal history), SSI (possibly through SOAR), general assistance, Goodwill (vocation), etc. are pursued. In addition, the HOCC committee includes a working group dedicated to improving collaboration and support to individuals who are homeless who become involved in the criminal justice system. PATH providers, including DHS are active participants in the working group.

Data

Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff in HMIS training. For any providers not fully participating in HMIS, please describe plans and timeline to complete HMIS implementation. Please note which HMIS product you are utilizing (ex ClientTrack, Mediware etc). Does your organization or CoC

NOT FINAL

have a written HMIS user manual for reference? If so, how is this made available to new and current employees?

All PATH providers are familiar and utilizing the HMIS system and in fact, HMIS is used by PATH providers to receive referrals on their bulletin board from Allegheny Link for individuals identified who may need targeted outreach by the PATH outreach providers. This is another example of how PATH providers are connected with the CoC. Although there is no user manual, trainings and technical assistance are always available to PATH providers to assist with any training or technical issues. New staff are invited to HMIS training. Currently, ACDHS uses its own system. HMIS is routinely monitored by DHS staff to ensure PATH providers are utilizing the system in a timely and consistent manner

Alignment with PATH Goals

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

The PATH providers and County PATH Coordinator continue to focus on ultimately helping those that are literally homeless obtain and maintain housing. A close collaboration with the CoC allows ongoing communication between Coordinated Entry and PATH providers to help identify and develop strategies to identify, engage, ad serve are most vulnerable PATH-eligible clients. Outreach and case management continues to be the initial process in servicing/linking consumers to appropriate services.

Alignment with State Comprehensive Mental Health Services Plan

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

DHS's Hunger/Homeless Program maintains a primary focus on any homeless plans regardless if it is from national, state or local level.

Other Designated Funds

Indicate whether the federal Community Mental Health Services Block Grant, Substance Abuse Block Grant, or other general revenue funds (state or county) *are designated specifically for serving people who experience homelessness and have serious mental illness.* Please indicate if any of these funds are earmarked for PATH services specifically.

In addition to the PATH allocation dollars for FY 2019-2020, agencies such as Urban League, Catholic Charities, LIHEAPP, etc. are financial linkages available for PATH eligible consumers. ESG Grants (through Hunger/Homeless) are funds utilized to support homeless programs to serve the homeless population.

NOT FINAL

Programmatic and Financial Oversight
DHS County PATH Coordinator maintains oversight of PATH dollars utilized by PATH provider agencies by:

- Requesting financial quarterly reports
- Schedule meetings with all PATH providers when needed
- Coordinate county site visit with State PATH Coordinator (Ms. Michelle Baxter)
- Encourage PATH providers to develop charts on PATH enrolled consumers
- Maintain demographic/financial documentation in reference to PATH Contingency Funds
- Monitoring utilization of HMIS

SSI/SSDI Outreach, ACCESS, Recovery (SOAR)
For fiscal year 2019-20:

- Total number of staff (including SOAR Coordinator) and number of new hires during this time: 6 Total Staff
  5 FTE SOAR Benefits Coordinators, 1 SOAR Program Coordinator (1/3 time dedicated to SOAR)
  New Hires during this period (2/18/19 and 5/28/19 start dates)
- Number of individuals served during the timeframe of 7/1/18 to 6/1/19. Please break down the following: 550
  - # of SOAR Applications submitted: 104
- # of Technical Assistance Cases: 48
- # of Active Cases: 48
  - 17 Active awaiting application submission
  - 31 Applications Submitted Currently Awaiting a Decision
- # of Cases Pending: 210
  - 12 Cases Awaiting an intake appointment
  - 23 Cases Attended Intake awaiting disposition
  - 175 Individuals Currently on the waiting list
- # of Cases Closed: 315

NOT FINAL

Housing
Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

PATH provider agencies are familiar with various strategies regarding availability of suitable housing. Such strategies include:

- Helping PATH clients apply for SSI/SSDI for financial assistance. Many consumers can be referred to SOAR regarding this process.

- Help PATH clients apply for Housing Vouchers and site based subsidized housing via the City and County Housing Authorities, HUD housing, etc.
- Encourage PATH clients to complete Vi-SPDAT assessment so they can be prioritized and placed on waiting list for Permanent Supportive Housing (PSH); Rapid Rehousing Housing (RRH); and transition housing options via the CoC by contacting Allegheny Link.
- Referring PATH clients to mental health residential housing via OBH which includes various levels of housing for people with SMI listed below.
- Utilizing PATH Contingency Funds for security deposits, first month rents, etc.

Allegheny County's OBH continues to have a centralized referral process for mental health residential housing. 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

NOT FINAL

Coordinated Entry

Indicate if/how your organization engages with the local coordinated-entry process of your CoC. Please describe how PATH-eligible clients fit into the coordinated assessment process. Does your CoC's assessment/prioritization process produce any barriers to housing/treatment for PATH-eligible consumers (transition age, different funding stream, etc.)? If so, please describe.

Allegheny Link is the CoC's coordinated entry system and it is under the umbrella of ACDHS in the Office of Community Services (OCS). It is a service available to anyone in Allegheny County. PATH-eligible clients are encouraged to contact Allegheny Link by calling, going in person, or meeting with one of their field service coordinators in the community. Allegheny Link uses the Vulnerability Index-Service Prioritization Decision Assistance Tool (Vi-SPDAT) to prioritize clients for CoC housing. Individuals who are chronically homeless per the HUD definition are given the highest priority. Because PATH-eligible clients have SMI, they would have a verified disability but may not meet the HUD definition of homeless which only includes living in shelters or in places not meant for human habitation. PATH outreach providers who document their outreach efforts with their PATH clients in HMIS help to verify homelessness and it keep clients active on the waitlist for CoC housing. Allegheny Link also refers PATH-eligible to PATH outreach providers for targeted and ongoing outreach and engagement. There are no barriers to housing/treatment for PATH-eligible consumers. The CoC uses a housing first approach. People who are chronically homeless, veterans, TAY, and families are given priority.

Justice Involved

Please indicate if Crisis Intervention Team training is being used in your county/joinder. If so, please provide approximate percentage of law enforcement that has been CIT trained and any feedback on outcomes and effectiveness.

Crisis Intervention Team (CIT) trainings in Allegheny County began in 2007 under a grant which helped fund them on a quarterly basis. There were two partners in this process: Pittsburgh Bureau of Police and Allegheny County Department of Human Services. In 2015, CIT classes and enrollments expanded in Allegheny County. In 2017, an Allegheny County Port Authority Police officer joined the CIT training coordinator team. Since 2017, the Pittsburgh Bureau of Police has increased the frequency with which classes are offered and has encouraged its officers to attend. Two trainings a year are reserved for Pittsburgh Bureau of Police recruits, and the remainder are open to all police departments throughout the county - including approximately 100 municipal, Port Authority, university, Pittsburgh Public Schools, and Allegheny County, as well as the FBI, US Federal Marshals, Pennsylvania State Police, Allegheny County Fire Marshals and Allegheny County 9-1-1. CIT class sizes are between 25-30 attendees per month. There have been 1,153 public safety officers trained in Allegheny County to date with 58% of them having been trained since 2015. Fifty-five police departments in addition to the Pittsburgh Bureau of Police have had at least one officer engaged in CIT training since 2007 (42.3% of all departments).

CIT advanced classes have also been offered more regularly in the past two years to train on veterans and children/adolescent issues. Anyone who has completed the 5-day basic CIT training is able to attend the advanced classes.

Local CIT training has been shown in pre- and post- evaluations to improve:

- Comfort level and preparedness in dealing with people with mental illnesses or who are suicidal,
- Knowledge about mental illnesses and developmental disorders
- Knowledge of mental health commitment laws and mental health community treatment and crisis resources, and
- Reduction in the mis-conception that the average person with mental illnesses is more aggressive than the average person in the general population.

Nationally, the program is associated with fewer injuries to police and people they stop who have mental illnesses.

Staff Information

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

The Allegheny County Department of Human Services values inclusion and will take affirmative steps to recognize and respect all individuals and encourages full participation in all areas of agency work and practice without exclusion. DHS believes that each person should have the

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opportunity for an empowering, impactful and positive experience. DHS embraces the diversity of life experiences, cultures and identities in the completion of its mission.

- Allegheny County DHS has tremendous diversity in its hiring practices. The County PATH Coordinator and administrator are white females. The coordinator 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.

- ACDHS has several ongoing training and initiatives to promote cultural competency and to address health disparities including: DHS Inclusion; LGBTQU Champions and Safe Space Champion; Resources for Immigrants & International; SOGIE training; and Language Assistance Services. All DHS staff are expected to participate in trainings annually.

- There are no Certified Peer Specialist or Certified Recovery Specialists at the county level regarding PATH.

Client Information

Please refer to individual provider agencies' IUP's.

During the fiscal year 2017-2018, PATH contingency funds were given to a total of 125 individuals:

Gender:

- Females 90
- Males 34
- Doesn't know 1

Age:

- 18-23 3
- 24-30 17
- 31-40 54
- 41-50 6
- 51-61 42
- 62 and over 3

The projected number of individuals to be contacted who will need contingency funds is 120 and it is expected that 100% of them will be PATH-eligible and enrolled into PATH.

The estimated percentage of adult clients who are literally homeless is 25%.

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Consumer Involvement
Consumer involvement includes, but not limited to the following:

- Complete satisfaction surveys based on services provided
- Consumers are encouraged to become Peer Support Specialist
- With consumer's consent, family members are encouraged to treatment team meetings
- Regarding PATH Budget public hearings are announced that involves the county budget for public feedback
- PATH-eligible individuals serve on the Homeless Advisory Board to the CoC.

Health Disparities Impact Statement
Healthy People 2020 defines a health disparity as a "particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; other characteristics historically linked to discrimination or exclusion."

Health disparities, that exist amongst various racism, ethnicity, age groups, gender, are issues that need to address when providing services for the PATH eligible consumers. Specifically, the major disparity that exist amongst the youth and young adult (*YYA ages 18-30) is drug/alcohol/teenage drinking.

- Subpopulations of PATH-eligible populations include LGBTQUIA, TAY, Females, and Blacks. In 2018, PATH served few TAY or transgender individuals, although HMIS data indicates they've been received homeless services. Targeted outreach to these at-risk populations will be a priority for Fiscal Year 2019-2020.
- For Fiscal Year 2019-20 an estimated number of YYA individuals to be served is from 16 to 20.
- Types of services would include, outreach, case management, mental health and drug and alcohol treatment, financial assistance, linkage to housing, etc.
- Comprehensive treatment plans involving targeted goals, follow up measures and outcomes, are individualized to meet the needs of individuals in overcoming health disparity barriers.

Limited English Proficiency
ACDHS is committed to providing services that are culturally and linguistically appropriate, consistent with its organizational values, the needs of an increasing divers population, and Title VI of the Civil Rights Act of 1964, which protects individuals from discrimination based on race, color or national origin.

ACDHS has in-person interpretation, telephone interpretation and written translation services to help DHS staff effectively interact with individuals with limited English proficiency (LEP) who

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need services or just seeking information. All DHS-contracted providers, including PATH providers may access this service. As an added note, those that are hearing impaired can be provided a sign language interpreter or be referred to the Hearing Deaf Program.

Allegheny County continues to expand, in regard to, a culturally diversified population. In addition, you will still find existing "pockets" of neighborhoods that maintain their ethnicity from their nature homeland. Both PATH providers and DHS are sensitive to such diverse backgrounds and are prepared to assist in the following areas, but not limited to:

1. Language barriers
2. Religious beliefs
3. Socio economical barriers

Budget Narrative

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

PATH funds are primarily used to fund outreach services, case management services, and behavioral health care services via CHS and outreach and case management services via OSN, including the Wellspring drop-in center, an outreach program of Operation Safety Net, serving the PATH-eligible individual. Through the offering of meals, lockers, transportation assistance, and space to access medical, mental health and SUD providers and Allegheny Link field service coordinators, it serves as a hub to identify, engage, and provided case management services to PATH eligible individuals. PATH contingency funds are included in the OSN budget and are used to help PATH-eligible participants obtain housing or prevent eviction by paying for security deposits and rent and utility arrears and is managed by the County PATH coordinator.

FY2019-2020 PATH Allocation

	Allocations	Federal	+	State Match
Operation Safety Net	$534,350	($400,740	+	$133,610)
Community Human Services	$ 67,992	($ 50,994	+	$ 16,998)
Allegheny County DHS	$ 13,303	($ 10,000	+	$ 3,303)
TOTAL	**$615,645**	**($461,734**	**+**	**$153,911)**

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Allegheny County Department of Human Services
PATH Program
Fiscal Year 2019-2020

Line Item	Annual Salary	PATH Funded FTE	PATH Funded Position	Total
County PATH Coordinator	$40,000	0.25	$10,000	$10,000
Fringe Benefits	0	0	$3,303	$3,303
Travel	0	0	0	0
Equipment	0	0	0	0
Supplies	0	0	0	0
Other	0	0	0	0
TOTAL			**$13,303**	**$13,303**

The Allegheny County PATH Coordinator's position is allocated $13,303.00 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.

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Allegheny County Department of Human Services PATH Program Comprehensive Budget Fiscal Year 2019-2020				
Line Item	**OSN**	**CHS**	**ACDHS**	**Total**
Personnel	$ 303,390.00	$ 61,500.00	$ 10,000.00	**$ 374,890.00**
Fringe		$ 2,255.00	$ 3,303.00	**$ 5,555.00**
Travel/training/Staff development	$ 35,909.00			**$ 35,909.00**
Equipment				**$ -**
Indirect Cost				**$ -**
Contingency Fund				**$ -**
Rent/Utilities/Food	$ 64,304.00			**$ 64,304.00**
Rent		$ 800.00		**$ 800.00**
Administrative Cost		$ 3,437.00		**$ 3,437.00**
Vehicle expenses/Consumer transportation/Management fees	$ 26,291.00			**$ 26,291.00**
Office and Building supplies, maintenance, postage, lease, communications	$ 60,451.00			**$ 60,451.00**
PATH Contingency Funds (Managed by County PATH Coordinator)	$ 29,936.00			**$ 29,936.00**
Professional Services	$ 1,363.00			**$ 1,363.00**
Depreciation Interest, Insurance(s)	$ 12,706.00			**$ 12,706.00**
Total	**$ 534,350.00**	**$ 67,992.00**	**$ 13,303.00**	**$ 615,645.00**

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Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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

NOT FINAL

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

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

Source(s) of Match Dollars for State Funds:

Community Human Services will receive a total of $67,992 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 100

Estimated Number of Persons to be Enrolled: 75

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

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

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Allegheny County - Community Human Services Corporation (CHS)

2019-2020 PATH Intended Use Plan

Local Provider Description

PA:035 Allegheny: Community Human Services
2525 Liberty Avenue
Pittsburgh, PA 15222
t: 412-246-1639
f: 412-697-2049
e: cmcwhertor@chscorp.org

Community Human Services Corporation (hereafter referred to as 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 include outreach, assessment and service referral as part of the housing programs provided by the agency. This fund supports a mental health clinic at The Residences at Wood Street (formerly Wood Street Commons).

Additionally, CHS is contracted by Allegheny County Office Behavioral Health to collaborate within a SAMSHA grant, Healthy Housing Outreach (H2O). Similarly to PATH, the focus is to have targeted outreach to identify homeless, chronic homeless, homeless veterans, homeless families, and homeless transition-aged youth with mental illness and need for connection to behavioral health supports. The H2O grant is currently wrapping up and PATH funds have been increased for 2019-2020 to replicate the outreach that was provided through the H2O program.

The expanded PATH services allow CHS to continue to augment access to mental health services through our Central Intake Department, which also oversees CHS street outreach teams. CHS will work to extend the PATH clinic to our central location with the possibility of working in conjunction with the psychiatrist or alternate mental health professionals (psychiatrist or psychiatric nurse practitioner). This ensures the highest quality of service provision as it supports a centralized/coordinated intake and assessment process, collaboration with the Allegheny Link, the CoC's coordinated entry system, in determining the most vulnerable and increasing access to housing, assessments and behavioral health supportive services, expanded life skills and psycho-educational training, expanded rental assistance, and expanded use of harm reduction and housing first approaches. CHS centralized the majority of its programming, except residential programs, in an office that is easily accessible by public or private transportation in the Strip District of Pittsburgh.

The agency's address is: 2525 Liberty Avenue, Pittsburgh, PA 15222.

The name of Provider as it appears in PDX: PA-035 Allegheny: Community Human Services.

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For 2019-2020, the agency anticipates receipt of $67,992 in PATH funds ($50,994 in federal and $16,998 in state funds) allocated through the Allegheny County Department of Human Services Office of Behavioral Health which will provide for mental health services for the behavioral health clinic at The Residences at Wood Street approximately three hours per week to adult individuals (18 years of age and above) and for continued outreach and case management services. Please reference the Budget Section and Budget Template attached for further detail.

Collaboration with HUD Continuum of Care (CoC) Program

CHS is one agency within the Allegheny County Continuum of Care (CoC), PA-600. Members of CHS staff have a long history of involvement and planning within the CoC and CHS is a significant contributor to the effort to end homelessness in the CoC. CHS staff members attend the Allegheny County Homeless Alliance and its subcommittees as meetings are scheduled. Through these committees, providers are identifying and addressing the causes of homelessness, its perpetuation and the delivery of service throughout the homeless provider network and mainstream resources. Staff members attend regular meetings with local providers, Homeless Advisory, Allegheny County-Department of Human Services-Offices of Behavioral Health and Homeless Services. They use these forums to stay connected to community wide housing and supportive service efforts, county staff and resources in the community. This regular contact allows staff to share resources and appropriately make and coordinate referrals. The CHS PATH program receives and accepts referrals from Allegheny Link for individuals who need targeted outreach and support who are street homeless and/or behavioral health assessments and treatment to help verify disability and address barriers to obtain and maintain housing related to behavioral health needs. The PATH program links individuals to the CoC and provides ongoing support to PATH participants to help them obtain housing via the CoC.

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. **Healthy Housing Outreach (H2O)** is a SAMSHA funded collaborative partnership between Allegheny County Department of Human Services, Community Human Services, Western Psychiatric Institute and Clinic, Pittsburgh Mercy Health System Operation Safety Net, and Chartiers Center. CHS is funded to have a full time outreach case manager and partially funds the Director of Customer Service and Intake who oversees the central entry point for all of CHS services. The goal is to target homeless individuals and families in need of behavioral health supports and provide targeted mental health services and reduce barriers to housing. The H2O program is currently wrapping up operations and the expanded PATH funding will replace much of the work that CHS completed through the H2O program.
2. **The Residences at Wood Street (Wood Street Commons)** is a part of CHS's continuum of care. Housing, both temporary and long term is available. CHS manages a 32 bed shelter program, a 15 bed CMI Bridge Housing program, a 20 bed permanent HUD funded housing program and a 6 bed program specifically for individuals currently in the probation system. CHS community support specialists work with building residents to secure and maintain affordable housing. Both Medical and Mental Health services are available on site. The behavioral health services at the mental health clinic at Wood Street Commons is funded by CHS's PATH allocation.
3. **Housing Authority:** All clients of CHS complete applications for City of Pittsburgh and Allegheny County Housing Authorities with their community support specialist. CHS also

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works with the housing authorities to prevent evictions of particularly vulnerable tenants (medical/mental health issues).

4. **Veterans Administration Healthcare for the Homeless Program** provides medical care and supportive services for homeless veterans referred by CHS staff.

5. **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.

6. **Bethlehem Haven** is a collaborative partner. Staff assisted women in the shelter to connect with housing and other services. Bethlehem Haven provides shelter, Drug and Alcohol based housing, a modified safe haven program for women, transitional homeless housing and essential clinical services.

7. **Drop in Centers & Feeding sites** throughout Allegheny County provide outreach sites for CHS staff and also provide socialization opportunities for homeless consumers.

8. **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 mental health staff to ensure comprehensive primary and behavioral health supports to homeless individuals.

9. **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.

10. **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.

11. **Western Psychiatric Institute and Clinic** has a full range of homeless housing and mental health services within their homeless continuum.

12. **University of Pittsburgh Schools of Pharmacy, Social Work, Public Health, Nursing, Occupational Therapy and Psychology** have the ability to place intern rotations within the CHS programs, providing crucial project and services to individuals served within the agency. Interns consistently are placed within the CHS programs and at the Residences at Wood Street (Wood Street Commons).

13. **UPMC Health Plan/Community Care Behavioral Health Organization** and CHS work collaboratively and are contracted to provide shelter plus care permanent HUD homeless housing services to greater than 25 medically compromised individuals.

14. **Allegheny Health Network** and CHS work collaboratively and are contracted to provide housing services to medically compromised individuals in a pilot medical respite program.

Service Provision

PATH eligibility determination

PATH eligibility is determined at the initial contact when possible. Criteria to be met include homelessness, propensity to become homeless, and the desire to enter mental health services. Individuals are enrolled into PATH services once eligibility is verified and the individual agrees to PATH services.

Alignment with PATH goals

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

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community. While PATH funds do not cover any service costs entirely, the following PATH services are provided by the PATH supported staff: outreach, case management, 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. PATH eligibility is determined at the initial contact when possible. Once eligibility is verified and the individual agrees to accept PATH services, the client is enrolled. Typically, individuals are enrolled at the initial appointment within the mental health clinic. Individuals identified via outreach services will be enrolled at first contact when possible, but further engagement may be needed before a PATH eligible individual will accept PATH services. Enrollment is then recorded via the CHS clinical record as well as Allegheny County HMIS and CIPS data platforms. Criteria to be met include homelessness, propensity to become homeless, and the desire to enter mental health services.

Maximizing use of PATH funds
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. CHS also will leverage PATH funds by billing Behavioral HealthChoices through Community Care Behavioral Health Organization (CCBHO). Because many clients can be dual eligible with PATH any funds obtained through billing can support the program.

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.

Gaps in current service system
Several gaps exist in the current service delivery system and have been of a persistent nature.

1. There are not enough funds to meet the ever growing demand for health/behavioral services and housing. Second, traditional services continue to take longer periods to access once an individual is able to willingly accept and engage. It is typical 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.

2. There is a lack of affordable housing available in our community. The local wages do not meet housing costs. 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 Authorities are often cut each year making less affordable housing available. Applications for this housing become more and more competitive.

3. 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

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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 overburdened and underfunded.

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

5. 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.

6. 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.

7. Limited shelter stays also create a barrier to stability. Individuals can only rely on shelter 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.

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

42 CFR Part 2 regulations
Regarding 42 CFR Part 2, CHS is not a funded/licensed substance use provider.

Justice-involved
CHS strives to maximize 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 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 one program that directly

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serves individuals with criminal histories and involve housing crises. Greater than 50% of individuals involved in the PATH program have criminal histories.

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. CHS has additional staff who are available and prepared to data enter HMIS activity as the agency uses the HMIS system routinely within many of the funded homeless programs. Allegheny County Department of Human Services provides training and written materials at no cost to providers utilizing both HMIS and CIPS platforms. Any current or new employee requiring HMIS training has ready access to training through internal resources or at the County level.

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. While historically the funds were not utilized for direct outreach but only for direct mental health services to individuals who are homeless or have the propensity to become homeless, with the expansion for 2019-2020 there will be an outreach and case management component. Internal agency programs will also continue to be relied on for outreach and case management in certain situations. Other external partners and resources will also continue to provide referrals and resources for PATH participants. This will be a continuation of the collaboration which started with H2O.

Alignment with State Comprehensive Mental Health Services Plan

CHS PATH funds provide outreach, case management and direct mental health services to individuals. 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. CHS delivers services with low barriers and in a culturally competent manner. CHS follows the harm reduction model which does not require any specific action from a participant and encourages active participation in treatment. CHS works to reduce the stigma of receiving mental health services by offering services directly on site at The Residences of Wood Street (Wood Street Commons) by bringing providers on location to serve individuals. CHS expects all staff and contractors to work in collaboration with individuals to meet their defined treatment goals and to allow the individual to lead in the planning of such goals. CHS strives to be non-judgmental and not restrict anyone from receiving services while also providing outreach to bring harder to serve individuals into mental health services.

Other Designated Funds

The PATH funds provide direct mental health services to individuals who are homeless which often includes linkage and referral to mainstream services and supports. Limited administrative case management is provided via the supervising nurse or alternate clinical staff member, who is not PATH funded. Additional case management and street outreach is also provided by the PATH funds. Additionally, further case management funding is provided through other sources including: 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

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billable services will augment existing internal PATH funding.

Programmatic and Financial Oversight

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

For 2019-2020, the agency anticipates receipt of $67,992 in PATH funds ($50,994 in federal and $16,998 in state funds) allocated through the Allegheny County Department of Human Services Office of Behavioral Health which will provide for mental health services for the behavioral health clinic at The Residences at Wood Street approximately three hours per week to adult individuals (18 years of age and above) and for continued outreach and case management services.

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

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

SSI/SSDI Outreach, Access, Recovery (SOAR)

CHS currently has limited staff within the housing departments that are SOAR trained. One staff member trained is the Director of Intake and Customer Service, who was heavily involved with the H20 program and will continue to be involved with the expansion of PATH. Additionally, CHS is having a new employee complete the training in the housing department which can be a resource to the PATH program. 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. 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. External resources are utilized for SOAR specific referral, inclusive of Allegheny HealthChoices, Inc. and Mercy Behavioral Health. CHS will assess whether training further staff in SOAR is feasible, especially with the expansion of the PATH program.

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

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months to a year, even if contact has not been made. Cases are not closed until the outreach staff attempt to locate the consumer to re-engage in services. Additionally, missed clinic appointments are re-scheduled automatically a minimum of two times 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.

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 CHS Housing 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.

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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. CHS routinely assists to link individuals/families to Allegheny Link and have the ability to assist to monitor their status. This is not necessarily a PATH specific activity.

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 one program that directly serves individuals with criminal histories and involved housing crises. Greater than 50% of individuals involved in the PATH program have criminal histories.

Allegheny County and the City of Pittsburgh have Crisis Intervention trained public safety officers. It is anticipated that less than 50% of law enforcement is trained within Allegheny County. CHS have staff complete Mental Health First Aid (MHFA) trainings when available and appropriate, which is a crucial part of understanding crisis situations and responding in an appropriate manner.

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 members receive training on cultural diversity/sensitivity and service provision within the agency through their new hire orientation and ongoing during employment. Staff members are involved in organized trainings at low or no cost through internal and external resources. Staff members 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. Mental Health First Aid (Adult – USA) is offered and an annual competence for all staff will be to attend an adapted Comprehensive Crises Management training relevant to CHS. At this moment CHS does not have any staff members who are Certified Peer Specialists of Certified Recovery Specialists.

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.

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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.

CHS agency PATH funds are not utilized for training staff. Alternate agency funds are utilized and free trainings are explored. The primary staff members funded by PATH funds (nurse, psychiatrist, social worker) have or require professional licenses and have a bi-annual requirement regarding continuing education hours, which are consistently satisfied.

Client Information

The program expects to provide PATH funded services to a minimum of 100 unduplicated individuals during 2019-2020 although work will be done in an attempt to exceed this number. 100% of those individuals are anticipated to be homeless or near homeless at enrollment. This will include a minimum of 30 individuals through the mental health clinic. The remaining 70 will be through outreach and will be street homeless, of which we expect 45 to be enrolled in PATH while the remaining will be encounters that do not necessarily materialize into an enrollment. Outreach clients are also expected to access the mental health clinic in many circumstances. 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). The program also expects to significantly increase the number of Transition Aged Youth, 18-30 years of age, as part of the expansion of funding to support outreach. This is a population that has been low in previous years and is an important one to reach.

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Below is a table outlining 2018-2019 statistics regarding Ethnicity/Race/Gender/Age, these statistics are based solely on reporting obtained from Allegheny County HMIS:

ETHNICITY/RACE	UNDUPLICATED NUMBER OF CLIENTS	GENDER/AGE	UNDUPLICATED NUMBER OF CLIENTS
Black	5	Male	7
White	14	Female	14
Asian	0	Transgendered	0
Multi-Racial	2		
		18-30 years of age	0
		31-34 years of age	1
		35-64 years of age	17
		65-74 years of age	2
		>75 years of age	1

2019-2020 statistics are expected to increase significantly from the year 2018-2019 statistics. Unduplicated individuals served annually were anticipated at 30 per year and only 21 unduplicated individuals were served to date. This is due to the absence of a psychiatrist for

much of the year, a position that is planned to be filled shortly. There have been many challenges to finding a psychiatrist available for the pay rate and the necessary 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 4-6 months.

Consumer Involvement

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

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

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

Health Disparities Impact Statement

Health and Behavioral Health Disparities are previously addressed in Section **Service Provision** of this intended use plan, with the exception of transitional age youth (TAY). Transitional age individuals, 18-30 years of age, are served through the mental health clinic. So far the number of TAY seen has been zero in 2018-2019. PATH funds are not utilized directly for assistance to TAY individuals, but towards the service provided to the individuals through the mental health clinic. 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 Project Silk. Increasing this number will be a priority in the expansion of PATH services with the addition of outreach services. This outreach can be done in conjunction with Project Silk, where active referrals can be completed.

NOT FINAL

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

Budget Narrative
For 2019-2020, the agency anticipates receipt of $67,992 in PATH funds ($50,994 in federal and $16,998 in state funds) allocated through the Allegheny County Department of Human Services Office of Behavioral Health which will provide for mental health services for the behavioral health clinic at The Residences at Wood Street approximately three hours per week to adult individuals (18 years of age and above) and for continued outreach and case management services. CHS will have a Registered Nurse to oversee clinic activities. There will continue to be psychiatric services provided through a contracted agreement once a psychiatrist is found. The expansion of the PATH funds will allow for an Outreach Therapeutic Intervention Specialist to continue much of the work that the H2O program had begun and there will be partial time for the Director of Intake and Customer Service, who is essential in building and performing outreach to homeless individuals and referrals and was intricately involved in the H2O program. 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 feet. Some minimal administrative costs are also included and only 5% of the entire budget, below normal administrative costs for CHS.

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BUDGET TABLE

Allegheny County

Community Human Services

PATH Program-Wood Street Commons Mental Health Clinic
FY 2019-2020 Budget

PERSONNEL Position	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Registered Nurse	$50,000.00	0.10	$5,000	$5,000.00
Psychiatric Physician or other Mental Health Professional (Psychiatric Nurse Practitioner)	$125/hour	3 hrs weekly (sub-contracted position)	$14,500.00	$14,500.00
Outreach Therapeutic Intervention Specialist	$40,000	0.50	$20,000.00	$20,000.00
Director of Intake and Customer Service	$55,000.00	0.40	$22,000.00	$22,000.00
sub-total			**$61,500.00**	**$61,500.00**
FRINGE BENEFITS				
FICA Tax			$1,340.00	$1,340.00
Health Insurance			$84.00	$84.00
Retirement			$352.00	$352.00
Life Insurance			$211.00	$211.00
Workers' Comp, Ins.			$268.00	$268.00
sub-total			**$2,255.00**	**$2,255.00**
TRAVEL				
n/a				
SUPPLIES/EQUIPMENT				
n/a				
Other				
Rent Expense (Office)			$800.00	$800.00
Administration			$3,437.00	$3,437.00
sub-total			**$4,237.00**	**$4,237.00**
Total PATH Budget			**$67,992.00**	

NOT FINAL

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	n/a
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

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

Estimated Number of Persons to be Contacted: 900

Estimated Number of Persons to be Enrolled: 600

Estimated Number of Persons to be Contacted who are Literally Homeless: 855

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Operation Safefy Net
2019-2020 PATH IUP

1200 Reedsdale Street, Pittsburgh, PA 15233

Marriles Maga, Case Manager
903 Watson Street, Pittsburgh, PA 15219
412-689-0925

Local Provider Description

- Mercy Life Center Corporation, more specifically, Pittsburgh Mercy Operation Safety Net is a Community Mental Health organization.
- Pittsburgh Mercy serves Allegheny County
- Pittsburgh Mercy receives $534,350 in total funding. (($133,610 State Match; $400,740 Federal)
- In the PDX Operation Safety Net is PA-040

Collaboration with HUD Continuum of Care Program

Pittsburgh Mercy is a large provider of mental health, behavioral health, and homeless services within in the Continuum of Care. All of the agencies within the Continuum of Care receive referrals from the Allegheny County Department of Human Services, more specifically Allegheny Link. Allegheny Link can be reached at 1-866-730-2368.

Collaboration with Local Community Organizations

Pittsburgh Mercy partners with various outreach teams throughout the City of Pittsburgh and Allegheny County. A few of those outreach teams include Northside Housing Alliance and Downtown Partnerships. We also partner with Healthcare for the Homeless to assist clients in obtaining necessary health, and dental needs. Pittsburgh Mercy primarily partners with Western Psychiatric Institute (apart of UPMC Health System) for mental health care within H2O services. H2O (Healthy Housing Outreach) is comprised of Pittsburgh Mercy, Community Human Services, Chartiers Center, and Western Psychiatric Institute. H2O helps individuals who are chronically homeless and have a mental health diagnosis or are struggling with drug and alcohol. Within H2O clients are able to receive a psychiatric evaluation, supportive services, and assistance with housing. The primary goal of H2O is mental health, but they assist with all the needs of clients. Wellspring is implementing various programming goals, including Referrals, mental health, behavioral health, housing and employment. Each programming goal will be on a specific day of the week.

Service Provision

Alignment with PATH goals

NOT FINAL

PATH funds are used to pay for the salary of one street outreach worker, one case manager, and a drop in center for homeless individuals. The services provided by the PATH staff case management and street outreach to unsheltered homeless adults with mental illness as well as those struggling with a co-occurring substance abuse disorder. This low barrier project provides linkage and supportive services to the service-resistant, unsheltered homeless individuals in Allegheny County. This program provides service linkage and resources to the most hard-to-reach of the homeless population, often those who do not fit anywhere else and are not connected with any other supports. PATH case management and street outreach are often the first step for this population to be safely assisted and reconnected to mainstream society. This project targets the unsheltered homeless who have fallen through the cracks of existing services and are often unable to immediately participate in mental health treatment or other supportive services as many in this population often isolate from mainstream society. Social interaction, behavioral health treatment and improved personal care are encouraged. Outreach, engagement and relationship building are a major focus as it is necessary for trust to be developed in order for an individual to accept services and to succeed with their personal goal plan. Case Managers ensure that participants are individually assisted to obtain mainstream health, social, and employment benefits.

Maximizing use of PATH funds
Pittsburgh Mercy receives at total of $534,350 in PATH funds. $382,211 of the PATH budget is put towards the cost of running the Wellspring Drop-In Center. Wellspring serves individuals with mental health, regardless of their homeless status. Wellspring offers a variety of services that include mail for individuals who do not have a stable address to get mail and receive benefits, a hot lunch 5 days a week, walk-in case management, and medical services. PATH receives $152,139 in funds $29,936 of the PATH budget is set aside for PATH contingency funds. The county PATH coordinator oversees the use of the PATH contingency funds. The PATH budget is also used to assist individuals in getting a photo ID and/or birth certificate when it is needed.

Gaps in current service system
A gap that exists in the Allegheny County service system is that individuals are unable to receive mental health services without having documentation. PATH is able to fill that gap due to our consumers not needing documentation for 90 days. The Street Outreach staff is mobile and is able to meet with and reach out to consumers where they are, whether they are living in a tent or in a shelter. Pittsburgh Mercy also has a Drop-In Center where consumers are able to come and receive PATH services 5 days a week.

Co-occurring services available
Through PATH consumers with mental health are able to be connected to various programs. They can include Service Coordination, Mental Health Case Management, Healthy Housing Outreach (H2O) which is bridging the gap between mental health services and homelessness, Outpatient mental health, and Crisis Services. Consumers with substance abuse disorders are able to get connection to AA or NA meetings, in-patient and outpatient services. PATH primarily utilizes Central Outreach services to connect clients with in-patient drug and alcohol services. Central Outreach will do a brief assessment on client, get their insurance information, and then call in-patient rehabs that have a bed available. Once a bed is found, Central Outreach

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will schedule the client's pick-up. This process typically takes about an hour to complete, from the time they call to having their pick-up scheduled. Consumers with substance abuse disorders are also eligible for H2O services. The PATH case manager, as well as, all of the case managers within Operation Safety Net assess clients and refer them to services on an individual basis. The services can include free behavioral health, physical health, and dental clinics. PATH clients are able to be connected to in and out-patient mental health services. If a higher level of care is needed referrals to service coordination, IDDT, CTT, or any other services needed are able to be referred through PATH. PATH funds are also used to train and maintain training for the staff to learn how to better assist our clients with their individual needs.

42 CFT Part 2 regulations
Pittsburgh Mercy follows 42 CFR Part 2 Regulations by requiring a release of information to speak to anyone outside of Pittsburgh Mercy Family of Services. Pittsburgh Mercy also follows all confidentiality regulations. Pittsburgh Mercy also has a Compliance Department to ensure that all regulations and laws are followed.

Justice-involved
Pittsburgh Mercy does not turn a consumer away regardless of their criminal history and does not require any consumer to have a background check. Pittsburgh Mercy also offers mobile Street Outreach, the Mobile Medical Unit that goes to various locations throughout Allegheny County and the City of Pittsburgh. Pittsburgh Mercy has a Health Center that offers primary and follow up care. Pittsburgh Mercy participates in Coordinated Entry for homeless services to ensure the most vulnerable are being assisted first. Pittsburgh Mercy also has a Peer Support Program that will offer 6 months of training and then a paid internship for 6 months. Many of our Peer Support Staff are hired by Pittsburgh Mercy at the end of their internship. The only requirement for the Peer Support Program is that the consumer has to have their High School Diploma or GED.

Data
Initially, PATH staff participate in a basic HMIS training through the Department of Human Services. Pittsburgh Mercy enrolls all of their PATH clients in HMIS. Pittsburgh Mercy has recently added a Data Quality manager to our team which focuses on complete, accurate, and timely data management.

Alignment with PATH Goals
PATH funds are used for individuals who are currently homeless or at risk of homelessness for purposes of using the money for first month's rent, security deposit, or a utility bill. The individual is able to get up to $300 that they can receive once every three years. Prior to receiving funds, the staff member must search for available funds outside of PATH. PATH partners with Allegheny Link and the Urban League for primary sources of outside funding. If the staff member exhausts 3 other funding sources they are able to submit the application to PATH funds. The majority of the time, Pittsburgh Mercy will use foundation funds to assist the individual with the full amount they need if PATH funds do not cover the full amount the individual needs. PATH allows clients to keep any important documents such as their birth

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certificate, social security card, and/or proof of income in a labeled file so they do not have to replace documents or worry about documents being lost if their belongings are stolen.

Alignment with State Comprehensive Mental Health Services Plan
Pennsylvania has a state initiative to end homelessness. It is in this initiative that drives the Pittsburgh Mercy PATH services. PATH funds are able to be used for individuals who are homeless or at risk of being homeless to assist them with their security deposit, first month's rent, and eviction prevention. Pittsburgh Mercy and PATH assist clients who are homeless in obtaining safe and stable housing. PATH strives to remove barriers, navigate the housing system, and obtaining necessary resources. PATH also ensures that those individuals who are housed are able to maintain their housing.

Other Designated Funds
The Community Mental Health Services Block Grant and Substance Abuse Block Grant are designated specifically for serving people who are experiencing homelessness and have severe mental illness. Currently, Operation Safety Net supplies an Enhanced Case Manager (ECM) who works through the mental health block grant. In turn, when a person served meets the criteria for a higher level of care, a referral is made to ECM in order to meet individualized goal plans and referrals for higher levels of care can be made this way. In addition, follow along support is provided during the housing process to ensure that individualized support is available to the person served.

Programmatic and Financial Oversight
The Office of Behavioral Health will coordinate and provide PATH oversight to this organization as a part of its contract with PA DPW/OMHSAS. Staff supervisor will provide monthly visits as well as supervisions with PATH staff will be conducted to ensure that work is being conducted as expected through this intended use plan. Pittsburgh Mercy's fiscal department tracks spending for PATH funds used from the county. Quarterly phone interviews with county representatives are held to ensure that PATH funds are adequately dispersed and utilized correctly.

SSI/SSDI Outreach, Access, Recovery (SOAR)

- At this time there are no PATH staff trained in SOAR. This is due to Pittsburgh Mercy oversees and operates SOAR Works in Allegheny County. All of the PATH staff complete a SOAR application and send it to the SOAR team, who will then take over the case.
- The number of PATH staff who provided assistance with SSI/SSDI applications using the SOAR model was zero. Again, this is due to Pittsburgh Mercy overseeing and operating SOAR Works in Allegheny County. All of the PATH staff complete a SOAR application and send it to the SOAR team, who will then take over the case.
- Through the entire SOAR program, a total of 251 individuals have been assisted, but not every person was active in PATH.

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- From July 1, 2017 through May 21, 2018 the approval rate for SOAR is 79.3%. The average time from submission to decision is 77.46 days.
- At this time there are zero PATH staff dedicated to implementing SOAR, due to Pittsburgh Mercy overseeing and operating SOAR Works in Allegheny County. All of the PATH staff complete a SOAR application and send it to the SOAR team, who will then take over the case.

Housing
The start to all suitable and sustainable housing starts with Coordinated Entry. Clients are assessed and referred to all appropriate services within the CoC. PATH Case Managers also assist in looking online for housing, completing applications, and looking at units with clients.

Coordinated Entry
All of the rapid rehousing and permanent supportive housing programs receive their clients through the CoC. Specifically, PATH does not participate in the coordinated entry. PATH clients are met with on the street and at the Wellspring Drop-In Center. The PATH outreach team works to build rapport and to get the individual ready to meet with case management or other services. The PATH case manager will enroll the client in the PATH program. PATH case managers also ensure the clients are assessed for the housing needs. Through PATH clients are given an initial assessment. PATH case managers assist in calling the Allegheny Link with the client. The PATH case managers are able to help bridge and be a liaison between Allegheny Link and the client. Allegheny Link mobile staff members are at Wellspring twice a week on an on-going basis.

Justice Involved
Currently, Pittsburgh Mercy is part of the initiative in providing CIT training for officers in Allegheny County. The training is required for law enforcement providers in Allegheny County. During the training, officers involved go through daily life activities while wearing headsets which confront officers with distressing voices while they go through a series of activities including a job interview, an assessment with an interviewer (mock psychiatric assessment). According to Kimberly Falk from Allegheny County, who is also an evaluator for CIT, around 30 officers from many different jurisdictions are trained on a monthly basis at our South 9th St. office and it is reported via questionnaires following trainings that there are positive outcomes including knowledge about working better with people who have severe mental illness.

Staff Information
- Operation Safety Net is a very diverse agency. Operation Safety Net employs 30 individuals who directly or indirectly work with PATH clients. Of the 30 there are 8 African-American females and 3 African-American males. There are also 12 White females and 7 White Males. The staff includes case managers, outreach staff, medical team, and Wellspring staff. PATH staff includes 3 females, two are African-American

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- and one is White. There are also 4 males, 3 of whom are white and one is African-American.
- Each and every one of our 29 staff members are open and welcoming to our clients regardless of their age, race, gender, disability, and sexual orientation. All of our staff recognizes that each person comes to us with their own set of struggles that are specific to their lives and background. Staff members treat every client as an individual and with respect to those differences and struggles.
- Operation Safety Net staff is very receptive to differences of clients. Our staff is able to work with clients no matter what their background, gender, age, race, or sexual orientation.
- Operation Safety Net staff are able to participate in training, both online and in person, that are hosted by Pittsburgh Mercy to broaden their knowledge of cultural competence and health disparities. Operation Safety Net staff are also given the opportunity to attend conferences on one or both topics discussed. Pittsburgh Mercy staff also participates in Diversity Training, Working with the Homeless, basic First Aid, Mental Health and Behavioral Health trainings.
- PATH has one staff member who is both a Certified Peer Specialist and Certified Recovery Specialist. Another member of our staff is currently working on becoming a Certified Peer Specialist.

Client Information

- At this point, there is Pittsburgh Mercy does not have a way to track the demographic information of the clients who come to Wellspring. However, a system will be implemented within the next year for us to be able to track client involvement. For PATH specific clients in the current fiscal year who were enrolled there were 65.5% Male, 31.5% female. 48.1% were African American, 44.4% White, 3.7% Multiple Races, 1.9% American Indian, and 1.9% Asian. 1.9% of the individuals enrolled were age 18-24; 18.5% age 25-34; 26% age 35-44; 35% age 45-54; 16.7% age 55-64; 0 were age 65 or above; and there was 1.9% who did not report their age.
- The number of individuals to be contacted through Street Outreach, Linkage services, and Wellspring is estimated to be 900 unique clients.
- Through the three programs, Street Outreach, Linkage services, and Wellspring we expect to enroll 600 clients into PATH.
- The percentage of adults who receive PATH funds and are literally homeless is approximately 95%.

Consumer Involvement

Pittsburgh Mercy values the lived experience our clients have gone through and see these individuals as an important part of us becoming better. Pittsburgh Mercy takes pride in hiring individuals with lived experience when we are able. The lived experience can include formerly homeless, individuals who are currently in recovery, individuals with a mental health diagnosis. Pittsburgh Mercy has Peer Support specialty positions that are the perfect bridge to becoming truly self-sustainable in the community. Operation Safety Net implements the Homeless Advisory Board. With the Homeless Advisory Board individuals we serve are able to come

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together and tell their story, and share opinions on what led them to be homeless. The Homeless Advisory Board meets quarterly. Operation Safety Net strives to include family members who are actively involved with our clients. PATH case management also attempts to rebuild bridges that have been broken down within families so our clients have much natural support as possible as they rebuild their lives and home.

Health Disparities Impact Statement

- The female homeless population faces unique barriers. Operation Safety Net has seen females be the victims of abuse, especially on the street. A barrier PATH staff finds when helping victims of abuse are the limited shelter beds available. Also, females are accepting apartments that are not the best or in the best neighborhood just to get off of the street and away from the abuse they may be facing.
- The unduplicated number of YYA individuals who are expected to be served using PATH funds, including Street Outreach, PATH, and Wellspring is 400.
- The total amount of PATH funds expected to be expended on services for the YYA population is estimated to be $240, 450.
- YYA individuals have various PATH funded services available to them. Including, the use of Wellspring, Street Outreach if it is needed, case management, and the contingency funds. H2O services are also available to the YYA population if they are considered chronically homeless and eligible for permanent supportive housing.

Limited English Proficiency

Pittsburgh Mercy does not discriminate or turn away clients due to language barriers. At this time, PATH has not encountered any clients with a language barrier. Pittsburgh Mercy is able to utilize phone and face-to-face interpreting to assist clients during the entirety of their involvement.

Budget Narrative

Operation Safety Net will receive a total $534,350 in PATH funding. ($133,610 State Match; $400,740 Federal)The funding is used to operate the Wellspring Drop-In Center, Case Management Services as well as Outreach services.

- $303,390 will go towards staff wages and benefits. The wages are used for 1.5 outreach positions, 1 case manager, 1 supervisor, 1 front desk staff, 1 cook, and 1 safety officer. This was calculated based on historical records of this specific expenditure. .
- $29,936 will go towards the county-wide contingency fund. This fund provides stipends of up to $300 to homeless clients in need of assistance with security deposits, rental assistance, utility assistance, and/or eviction prevention. This expenditure is put towards on-going activities.
- $35,909 will go towards travel, training, staff development, and management fees. This expenditure is based on on-going activities and market rates.
- $64,304 will go towards rent, utilities, and food for the Wellspring Drop-In Center. This is based off of historical records and market rates for this expenditure.

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- $26,291 will be put towards vehicle expenses of company vehicles, consumer transportation, including bus tickets, and management fees. This expenditure is based on on-going activities and market rates for this expenditure.
- $60,451 will go towards Office & Building maintenance, the lease of the Wellspring Drop-In Center, Supplies, Maintenance, Postage, and Communications. This is based on historical records, market rates, and quotes received from vendors.
- $1,363 is used for Professional Services. This is based on quotes received from vendors.
- $12,706 is for Depreciation, Interest, and Liability Insurance(s). This is based on market rates, historical records, and quotes from vendors.

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Operation Safety Net Budget
Allegheny County PATH Program
FY 2019-2020 Budget

PERSONNEL Position	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
6.5 FTEs *(includes total benefits)* 1 Case Mgr., 1.5 Outreach, 1 Cook, 1 Front Desk (C4), 1 Supervisor & 1 Safety Officer	$303,390	6.50	$303,390	$303,390
sub-total				303,390
TRAVEL				
Travel, Training, Staff Development, and Management Fees				35,909
sub-total				35,909
SUPPLIES/EQUIPMENT				
Rent, Utilities, Food				64,304
Vehicle Expenses, Consumer transportation, and management fees				$26,291
Office & Building Supplies, Maintence, Postage, Lease, Communications,				60,451
sub-total				151,046
Other				
PATH Contingency Funds				29,936
Professional Services				1,363
Depreciation, Intrest, Insurance(s)				12,706
sub-total				44,005
Total PATH Budget				**$534,350**

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Armstrong-Indiana County
120 South Grant Avenue, Suite 3
Kittaning, PA 16201
Contact: Tammy Calderone

Provider Type: Social service agency
PDX ID: PA-032
State Provider ID: 4232
Contact Phone #: 7245483451

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 45,258**	**$ 15,086**	**$ 60,344**	

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 45,258	$ 15,086	$ 60,344	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**none**
l. Grand Total (Sum of j and k)	$ 45,258	$ 15,086	$ 60,344	

Source(s) of Match Dollars for State Funds:

Armstrong/Indiana Counties will receive a total of $60,344 in federal and state PATH funding.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

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

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

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Armstrong-Indiana Behavioral and Developmental Health Program

County Summary Intended Use Plan
FY 2019-2020

Local Provider Description

The Armstrong-Indiana Behavioral and Developmental Health Program (the AI BDHP) is located in rural West/Central Pennsylvania. The AI BDHP is the county government agency created by the Mental Health Procedures Act of 1966 to serve as the administrative entity and primary oversight authority of all Behavioral Health/Mental Health, Intellectual Disabilities, Early Intervention services and the Health Choices Program in both Armstrong and Indiana Counties. In fiscal year 2008-2009, the AI BDHP first applied and received funding to operate a PATH program in each county, becoming the PATH provider. From 2008 through 2012, the AI BDHP operated in the capacity of grantee and provider. In 2012, the decision was made to transfer the program operation to local providers who could provide a better quality based program to serve more individuals. As of fiscal year 2019-2020 the AI BDHP contracts with the Family Counseling Center of Armstrong to operate the Armstrong County PATH Program. The Indiana County PATH Program is operated by the Indiana County Community Action Program. The Family Counseling Center (FCC) is the main mental health treatment provider in Armstrong County, serving also as the mental health Base Service Unit. The Indiana County Community Action Program (ICCAP) is the Local Lead Agency (LLA) and main housing provider in Indiana County. The agency also provides representative payee services and operates the county's Pathways Homeless Shelter.

The chart below provides current contact information for the Armstrong-Indiana Behavioral and Developmental Health Program and its contracted PATH Providers.

AGENCY NAME	MAILING ADDRESS	PROVIDER PDX NAME	PDX ID #
Armstrong-Indiana Behavioral and Developmental Health Program	120 South Grant Avenue, Suite 3 Kittanning, PA 16201	Armstrong-Indiana MH/MR Program	PA-032
The Family Counseling Center of Armstrong County	300 South Jefferson Street Kittanning, PA 16201	Family Counseling Center of Armstrong County	PA-078
Indiana County Community Action Program	827 Water Street Indiana, PA 15701	Indiana County Community Action Program	PA-068

For FY 2019-2020, it is anticipated that the Armstrong-Indiana Behavioral and Developmental Health Program will receive a total PATH allocation of $60,344. This would include a Federal allocation of $45,258 and a State match allocation of $15,086. The total allocation will be divided equally between each PATH provider, with the Family Counseling Center of Armstrong County receiving a total allocation of $30,172 ($22, 629 federal dollars and $7,543 in state match

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funds). The Indiana County Community Action Program will then receive a total allocation of $30,172 ($22,269 federal dollars and $7,543 in state match funds). Along with this comprehensive Intended Use Plan submitted by the AI BDHP for both Armstrong and Indiana County PATH programs, plans will also be submitted for the Indiana County Community Action Program and the Family Counseling Center of Armstrong County.

Collaboration with HUD Continuum of Care (COC) 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 Pennsylvania Homeless Management Information System (PA HMIS). The AI BDHP is not a member of the local PA-601 Western Continuum of Care, (CoC); also known by the new name "One by One, Ending Homelessness in Western Pennsylvania". Our office does, however, have a strong working relationship with the Local Lead Agencies in both counties, the Armstrong County Community Action Agency and the Indiana County Community Action Program who are very active with the Western Pennsylvania Continuum of Care and the Southwest Regional Homeless Advisory Board. Staff from the LLAs provides CoC updates at local housing meetings held at least quarterly in each county which AI BDHP housing staff attend as well.

Despite not having a direct working relationship with the PA-601 Western Continuum of Care, the Armstrong and Indiana PATH Program maintain a high degree of outreach, education, case management and coordination of services which is vital to sharing information and providing assistance to those who are homeless or at risk of becoming homeless in the two counties. Coordination of resources and outreach efforts are achieved primarily through the work of the Behavioral Health Housing Liaisons/PATH Case Managers. Staff provides outreach and education to all local human service agencies and consumers. If their services are accepted by consumers, the BHHL/PCMs can then coordinate with staff from the local human service agencies in researching housing options, obtaining housing options and funds to assist individuals secure or maintain their housing, and then providing case management services to help link individuals with beneficial services that can assist them in sustaining their housing. They also are available to work with staff from the Coordinated Entry system (a CoC initiative) to ensure individuals are entered into the system and then help to ensure individuals follow up with housing options identified for them.

Collaboration with Local Community Organizations

As stated previously, the Armstrong-Indiana Behavioral and Developmental Health Program has a long standing history of developing and maintaining collaborative agreements with local community/human service agencies. These partnerships are crucial to providing the best overall service to those with mental health, intellectual disabilities and early life developmental challenges who are homeless or at risk of becoming homeless. The extensive list provided below indicates the local organizations that the AI BDHP and the Behavioral Health Housing Liaisons/PATH Case Managers partner with on a continual basis. The list represents Human Service Agencies, the Criminal Justice System, Employment Services, Behavioral and Physical

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

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

Through building and maintaining a good working relationship with the organizations listed above, the AI BDHP has been able to partner to provide support for a number of several creative and successful initiatives aimed at helping consumers overcome and eliminate barriers to locating, obtaining, and sustaining safe and affordable housing. As each county presents its own unique challenges in developing and maintaining housing options, each agency partner also brings unique expertise and funding resources to make those options possible. The following are a few examples of activities and initiatives achieved in recent years:

- Establishment of a homeless program using PHARE dollars
- Fair Housing training and education
- Prepared Renter Program (PREP) training
- Extensive outreach to locate homeless individuals through the PATH Program and annual Point in Time Surveys
- Local landlord workshops/education/engagement sessions
- Development and implementation of a behavioral health Bridge Housing Program

A key in providing strong coordination and outreach to other systems and agencies has been the effort put forth by our Behavioral Health Housing Liaisons/PATH Case Managers in each

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county. These staff members have been working to improve the coordination efforts between housing services and drug and alcohol services, justice related services, and behavioral health services (including crisis and mobile medication services). Through their work with our consumers and families, they ensure that those in need can make informed decisions about services and care and are available to help link/refer individuals to those services. The BHHL/PCMs have also worked to educate the outreach-based service providers such as crisis, Targeted Case Management, Family Based services, and Peer Support services as to what emergency housing options are available. The consumers, in turn, have received comprehensive care and support while addressing their housing situations.

Service Provision

Armstrong-Indiana PATH Referral and Enrollment Process

The Behavioral Health Housing Liaison/PATH Case Managers are the PATH provider staff responsible for processing all referrals, assessments, and enrollments for the Armstrong and Indiana County PATH Programs. The liaisons/case managers first meet with a client who is either homeless or imminently homeless that discloses mental health issues and is at least eighteen (18) years of age, or is an emancipated minor with legal documentation. The PATH program is then explained to the client. If the client is interested in being enrolled in PATH, releases are signed to obtain the necessary documentation. Once all documentation has been received, the client is then enrolled them into the PATH program and their information is entered into the Homeless Management System. The client may be enrolled in the PATH program for 90 days before they are required to obtain documentation of their mental health diagnosis. In the event that the client does not wish to be enrolled the information would be entered as a pre-enrollment contact in the HMIS system.

Armstrong-Indiana PATH Service Description

Street Outreach, Education, and Engagement

Outreach to individuals who are homeless or are at risk of becoming homeless continues to be a priority for the Armstrong and Indiana PATH Programs. Because of the rural nature and terrain of both counties, outreach efforts present a series of challenges. It is extremely difficult to locate those most vulnerable and most in need. Further complicating efforts is the fact that often times clients "couch surf" from one situation, making it nearly impossible to get a true handle of all those in need. In order to help overcome these obstacles, the outreach effort of the Behavioral Health Housing Liaisons/PATH Case Managers will continue to be a priority this year. Outreach efforts will continue to be concentrated in areas where those with mental health challenges are known to receive services or spend their leisure time. Increased efforts include partnering with the local drop-in centers so that the BHHL/PATH Case Managers are on the monthly schedules at the center. This allows consumers to know when staff will be there if they would like to meet with them in person. The liaisons also visit the peer support providers in each county on a regular basis to meet with consumers and staff. Outreach to the Blended Case Management departments in each county has also increased and has improved the overall coordination between BHHL/PATH Case Managers and Targeted Case Managers. The housing liaisons/case managers will also continue to conduct homeless street outreach in areas such as local parks,

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Community Support Program meetings, Suicide Task Force meetings, stores, churches, homeless shelters, domestic violence shelters, veteran service locations, hospitals and other community settings. Outreach efforts also continue through interaction with local social service agencies, correctional facilities, and law enforcement.

Another function carried out by PATH Case Managers/housing liaisons is to provide education to consumers, families, and local human service agencies, school districts, local landlords and the general public, in the hopes of increasing engagement with the PATH-eligible population. Education includes informing individuals about what the PATH and behavioral health services are available. In addition to providing PATH clients and local agencies with service education, they also conduct educational presentations in the community. Each housing liaison/case manager presents about PATH and community services at the local Drop-in Centers, CSP meetings, agency/systemic trainings, NAMI meetings and other community events in hopes of reaching as many vulnerable individuals as possible. This has proven effective in increasing the overall engagement of PATH eligible individuals.

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

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

who are eligible for PATH in both Armstrong and Indiana Counties usually already have obtained Social Security and Medicaid benefits prior to becoming involved in the PATH Program.

Service System Gaps
Despite the number of behavioral health and housing services available to residents of Armstrong and Indiana Counties, gaps do remain. For example, currently no emergency shelter is available for Armstrong County residents. And now, with recent funding cuts, the emergency homeless shelter in Indiana County is in jeopardy. In both counties, there is a significant gap in services for individuals or heads of households who have credit issues and need budget counseling who may have a criminal history, drug & alcohol issues, or past landlord concerns. An individual with a mental health diagnosis could have had one or more of these concerns at any time on their road to recovery, making their housing needs more precarious if a provider or landlord does not understand and support recovery. Another complication is true lack of affordable housing in each county. 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. Landlords are also reluctant to offer their sites for Fair Market Value or accept Section 8 as a means of payment, which puts many homes out of the reach of PATH clients who have limited income. Also, despite education efforts, sigma towards those with mental illness still exists, especially amongst some landlords. These things create ever mounting barriers to our consumers and families searches for safe and affordable housing.

One other easy to identify gap in services in both counties is regarding the Youth and Young Adult (YYA) population. Currently, there is no specific treatment or housing system available to individuals 18-30 years of age. It is projected, however, that by late 2019 or early 2020, YYA Peer Support services will be available in both Armstrong and Indiana Counties. This service will provide the much needed connection between child and adult services and provide support as young adults make the transition to adulthood. Our PATH program will continue to focus a great deal of effort on trying to work with these individuals to help eliminate barriers they currently experience.

Finally, as Armstrong and Indiana are primarily rural communities and both counties have limited resources, limited employment services and very limited transportation. These conditions create major barriers. The lack of reliable transportation especially 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. Transportation continues to be a focus area for all planning initiatives for the AI BDHP.

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

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ARMSTRONG/INDIANA BEHAVIORAL HEALTH SERVICES

Adult Mental Health Services	Child/Adolescent Mental Health Services	Drug and Alcohol Services
• Screening and Assessment Services • Psychiatric Evaluation • Medication Management • Partial Hospitalization • Inpatient Hospitalization • Intensive Outpatient Services • Mobile Medication Program • Clozapine Support Services • Blended/Targeted Case Management • Psychiatric Rehabilitation (mobile and site based) • Peer Support Services • Vocational Services • Drop-in Centers • Consumer/Family Satisfaction Team • Supported Living • Community Residential Rehabilitation Services (Maximum and Minimum) • Intensive Permanent	• Screening and Assessment Services • Psychiatric Evaluation • Medication Management • Partial Hospitalization • Inpatient Hospitalization • Intensive Outpatient Services • Individual/Family/Group Therapy • Blended/Targeted Case Management • Behavioral Health Rehabilitation Services • Strength Based Treatment • Family Based Services • Multi-Systemic Therapy • YYA Peer Support Services (2019-2020) • Community Residential Rehabilitation Services • MH Residential Treatment Facilities • MH/ID (dual program) Residential Treatment Facility • Early Intervention Services • Student Assistance Program • Consumer/Family Satisfaction Team Program • 24/7 Walk-in Crisis Services • 24/7 Mobile Crisis Services • 24/7 Telephone Crisis Services	• Screening/Assessment Services • Inpatient Treatment • Intensive Outpatient Treatment • Outpatient Treatment • Support Groups • Recovery Support Services • Prevention and Education • Tobacco Prevention/Cessation Services • Drug Court (Indiana) • Drug-Free Communities Coalition • Student Assistance Program • Halfway Houses • Oxford House Program • Consumer/Family Satisfaction Team Program • 24/7 Walk-in Crisis Services • 24/7 Mobile Crisis Services • 24/7 Telephone Crisis Service • Medical Assistance Transportation Program

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Supportive Housing Program (CHIPPS) • Enhanced Transitional Housing Program (CHIPPS) • Long Term Structured Residence • Emergency PHARE housing • 24/7 Walk-in Crisis Services • 24/7 Mobile Crisis Services • 24/7 Telephone Crisis Services • Medical Assistance Transportation Program	• Medical Assistance Transportation Program • Early Intervention Services • Community Development • Social or emotional Development Screening • Self-Help or Adaptive Development Screening • Cognitive Development Screening	

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

Behavioral Health/Criminal Justice Population
The Armstrong-Indiana Behavioral and Developmental Health Program is committed to supporting justice related services and re-entry initiatives in our communities. Staff from our office is active participants in each county's Criminal Justice Advisory Board. The boards work to address systemic and policy issues regarding the Criminal Justice System. Staff from the AI BDHP and an Armstrong County Commissioner has also been participating in the Stepping Up Initiative training sessions. This initiative is a nationwide effort to divert individuals who have mental illness from becoming incarcerated with the goal of getting them into treatment. This program will require strong communication and collaboration between local mental health agencies and components of the Criminal Justice System. Finally, Armstrong and Indiana Counties are partnering with surrounding counties to develop a Regional Forensic Plan. The plan is aimed at developing other placement options for those with mental illness facing incarceration where they can receive mental health treatment in secure settings. The proposal calls for creating a regional Long Term Structured Residence (LTSR), a regional Extended Acute Care facility (EAC), a regional Enhanced Personal Care Home, and Boundary Spanner positions across the counties.

Having safe and affordable housing options is a key discussion topic through all of the justice related initiatives. Staff from the Criminal Justice System sits on local housing consortiums where local agency and housing providers meet to discuss gaps in housing and possible collaborations to fill those gaps.

To help increase the success of PATH clients and individuals who may be eligible for PATH (who also have criminal justice histories), the Behavioral Health Housing Liaisons/PATH Case Managers are available to link individuals to behavioral health services, employment services, and housing. The staff work very diligently at trying to minimize the stigma and barriers individuals with criminal justice involvement often face. This is done by building and maintaining good working relationships with law enforcement, the courts, and the local jails. The BHHL/PCMs are available to provide education/training to criminal justice personnel and work closely with those individuals to transition individuals back into the community after incarceration. They have successfully case managed a number of individuals who have found permanent housing and have accepted behavioral health/human service assistance. One of the greatest challenges presented to our PATH program staff our those individuals who are released from jail/prison with nowhere to live and who must report to the Pennsylvania State Police and register as a Megan's Law Sexual Offender. While behavioral health support services are available to assist these individuals, often times housing is not. These individuals not only face limited housing choices available in the county, but face landlords who are not willing to rent to this population even if support services are involved. It is hoped that by educating landlords and prospective landlords about services to help sex offenders, more housing resources/options can be secured. It is estimated that approximately an average of 40% of all individuals served by the Armstrong-Indiana PATH Program have some type of criminal history.

Finally, to help address the housing needs of mental health consumers who also have criminal justice histories, the AI BDHP has partnered with its Indiana County PATH Provider, the Indiana County Community Action Program to develop a Mental Health Bridge Housing Program. The program offers tenant based rental assistance and support to those who are homeless or at risk of becoming homeless who have a mental health diagnosis and active Medical Assistance Coverage. The program works in conjunction with the local homeless shelter, also operated by ICCAP to house individuals as quickly as possible. Many of the people served by the shelter have mental health challenges and often times have been incarcerated at some point during their life. The Bridge Program provides the opportunity for a person to secure an income and start building a good credit rating and a positive housing reference. It is hoped that by helping a person build these positive things even with a criminal history, a landlord may be more inclined to consider an application from them for more permanent housing. The Behavioral Health Housing Liaisons/PATH Case Managers are also able to provide case management to clients if they choose which can help to ensure the individuals continue to remain out of jail and/or continue to meet the conditions of their release.

Data

The Armstrong-Indiana PATH Program has fully implemented the transition to Pennsylvania's Homeless Management Information System (HMIS). The product both counties are using Client

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Track. The Armstrong-Indiana Behavioral and Developmental Health Program, as well as our contracted PATH Providers, are all registered and trained the system, and work collaboratively in data entry, completing required reports, and analyzing data collected for the two counties. The BHHL/PATH Case Managers are also in contact with the state PATH contact located at the Department of Human Services, as well as staff from Pennsylvania's Department of Community and Economic Development (DCED) to resolve any data entry and reporting issues. All BHHL/PATH Case Managers will be required to attend any new training offered on the HMIS, including webinars offered by Client Track and PATH HMIS Learning Communities. Any new BHHL/PATH Case Managers hired will receive HMIS training from supervisory staff and by accessing the online training materials available on DCED's HMIS website. A hard copy of the most current PA HMIS manual is also available for staff to reference in their day-to-day activities. The manual is also located on the PA-601 Western Continuum of Care's website.

Alignment with PATH Goals

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

Alignment with State Comprehensive Mental Health Services Plan

The Office of Mental Health and Substance Abuse Services (OMHSAS) has required county behavioral health offices to complete County Mental Health Plans to demonstrate work being done to serve the mentally ill and to identify where system improvements need to be made. Over

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the last ten years, the state has shifted its focus from more of a treatment/medical model of care to the recovery and resiliency model. As part of this planning process, OMHSAS asked counties to develop a County Housing Plan in 2007. Counties are now required to submit a plan to the Commonwealth under the human services block grant initiative. Armstrong and Indiana Counties became block grant counties in fiscal year 2018-2019. The AI BDHP has begun working on aligning our services and programs with the block grant model. Housing is a vital part of that plan. It is through the guidance provided in these planning processes that the AI BDHP has begun to shift the focus of housing services to become more focused on recovery and resiliency. This has meant shifting core mental health residential services away from more traditional congregated living situations (i.e., group home living) to more of a Permanent Supportive Housing (PSH) approach. The PSH approach allows individuals to live in independent living situations that must be safe and affordable to them. To further the recovery philosophy, consumers are not required to accept services to live independently. The services they do choose to accept and participate in must be flexible and very individualized. The PATH Program has become an integral part in helping those transitioning out of integrated settings into their own independent living arrangements by providing support throughout the entire process.

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

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

Other Designated Funds

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The Armstrong-Indiana Behavioral and Developmental Health Program utilizes three funding resources available to help support our PATH Program. However, the only resource specifically earmarked for the PATH Program is money provided through our PATH grant. This funding is considered to be the last resort, being used when no other funding resource can be located to assist someone who is homeless or at risk of becoming homeless.

Another revenue source used to assist PATH clients is the Health Choices Reinvestment funding. This funding is available through a multi-year regional housing reinvestment plan. This fund is managed by the AI BDHP and the Southwest Behavioral Health Management Corporation. While it is not specifically earmarked per se to those in the PATH program, the fund is used to help fill in the gaps for people enrolled in PATH when needed. In order to access this fund, the individual has to be enrolled in Medical Assistance and have a documented mental health diagnosis. The fund can be used to provide one- time rental assistance (rent and security deposit) and for the purchase of household goods needed to establish a residence such as bedding, towels, utensils, etc.

The final source of other funding that can be used to help support the PATH program is the AI BDHP's MH Base Funding. This funding, when needed, is primarily used to help support the overall cost of staffing for our PATH Program. It may also be used to fund services that are not covered by Health Choices or for individuals who do not qualify for Health Choices but are deemed PATH eligible. Again, this money is not specifically earmarked for PATH services, but can be used if a need arises. It should be noted that as Armstrong and Indiana Counties are new block grant counties, funding strategies and resources to assist those who are homeless are under consideration and discussion.

Program and Financial Oversight

AI BDHP Financial

The Armstrong-Indiana Behavioral and Developmental Health Program staff maintains both programmatic and fiscal oversight over the Armstrong and Indiana County PATH Program. The AI BDHP fiscal staff work closely with PATH providers (both fiscal and program) on creating budgets for the program and fiscal report submissions. Regular program invoicing is also monitored on regular basis by fiscal staff. The AI BDHP housing point person must sign off on any requests from the Behavioral Health Housing Liaisons/PATH Case Managers to use PATH dollars to ensure eligibility requirements are met and that funds are being used appropriately. The housing point person also communicates frequently with the AI BDHP's fiscal staff to ensure billing is accurate and the PATH Providers are reimbursed accurately for any expenses incurred.

AI BDHP Program Oversight

The AI BDHP's Quality Management Coordinator is responsible for conducting annual program reviews of the Armstrong and Indiana PATH Programs. These reviews focus on program operational areas such as outreach/education, the PATH referral process, case management services, overall chart documentation and organization, data entry compliance, staff

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development, and the program's overall quality assurance processes. The reviews consist of chart audits and staff interviews. Consumer feedback is obtained through the Armstrong/Indiana Consumer and Family Satisfaction Program's interviewing process. Results of the reviews are shared with the PATH providers, the State Path Contact (SPC), and consumers/family members.

SSI/SSDI Outreach, Access Recovery (SOAR)

It is a requirement of the Armstrong-Indiana Behavioral and Developmental Health Program that all Behavioral Health Housing Liaisons/PATH Case Managers become SOAR trained within six months of their hire date. In fiscal year 2018-2019, the Indiana County Community Action Program had turnover in both Behavioral Health Housing Liaison/PATH Case Manager positions. The new staff is in the process of becoming SOAR trained. It is expected that both will complete the training by the end of 2019. The Armstrong County BHHL/PATH Case Manager is SOAR trained.

Number of PATH staff trained in SOAR	1
Number of staff who provided assistance with SSI/SSDI applications using the SOAR model	0
Number of consumers assisted through SOAR	0
Application eligibility results	0

It should be noted that to date, most individuals have already obtained SSI/SSDI benefits. Our Behavioral Health Housing Liaisons/PATH Case Managers are more than willing and able to assess individuals for the possibility of obtaining benefits and then work with them through the application process.

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Housing

The AI BDHP believes strongly that those with mental illness and/or co-occurring issues deserve the right to live in quality, de-segregated housing. In 2015, the AI BDHP implemented a Mental Health Residential Reform Project. With the support of staff from the Western Region Program Office of the Office of Mental Health and Substance Abuse Services, the AI BDHP worked with our residential provider to implement lengths of stay criteria on all MH residential beds. This has allowed more consumers to access these services which often serve as stabilizing programs for those who have had high inpatient admission rates, are stepping down from long term care institutions, or who have been become homeless in the community and need additional mental health support. All consumers now complete a Residential Transition Plan (RTP) with their plan manager. The BHHL/PATH Case Managers are able to assist with this plan and will be called upon to work with consumers to support their recovery journey into more independent living in permanent housing. Overall, this transition has reduced our reliance on segregated housing options for our consumers, shifting the focus to more integrated/independent housing.

In addition to transforming our own MH residential services, the AI BDHP took steps to collaborate with local housing experts to assess and try to better meet the overall housing needs

of consumers and their families. A subcommittee of the Indiana County Housing Consortium was created to explore unmet housing needs for those receiving behavioral health services in Indiana County. Representatives from the Indiana County Office of Planning and Development, the Indiana County Community Action Program, the Indiana County Housing Authority, local MH residential provider I&A Residential Services, the Family Promise Program of Indiana County participated in the discussions. The result of the efforts was the AI BDHP requesting and receiving funding through a multi-year regional housing plan using Health Choices Reinvestment Funding: The Health Choices Housing Reinvestment Plan permits funds to be used for four services/programs: Bridge Housing, Master Leasing, Housing Support/Housing Liaisons, and a Housing Contingency Fund. To access the Bridge Housing and Master Leasing Programs, individuals must be at least 18 years of age, be an active recipient of Medical Assistance, and have a documented serious and persistent mental illness (SMI). Individuals needing case management services through our Housing Liaisons/PATH Case Managers must be at least 16 years of age, be homeless or at risk of becoming homeless, and either have or be at risk of developing a serious emotional or behavioral disturbance. Those requesting assistance through our Housing Contingency Fund must be at least 16 years of age, be an active recipient of Medical Assistance, and either have or be at risk of developing a serious emotional or behavioral disturbance.

Funds became available for use in 2017. In early 2018, the Housing Contingency Fund was reinstated in both counties. This fund can be used rental assistance, utility assistance, and the purchase of household items necessary for someone moving into a new home. In March of 2018, plans were finalized to open a Mental Health Bridge Housing Program in Indiana County. At least four units will be available to serve the homeless or those at risk of becoming homeless. The program provides temporary tenant-based rental assistance to individuals and families to quickly establish decent, safe, and affordable housing until a more permanent source of rental assistance is obtained. This program serves PATH clients and will be beneficial in helping to overcome barriers to housing that many PATH clients have experienced. Referrals to the program are generated by the Indiana County Behavioral Health Housing Liaisons/PATH Case Managers. The program is operated by the Indiana County Community Action Program.

The final part of the Armstrong and Indiana portion of the regional Health Choices Housing Reinvestment Plan was to use reinvestment funding to renovate at least 2 apartments in Armstrong County through Capital Reinvestment. These apartments will be available for mental health consumers, including PATH clients. Once renovations are completed, the AI BDHP will be working with the housing provider to determine which type of Permanent Supportive Housing Program will work best. If money is still available at the completion of the entire project, the AI BDHP may look to expand the number of units under the new PSH program. The housing provider is the Alliance for Nonprofit Resources.

In addition to these new housing initiatives, the local partnerships that exist have created a number of housing options available to our PATH clients. The chart provided below outlines all of the housing options currently available in both counties by provider agency:

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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 AI BDHP)	Armstrong & Indiana Counties
Minimum Care Community Residential Rehabilitation Program (1 hour/day supervision)	I&A Residential Services, Incorporated (funded by the AI BDHP	Armstrong & Indiana Counties
Supported Living Program (1 hour/week supervision)	I&A Residential Services, Incorporated (funded by the AI BDHP	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
Family Promise of Indiana County	Family Promise of Indiana County	Indiana County
Section 8/ Low Income Rentals	Housing Authorities in each county	Armstrong & Indiana Counties
Meckling Shakely Veteran's Center	Veteran's Administration	Armstrong & surrounding Counties
Temporary Emergency Housing	Salvation Army, Red Cross, Local Ministries, PHARE/Armstrong County Community Action Agency	Armstrong & Indiana Counties
PA Homeless Assistance Program	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Bridge Housing	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Emergency Solutions Grant	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Homeowner's Emergency Mortgage Assistance Program	Armstrong Community Action & Indiana Community Action	Armstrong & Indiana Counties
Rental Properties	Armstrong Community Action & Indiana	Armstrong & Indiana Counties

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	Community Action	
Permanent Housing for the Disabled	Armstrong County Community Action & Indiana County Community Action	Armstrong & Indiana Counties
Armstrong/Fayette County Rapid Rehousing Program	Armstrong County Community Action	Armstrong County
Armstrong County Rapid Rehousing Program (formerly the Transitional Housing Program)	Armstrong County Community Action	Armstrong County
Armstrong County HUD-VASH Program	Butler County VA	Armstrong County
Indiana County HUD-VASH Program	Indiana County Housing Authority	Indiana County
Veterans Housing Project	NCCDC	Indiana County
Section 811 Rental Assistance Housing Units	Indiana County Community Action Program	Indiana County

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Coordinated Entry
The Coordinated Entry (CE) initiative in both Armstrong and Indiana Counties has been implemented. Both Local Lead Agencies (Armstrong County Community Action Agency and the Indiana County Community Action Program) are working closely with the PA-601 Western Pennsylvania Continuum of Care to ensure the implementation runs smoothly and complies with program guidelines, including use of the Homeless Management Information System, the data collection/entry/tracking system used by both the Coordinated Entry Program and the PATH Program.

The Armstrong and Indiana Behavioral Health Housing Liaisons/PATH Case Managers are able to make referrals to the Coordinated Entry Program on behalf of PATH eligible individuals. They are able to assist Coordinated Entry staff by providing documentation and information to help the individuals be placed on the CE housing list. They are also available to serve those who are assessed for Coordinated Entry and who might also be eligible for the PATH program by providing rental assistance to help secure housing.

Justice Involved
The AI BDHP has supported offering training to local law enforcement and court-related personnel in hopes of providing more education and insight into mental illness and how it affects the day-to-day lives of our consumers and family members. Crisis Intervention Team training has been provided to law enforcement/court personnel in both of our counties. This includes CIT training for Veterans. Overall, the training has been very well received and attended. It is estimated that 25% of all our enforcement/court related personnel have received CIT training. Staff has represented a number of agencies such as the district magistrate offices, local police departments, local sheriff offices, local jails, district attorney offices, and the Pennsylvania State

Police. Along with CIT Training, law enforcement/court-related personnel have also attended Mental Health First Aid Trainings (adult and youth) offered in our counties. Finally, the AI BDHP has also provided detailed training on the Mental Health Procedures Act to the law enforcement/court-related staff in each county.

Staff Information

The PATH Program staff employed by the Armstrong-Indiana Behavioral and Developmental Health Program is 100% Caucasian female. Both individuals hold Master's Degrees and have been employees of the AI BDHP for nearly 20 years. Our staff has worked with many persons who have varied cultural differences, many of whom have moved into the area to attend the Indiana University of Pennsylvania and other surrounding universities/colleges. The AI BDHP PATH staff is required to participate in all cultural diversity and cultural competency trainings as they are made available through various resources. The Armstrong-Indiana Behavioral and Developmental Health Program and its PATH providers (the Armstrong County Community Action Agency and the Family Counseling Center of Armstrong County) 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. Currently none of the PATH staff for the Armstrong and Indiana County PATH Programs are Certified Peer Specialists or Certified Recovery Specialists.

The demographics of the Family Counseling Center's (FCC) PATH Program staff are currently 100% Caucasian females with 29 years of experience serving the mental health consumers and families of Armstrong County. Staff was chosen to operate the PATH Program because of their expansive knowledge and experience in working with those with mental health challenges, those with financial difficulties, those with criminal and poor rental histories as well as those with dual diagnoses. They also have an expansive knowledge of community-based services. All staff members have college degrees and have received cultural competency and diversity training and continue to engage in Cultural Competency/Diversity webinars offered by SAMHSA. These staff members have extensive experience working with all age groups and all nationalities of people. The PATH staff has also earned their Bachelor's degrees. Armstrong County consists primarily of English-speaking citizens. Translation services, when needed, can be accessed through the Armstrong School District, the Armstrong-Indiana Intermediate Unit, or the Indiana University of Pennsylvania. The BHHL/PATH Case Manager and the PATH Program Supervisor are required to stay updated on cultural competency and diversity training.

The demographics of the Indiana County Community Action Program's (ICCAP) PATH Program staff are 100% female. Staff members combined service history of well over 25 years in various roles with one Behavioral Health Housing Liaison/PATH Case Manager having over 20 years of mental health service experience herself. One liaison has a bachelor's degree and the other has a Master's Degree in Adult Education. ICCAP supervisory staff members are seasoned veterans working with the homeless; many of whom also suffer from behavioral health challenges. All staff members are trained in cultural competency and diversity and continue to engage in Cultural Competency/Diversity webinars offered by SAMHSA. The Behavioral Health Housing Liaison/PATH Case Managers are supervised by the Client Service/Case Management Director. Indiana County consists primarily of English-speaking citizens. Should

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the need arise for interpretative services; assistance will be obtained through other human services agencies, the Armstrong-Indiana Intermediate Unit and the Indiana University of Pennsylvania. All BHHL/PATH Case Managers will be required to stay updated on cultural competency and diversity training.

In the 2018-2019 Block Grant application, the AI BDHP recognized the need to improve educational opportunities on cultural competency in both counties. As such, the AI BDHP made Cultural Competency Education as its third priority. The AI BDHP is in the process of developing a long-range plan that will promote and incorporate cultural competency in our behavioral health delivery system by collecting and analyzing demographic data on a regular basis and holding focus groups with local stakeholders to develop a cultural competency philosophy to enrich the behavioral health services in Armstrong and Indiana Counties.

Client Information

Indiana and Armstrong Counties are fairly homogeneous with the majority of residents identifying as Caucasian and English speaking with a collective average of approximately 95% falling into those categories. Our counties are also very rural with traditional high unemployment and low income.

The population to be served by the PATH Program will be those who are 18 years of age or older, are homeless or at imminent risk of becoming homeless, suffer from a serious and persistent mental illness and live in Armstrong or Indiana counties. For both counties, the overall projected number of those to be contacted is approximately 140 individuals, with at least 53 of these to be enrolled in PATH services. The total projected percentage of those who will be homeless or literally homeless is estimated to be around 30% which is an average between the two counties.

Consumer Involvement

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

Consumers and family members, including PATH clients and those who may be PATH eligible, are strongly encourage to be active members of local agency advisory and governing boards. The AI BDHP values the unique insights and perspectives of consumer and family members. The AI BDHP also strongly encourages all of its providers to not only include consumers and

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family members on their boards and have them be meaningful participants, using their knowledge and experiences to improve the overall quality of services in our two counties. Leading by example, the AI BDHP Advisory Board's chairperson is a self-identified family member. This individual is not only active on a local level, but is also highly involved on state committees.

Within our PATH Program itself, consumer and family member input strongly valued. Input is continually sought as a method for improving services provided. PATH Case Managers members build plans *with* the clients not *for* the clients. They are seen as partners, not clients. When a person graduates from needing PATH services, they are asked to complete an exit interview and are encouraged to share their thoughts and concerns about the PATH Program through that process as well. During state PATH site visits, PATH clients are invited and encouraged to fully participate, including talking directly with the Pennsylvania PATH Contact and other 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.

Health Disparities Impact Statement

County Specific
In reviewing Indiana County PATH data collected in the PA HMIS, two subpopulations vulnerable to behavioral health disparities were identified: those with a Co-Occurring disorder (MH/D&A) and those falling into the Youth and young Adult age group. The Indiana County PATH Program served 13 clients who identified as having a Co-Occurring disorder. Thirty-three percent (33%) of PATH clients fell between the ages of 18-30. Both subpopulations present similar barriers that put them at risk of homelessness and/or from finding safe and affordable housing options such as poor/no rental history, criminal justice history, no/low income, and mental health and/or substance abuse challenges.

In Armstrong County, the PATH data collected in the PA HMIS for fiscal year 2018-2019 showed that the main subpopulations represented included those between the ages of 30 and 50 who have (1) significance mental health challenges, (2) co-occurring disorders (MH/D&A), and (3) those who have a low socioeconomic status presenting with little to no income and no employment options. Residents are primarily Caucasian, English speaking individuals. The rural nature of the county and its limited resources has a direct impact on their lives, being impacted by limited employment opportunities, limited transportation options, and limited safe and affordable housing options. The majority of 2019-2020 PATH funding is expected to be used to serve these subpopulations.

Youth and Young Adult Population
The YYA population has long been identified as an underserved population in both of our counties in a number of ways and by a number of different human service agencies. It is also a population that seems to evade early identification. This makes it that much more difficult to prevent homelessness. For 2018-2019, we anticipate that on average between our two counties, the YYA population will represent approximately 37% of the total individuals served in our PATH Program. This is a 7% increase from 2017-2018. The total number of unduplicated

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individuals expected to be served by the AI BDHP's PATH Program is 22, which is also a slight increase from the previous year. The total amount of PATH funding expected to be used by the Armstrong and Indiana PATH Providers to help this population is $11,751 because of the high need for services this population often presents with, mainly the need for rental and security deposit assistance and case management. In fiscal year 2018-2019, the Behavioral Health Housing Liaisons/PATH Case Managers will work to increase outreach and engagement to those in the YYA Population. They will also continue to assist the PATH-eligible YYA Population in obtaining services to reduce barriers to housing and improve their overall quality of life. PATH funded services that will be offered to the Youth and Young Adult Population in Armstrong and Indiana Counties includes the following:

- Outreach
- Engagement
- Education
- Case Management/Housing Support
- Rental Assistance
- Security Deposit Assistance
- Transportation
- Information and Referral

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

- PATH service education: The BHHL/PATH Case Managers will continue their educational and outreach efforts to inform people who fall in this population and those who support them. This will include visiting local area school district staff and behavioral health community-based service staff. The goal is to build a more collaborative relationship with school teachers, guidance counselors and Student Assistance Program (SAP) workers. Staff from Blended Case Management, Family Based, Child/Adolescent Outpatient Services and Partial Hospitalization Programs will also be staff targeted to receive training about the PATH Program and what can be done to prevent homelessness.
- Personal documentation retrieval: The BHHL/PATH Case Managers will help the YYA population retrieve and access all pertinent personal documents such as birth certificates and photo identification that are needed to access services and housing.
- Applying for benefits: The BHHL/PATH Case Managers are to be SOAR trained so that they will be able to assist clients in applying for Social Security benefits. The BHHL/PATH Case Managers must also be knowledgeable about other resources and link clients to those if they so choose.
- Support service education and referral: The BHHL/PATH Case Managers must work with community providers to locate and secure support services to help the YYA

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population find and maintain their housing. These services can include such things as behavioral health services, money management services, daily life skill education, and financial rental assistance.
- Early identification of PATH- eligible YYA individuals: The AI BDHP Children/Adolescent Service System Program Coordinator (CASSP) works closely with AI BDHP's Quality Management and Housing Coordinator and the AI BDHP Clinical Care Manager 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 AI BDHP staff to work with the Behavioral Health Housing Liaisons/PATH Case Managers located at each of our PATH providers in creating a plan to help reduce or eliminate the risk of these young adults from becoming homeless. Once an individual is identified as eligible for PATH services, and if the client is in agreement, the housing liaisons/case managers will be invited to participate in Interagency Service Planning Team (ISPT) meetings to discuss housing options. The AI BDHP's CASSP and Clinical Care Management Coordinator will work with our behavioral health providers to secure all behavioral health services for the individuals as well.

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

Limited English Proficiency

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

Budget Narrative

NOT FINAL

The budget presented below is a comprehensive budget for the Armstrong-Indiana PATH Program. For FY 2019-2020, it is anticipated that the Armstrong-Indiana Behavioral and Developmental Health Program will receive a total PATH allocation of $60,344. This would include a Federal allocation of $45,258 and a State match allocation of $15,086. The total allocation will be divided equally between each PATH provider, with the Family Counseling Center of Armstrong County receiving a total allocation of $30,172 ($22, 629 federal dollars and $7,543 in state match funds). The Indiana County Community Action Program will then receive a total allocation of $30,172 ($22,269 federal dollars and $7,543 in state match funds). Along with this comprehensive Intended Use Plan submitted by the AI BDHP for both Armstrong and Indiana County PATH programs, plans will also be submitted for the Indiana County Community Action Program and the Family Counseling Center of Armstrong County.

Personnel:

For the Family Counseling Center of Armstrong County, a total of $16,250.00 in PATH funds is devoted to PATH Program Staff salary. Of that total, $728.00 helps support the supervisor's salary. The remaining allotment designated to staff salary supports the Behavioral Health Housing Liaison/PATH Case Manager at 50%. Both PATH program staff members are located at the Family Counseling Center of Armstrong County and are full time employees. The supervisor will be responsible to oversee the program and completing all reports. The Behavioral Health Housing Liaison/PATH Case Manager will be responsible for the operation of the program through working with the PATH clients to secure housing and support services they need.

For the Indiana County Community Action Program, a total of $21,166.00 is being requested to provide for the full-time salary (70% of the time) of the Indiana County Behavioral Health Housing Liaison/PATH Case manager position. This position will be located at the Indiana County Community Action Program, Incorporated's office. The housing liaison work concentrates on increasing and creating housing resources for those who are homeless or at imminent risk of becoming homeless and have a behavioral health illness.

Fringe Benefits:

The funding amount of $9,691.00 is being requested to provide the following fringe benefits for Armstrong County PATH Program Staff at the Family Counseling Center. Staff includes the supervisor and one full-time Behavioral Health Housing Liaison/PATH Case Manager position. Fringe benefits would have the following costs associated by category: FICA Tax ($1,299.00) Unemployment Compensation ($150.00), Retirement ($472.00), Health Insurance ($7,126.00), Dental and Vision Insurance ($549.00), and Workman's Compensation ($95.00)

For the Indiana County Community Action Program, the funding amount of $3703.00 is being requested to provide for the full-time fringe benefits of ICCAP's Behavioral Health Housing Liaison/PATH Case Manager. Fringe benefits include the following costs: FICA Tax ($1,619.00), Workers Compensation ($81.00), Pennsylvania Unemployment ($249.00), Health Insurance ($1659.00), Vision Insurance ($45.00) and Life Insurance ($51.00).

NOT FINAL

Travel:

At the Family Counseling Center of Armstrong County, PATH Program staff will travel to attend PATH Trainings on homeless/housing/mental health issues related to the PATH Program. Travel will also be used for outreach, distributing education materials and attending necessary meetings such as with the Housing Authority and landlords. A total amount of $442.00 is allotted for travel expenses on the Family Counseling Center's PATH budget.

The Indiana County Community Action Program is requesting funding is requested to pay for meal and travel costs for the BHHL/PATH Case Manager. Costs include monies for the Housing Liaison/Case Manager 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 $100.00 to pay for Housing Liaison's travel costs to attend specific trainings, Housing Task Force meetings, evaluation meetings and regional housing/homeless meetings; and $1700.00 to pay for outreach travel to housing entities, drop-in-centers, community support programs, etc.

Equipment:

The Family Counseling Center is not requesting that any PATH funds be used for equipment to operate the PATH Program in 2018-2019.

The Indiana County Community Action Program is not requesting that any PATH funds be used for equipment to operate the PATH Program in 2018-2019.

Supplies:

As with equipment, the Family Counseling Center is not requesting to use any PATH funds for supplies in 2018-2019.

The Indiana County Community Action Program is requesting and projecting to PATH funds to cover office supplies at the amount of $250.00 to operate the program. The agency is also projecting to use $850.00 in PATH funds for consumer-related items. The total amount requested for supplies is $1102.00.

Other:

The Family Counseling Center of Armstrong County 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 $3,061.00. Monthly rental amounts vary in the county area.

Other costs projected for the Indiana County Community Action Program, include the delivery of case management and support services, security deposits and one-time rental assistance payments for 8-12 individuals experiencing homelessness or at imminent risk at approximately $500.00 each, not to exceed $3,000.00. It is projected that $1,400.00 of that total would be

NOT FINAL

needed to provide one-time assistance to help consumers maintain housing and $1,000.00 for security deposits. Total request for other expenses: $3,000.00.
The Indiana County Community Action Program, Inc. (ICCAP) is the Local Lead Agency on Housing for Indiana County and provides numerous housing programs. In addition, although ICCAP is continuing a PATH program to specifically expand existing housing and increase new housing programs for homeless/near homeless mental health individuals, ICCAP provides housing components of $672,228.04 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.

NOT FINAL

TOTAL PROGRAM BUDGET
Armstrong-Indiana PATH Program
FY 2018-2019 Budget

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
FCC PATH Supervisor			$728.00	$728.00
FCC Behavioral Health Housing Liaison/PATH Case Manager	$32,500.00	.50 FTE	$16,250.00	$16,250.00
ICCAP Behavioral Health Housing Liaison/PATH Case Manager	$30,237.00	.70 FTE	$21,166.00	$21,166.00
Sub-total			**$38,144.00**	**$38,144.00**
Fringe Benefits				
FCC	$9,691.00		$9,691.00	$9,691.00
ICCAP	$3,704.00		$3,704.00	$3,704.00
Sub-total			**$13,395.00**	**$13,395.00**
Travel				
Local Travel for Outreach				
FCC	$442.00		$442.00	$442.00
ICCAP	$1,700.00		$1,700.00	$1,700.00
Travel to training and				

workshops				
FCC			$0	$0
ICCAP	$100.00		$100.00	$100.00
Sub-total			**$2,242.00**	**$2,242.00**
Equipment				
FCC	$0		$0	$0
ICCAP	$0		$0	$0
Sub-total			**$0**	**$0**
Supplies				
FCC	$0		$0	$0
ICCAP	$1,102.00		$1,102.00	$1,102.00
Sub-total			**$1,102.00**	**$1,102.00**
Other				
Staff training				
FCC	$0		$0	$0
ICCAP	$0		$0	$0
One-time assistance to maintain housing				
FCC	$3,061.00		$3,061.00	$3,061.00
ICCAP	$1,400.00		$1,400.00	$1,400.00
Security deposits				
FCC	$0		$0	$0
ICCAP	$1,000.00		$1,000.00	$1,000.00
Sub-total			**$5461.00**	**$5461.00**
TOTAL PATH Budget			$60,344.00	$60,344.00

NOT FINAL

Armstrong-Indiana County - Family Counseling Center of Armstrong County
300 South Jefferson Street
Kittanning, PA 16201
Contact: Holly Kamer

Provider Type: Community mental health center
PDX ID:
State Provider ID:
Contact Phone #:

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**none**
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Armstrong/Indiana Family Counseling Program will receive a total of $30,172 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 40

Estimated Number of Persons to be Enrolled: 28

Estimated Number of Persons to be Contacted who are Literally Homeless: 4

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Family Counseling Center of Armstrong County

Local Provider Intended Use Plan

FY 2019-2020

Local Provider Description

Originally founded as the Mental Health Clinic of Armstrong County in 1961, the Family Counseling Center of Armstrong County has a long and rich history of service to the community. The Family Counseling Center of Armstrong County (FCCAC) is a private, non-profit corporation funded under contract with the Armstrong-Indiana Behavioral and Development Health Program and the Pennsylvania Department of Public Welfare. The agency is responsible for providing mental health services, including assessment, therapy, medication management, rehabilitation, and case management, to those persons who are experiencing mental health problems, emotional distress, or problems in living. Early Intervention service coordination for children ages 0-3 and Support Coordination for adult and child consumers with intellectual disabilities are also available.

The PATH Program is housed within the Family Counseling Center of Armstrong County an is located at 300 South Jefferson Street, Kittanning, PA 16201.The agency has approximately 153 employees, (126 full- time and 27 part- time), dedicated to serving the residents of Armstrong County.

The Family Counseling Center of Armstrong County will be receiving PATH funds from the Armstrong-Indiana Behavioral and Developmental Health Program (AIBDHP) to serve Armstrong County residents. Our state allocation is projected to be $7,543 and the federal allocation will be $22,629. The total amount of the state and federal allocations will be $30,172.00.

The Family Counseling Center of Armstrong County is currently a user in PDX (Path Data Exchange) under the Provider Name: Family Counseling Center of Armstrong County, PA-078.

Collaboration with HUD Continuum of Care (CoC) Program

The Family Counseling Center of Armstrong County, which is a mental health treating provider, is not currently a member of the PA-601 Western Region Continuum of Care. The Family Counseling Center, as the PATH Provider in Armstrong County (and the PATH staff employed there) does however have a strong working relationship with our county's main CoC participant, the Armstrong County Community Action Agency, located at 705 Butler Road Kittanning, PA 16226. PATH staff also collaborates with staff from the local county domestic violence shelter, HAVIN (Helping All Victims In Need). Both the ACCAA and HAVIN are the agencies designated to enroll individuals into the Coordinated Entry System, established through the CoC. Through these collaborations, the FCC PATH staff is kept informed of and can partner with any HUD CoC initiatives, such as Coordinated Entry to help serve the mental health consumers of Armstrong County.

NOT FINAL

Collaboration with Local Organizations

The Family Counseling Center of Armstrong County is committed to providing as many services as we can to consumers to help them achieve stability independence. Due to this, the PATH Case Manager is actively involved with Housing Advisory Board, Community Support Programs (CSP) meetings, and the Human Service Council, which allows local community organizations and social service agencies to come together to communicate, collaborate, and solve homeless issues in Armstrong County. By attending these local meetings, this allows various agencies to become familiar with each other and is better able to assist clients in need due to these associations. Since the PATH Program is housed within Family Counseling Center, the PATH Case Manager works interchangeably with many Targeted Case Managers that are assisting consumers who have been diagnosed with a serious mental illness and are in need of additional supports in areas such as, housing, finances, social supports, education, or vocation.
These agencies have worked together for many years, therefore having developed a positive professional rapport that has been beneficial to the successful delivery of human services in Armstrong County. Due to this rapport, case managers at different agencies are able to better assist their consumers due to being able to refer them to other necessary mainstream resources. Some of the agencies represented at meetings are: The Armstrong-Indiana Behavioral and Developmental Health Program, Drug and Alcohol Commission, Area Agency on Aging, Mechling-Shakely Veterans Center, Armstrong County Housing Authority, Children, Youth, and Family Services (CYFS), Adagio Health, I & A Residential, Alliance for Non-Profit, Southwestern PA Legal Services, Salvation Army, Armstrong County Community Action Agency, Unity, and Kittanning Empowerment Center.

Besides the PATH grant, the Family Counseling Center of Armstrong County also operates a program called the Consumer Housing Contingency Fund for the Armstrong-Indiana Behavioral and Developmental Health Program (AIBDHP). AIBDHP is currently anticipating that their re-application for this funding through the Health Choices reinvestment plan will be successful. Upon confirmation, AIBDHP will award the operation of the program to Family Counseling Center of Armstrong County. The Consumer Housing Fund is not specifically for PATH consumers only, however, it can serve PATH consumers who are eligible. In order to be eligible, the consumer must have active medical assistance and they must also be dealing with at least one of the following, mental health disorder, substance abuse disorder, or any number of behavioral issues. The contingency fund is able to assist eligible individuals with essential household needs, security deposits, utility assistance, rental assistance for eviction, and other emergency needs as they arise.

To further help with cooperation amongst the various provider agencies in the Armstrong County Area, Family Counseling Center's Housing Liaison/PATH Case Manager is continuing the outreach initiative to increase knowledge about the PATH and Housing Liaison Programs and what services they are able to offer eligible clients. In this interagency effort, the Housing Liaison/PATH Case Manager used contacts made during meetings with the Housing Advisory Board, CSP, and Human Service Council as well as contacts made during regular street outreach to identify the major provider agencies in the area. Once the agencies have been identified, the Housing Liaison/PATH Case Manager contacted the agencies and offered to do individualized trainings. To date, six organizations have participated in the PATH-sponsored trainings: Family

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Counseling Center, Community Support Programs, HAVIN, Salvation Army, Family Psychological and Associates, and LINK.

The Housing Liaison/PATH Case Manager passes around a sign-in sheet at the beginning of the training to document the number of individuals trained. So far, 36 individuals have attended the trainings. Individuals who attend the training are provided with a packet that contains the following: brochures on the Behavioral Health Housing Liaison Program (BHHL) and the PATH Outreach Program, a typed explanation about the Behavioral Health Housing Liaison Program, a typed explanation about the PATH Outreach Program and how it can assist eligible persons, a document that explains the eligibility requirements for the PATH Outreach Program, a required document list for the PATH Outreach Program, and a blank referral form in order to refer a client to either the Behavioral Health Housing Liaison or the PATH Outreach Program. Family Counseling Center of Armstrong County has received positive feedback from professionals who have attended the trainings. The Housing Liaison/PATH Case Manager hopes to host multiple trainings to other agencies in the near future such as: Children, Youth, and Family Services and Holy Family.

Service Provision

PATH eligibility determination
The PATH eligibility is determined when a person is at least eighteen (18) years of age, or an emancipated minor with legal documentation, has a documented diagnosis of a serious mental illness, and is either at risk of homelessness or literally homeless. Next, enrollment begins once the consumer agrees to participate in the program and the Behavioral Health Housing Liaison/PATH Case Manager has met and obtained all necessary information. It is then that eligibility is documented by copying documents, keeping detailed notes, and entering information into the Homeless Management Information System (HMIS).

Alignment with PATH goals
Family Counseling Center will provide PATH funded housing services to eligible homeless Armstrong County residents who meet the "literally homeless or at risk of homelessness" definition as well as serious mental illness (SMI) definition. PATH funding will be used for one-time rental assistance and security deposits as needed. PATH funding will also be used to offer case management and referral services to mainstream resources (such as foodbank, medical transportation, substance abuse treatment, mental health treatment, and clothing assistance).

Maximizing use of PATH funds
To further serve PATH consumers, the Behavioral Health Housing Liaison collaborates with and refers consumers to Armstrong County Community Action Agency for a variety of housing programs. The Housing Liaison/PATH Case Manager is able to refer PATH clients to the different housing programs ensuring that they get as much assistance as possible. For those otherwise eligible individuals who are not applicable for funding in the other housing programs, PATH funding will be able to assist. Family Counseling Center of Armstrong County is also providing assistance through the operation of the Contingency Fund Program that will further assist those PATH clients who are eligible.

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Gaps in current service system

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

Most individuals who are unable to find housing in Armstrong County stay with family members or friends, creating more doubled-up (at-risk) situations than literally homeless situations. For those individuals who are unable to stay with anyone in the area, the lack of an emergency shelter poses an almost insurmountable difficulty. Armstrong County does have programs that offer some low-income housing assistance such as: The Housing Authority, which has a number of low-income rentals; The Section 8 program that offers vouchers; The Family Unification Program that offers vouchers; and a HUD-VASH program that also offers vouchers. The difficulty is that these programs are so inundated with applications that there are extremely long waitlists for each program. For example, the waitlist for our local Section 8 program is so long that they do not even open the program every year to accept new applications for the waitlist. Due to the rural nature of Armstrong County, our public transportation system is minimal. Other than the Town and County Transit Authority, there is no other means of public transportation in this area. The services provided by Town and County Transit Authority are limited to only servicing the mid-county region of Armstrong County; therefore, only encompassing a six (6) to eight (8) mile radius of the towns of Kittanning and Ford City. Although this selected area does include two or more densely populated areas in Armstrong, there is a considerable amount of the population that is outside of the selected area.

Those individuals who receive medical assistance are able to receive transportation to medical appointments through Armstrong County Community Action Agency's Medical Assistance Transportation Program; however, there are still many places that those individuals may need to get to. Due to this, Armstrong-Indiana Behavioral and Developmental Health Program has collaborated with other community agencies such as, Town and County Transit Authority, Armstrong County Community Action Agency, Family Counseling Center of Armstrong County, an Armstrong County Memorial Hospital to begin working on ways to resolve the need for additional transportation services in Armstrong County.

Co-occurring services available

In order to be eligible for PATH, individuals must have a serious mental illness (SMI) diagnosis. Like many other areas in the United States, Armstrong County is experiencing an increasing

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

Our community has a few initiatives that are attempting to increase information and outreach to individuals who are suffering with mental health diagnoses and/or addiction. There are a number of neighborhood groups that have been established to try to increase the education around drug usage and decrease the overall drug usage. These neighborhood groups also attend Armstrong County Drug Free Communities Coalition which is the lead in part by the Armstrong/Indiana/Clarion Drug and Alcohol Commission. During these meetings the community and the agencies in the area are invited to create a dialogue about addiction and try to come up with solutions to problems posed to the community. With that being said, our agency educates, provides trainings, and follows required HIPPA guidelines that are in compliance with the 42 CFR Part 2 regulations.

Also, Laural Legal and the Fair Housing Law Center are increasing their presence in the community to assist consumers with mental health, addiction, other disabilities and criminal justice histories by informing them about their rights as tenants. The Housing Liaison/PATH Case Manager attends coalition meetings and has attended fair housing training provided by the Fair Housing Law Center. The Housing Liaison/PATH Case Manager is also assisting the Fair Housing Law Center by informing other providers' agencies that fair housing trainings can be hosted by the Fair Housing Law Center. In addition, the Housing Liaison/PATH Case Manager stays in contact with the Armstrong/Indiana/Clarion Drug and Alcohol Commission to make sure those at-risk or homeless consumers participating in the Drug and Alcohol programs have access to PATH and Housing Liaison services. If the Housing Liaison/PATH Case Manager comes in contact with an individual who has a mental health or a substance disorder and isn't receiving treatment, the Housing Liaison /PATH Case Manager will refer the individual to those services. For PATH eligible individuals, the Housing Liaison/PATH Case Manager completes an Individual Service Plan (ISP) to address the client's goals. The Housing Liaison/PATH Case Manager will make sure that the individual has access to housing before other goals are addressed. Other than Housing, some other goals that are addressed are the need for such refers as clothing, food, medical care, mental health/drug addiction services, etc. Many landlords in Armstrong County refuse to rent to individuals who cannot pass a background check. The Housing Liaison/PATH Case Manager can act as an advocate for the client by reminding the landlords about fair housing practices if needed.

Justice-involved

NOT FINAL

Although the AI BDHP's recent Behavioral Health Justice Related Services program ended in 2017, the PATH staff at the Family Counseling Center continues to be available to assist those individuals who are transitioning back into the community by providing support and case management services. PATH staff can and does collaborate with jail and prison counselors and re-entry staff to research housing options and funding resources for those being released, as well as those individuals in the community who are risk of becoming involved in the Criminal Justice System. PATH staff is also available to help link individuals to human service agencies/programs that would offer support and help them succeed in the community. These services include mental health and substance abuse treatment, employment services, benefit resources such as Social Security and Medical Assistance. PATH staff is available to assist any criminal justice personnel with creating a plan for release into the community. Also, both the re-entry staff and the Armstrong County PATH Case Manager are active members of the Armstrong County Homeless Advisory Committee where collaboration occurs to help those who are mentally ill and involved in the Criminal Justice System.

Data

Family Counseling Center of Armstrong County's PATH Program/ Housing Liaison staff fully utilizes the Homeless Management Information System (HMIS) to back-up, store, and organize consumer information. The Housing Liaison/PATH Case Manager is trained and authorized to use the PA/HMIS/Client Track system. The Housing Liaison/PATH Case Manager will continue to attend all webinars offered through PA HMIS/Client Track as well as PATH HMIS Learning Communities to stay continuously updated on guidelines and regulations within the database and the program. All case management, contacts, and other allowable services are entered into the database in a timely and comprehensive manner to ensure data quality. The Housing Liaison/PATH Case Manager maintains a PA-HMIS /Client Track reference folder to refer to if any questions should arise. Should any questions arise that cannot be addressed by the reference folder, we are able to refer to David Weathington, who is a PA-HMIS Administrator, and Brian Miller who also works closely with PA-HMIS and Client Track. Any new staff members to the PATH Program will be trained to use the database using peer-to-peer support, the PA-HMIS folder, and recordings of past PA-HMIS/Client Track webinars are available on the PA-HMIS/Client Track system.

Alignment with PATH Goals

The PATH Program at Family Counseling Center of Armstrong County (FCCAC) continually strives to serve the most vulnerable adults combatting obstacles associated with serious mental illness and homelessness by offering outreach, engagement, education, case management, and referral services. Our PATH Program has two outreach initiatives to increase access to PATH services. The first initiative is to go on street outreach to parks, local businesses, and or places not meant for human habitation in order to see if there are any individuals in need of services staying in those locations. Traditionally, this is how most PATH Programs finds individuals for their program; however, the homeless individuals in Armstrong County are not often found in these types of places. Even when there doesn't seem to be any individuals residing in places not meant for human habitation in the area, we distribute brochures and flyers to these locations. The second initiative is to go on service provider outreach in the form of educational trainings about

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the PATH Program. Educating other providers on what the PATH can do to help individuals increase the likelihood that they will share information about PATH to their consumers who may not have considered housing assistance at our agency before.

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

Alignment with State Comprehensive Mental Health Services Plan

The PATH Program was created under the McKinney Act to assist individuals with serious mental health conditions, or co-occurring mental health and substance use disorders, an experiencing homelessness find and maintain stable housing. Our PATH Program mimics the state's plan to end homelessness for those with mental illness by assisting out clients to recover from homelessness and maintain resiliency by managing their own mental health and co-occurring conditions. We outreach to these individuals through our community using street outreach an interagency outreach. Once individuals are identified and engaged in the PATH Program, we follow the Housing First initiative by making sure that the consumer is in a stable living environment before we refer them to mainstream resources (i.e. mental health or substance abuse treatment). After housing has been found, we encourage stability and independence by involving them into treatment services and offering case management which might include budgeting and life skills. With the collaboration of the Housing Liaison/PATH Case Manager, the consumer, and the mental health professionals, the PATH consumer's ability to maintain their stable housing status greatly increases. In comparison to the outcomes of individuals with similar backgrounds and boundaries who are not involved in services, individuals graduating from PATH are more successful and more independent.

Other Designated Funds

At this time, Family Counseling Center of Armstrong County does not receive any other funds specifically designated for individuals who are experiencing homelessness and have a serious mental illness. We do, however operate a program called the Contingency Fund Program, which was granted to us by the Armstrong Indiana Behavioral and Developmental Health Program (AIBDHP). The Contingency Fund Program was built to assist clients who have medical assistance and are at-risk of or experiencing a serious behavioral challenge. The Contingency Program can potentially assist with rental assistance, security deposit assistance, procuring adequate necessary furniture (i.e. bed), and limited utility assistance. At this time AIBDHP is

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anticipating the renewal of the Contingency Program through the Health Choices reinvestment plan. The funding will not only continue the Contingency Fund Program, but it will also assist with salary costs associated with the PATH Program (i.e. the salary of the Housing Liaison/PATH Case Manager). The Housing Liaison/PATH Case Manager will be the operator of the Contingency Fund Program: therefore, clients in the PATH Program or in the Housing Liaison Program will be immediately evaluated to see if the Contingency Fund Program can assist them.

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

SSI/SSDI Outreach, Access, Recovery (SOAR)
The Family Counseling Center of Armstrong County currently has a total of 1 SOAR trained Case Manager, which is the Housing Liaison/PATH Case Manager. As an agency we plan to assist as many eligible consumers with SOAR as possible, however, at this time there is currently only one consumer that could possibly benefit from the SOAR process. Although Armstrong County is notably a rural county, the majority of individuals we see that would qualify for SSI or SSDI already receive benefits. Due to this, the Housing Liaison/PATH Case Manager does not dedicate a significant portion of their time to the SOAR program. Should a SOAR eligible consumer be found, the SOAR trained staff member will use resources on the SAMHSA SOAR TA Center and track their progress on the Online Application Tracking (OAT) System.

Housing
Family Counseling Center of Armstrong County is committed to assisting all individuals who are in need of shelter, including those who are eligible for the PATH Program. Upon being interviewed by the Housing Liaison/PATH Case Manager, they begin to collaborate with other outside agencies to find the best solution available for the individual. The resources outside 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. Family Counseling Center's Targeted Case Management Department, along with the Housing Liaison/PATH Case Manager has developed a good relationship with various landlords throughout the community
- Armstrong County Housing Authority: Family Counseling Center has a working relationship with the Housing Authority. This agency has section 8 voucher and high-rise units available

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- Department of Human Services (formerly known as Department of Public Welfare) assists consumers with multiple of needs including emergency shelter 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 help people that need a place to stay temporarily
- American Red Cross: will provide 3 days of motel stay for displacement from a home due to fire victims are helped regardless of income
- Real Estate Agencies: a network of real estate agencies that have available rentals assist in housing consumers having a hard time finding an affordable rental
- Local Ministries: cluster of churches that assist persons who need housing, on an emergency basis only
- Allegheny Kiski Hope Center: provides housing services to homeless consumers in our area.
- Just for Jesus: a homeless shelter located in Brockway, PA that accepts our referrals and provides transportation for consumers to get to their shelter

Coordinated Entry

The PATH Program supports the local COC (s) by referring and maintaining on going contact. A person is directed to the local COC (s) to be assessed for the Coordinated Entry system prior to possibly becoming PATH eligible, but often this is delayed due to the lack of required documentation, i.e. birth certificate, social security card, and photo ID. This seems to be the only barrier we have encountered thus far, especially for the YYA population.

Justice Involved

Training and education continues and in past years in Armstrong County Crisis Intervention Training (CIT) has been provided to law enforcement. The training has been well attended and received. HAVIN (Helping All Victims In Need) continues to host Mental Health First Aid for adults as well as youth. AIDBHP also provides training on Mental Health Procedures to law enforcement.

Staff Information

Family Counseling Center of Armstrong County's PATH Program staff members are currently two (2) Caucasian females with 29 years of experience serving the mental health community. Staff members were specifically hired for PATH due to their knowledge and history assisting those with mental disorders and illnesses. FCCAC is committed to serving clients regardless of age, gender, race, ethnicity, sexual orientation, or creed. The Housing Liaison/PATH Case Manager has attended a live training on fair housing laws, and multiple webinars on how to eliminate barriers surrounding those with a serious mental illness find and maintain housing. In

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the future, PATH staff will continue taking advantage of available training opportunities to increase cultural and social competency. Currently our PATH Program does not have any staff that are Certified Peer Specialists or Certified Recovery Specialists.

Client Information

Armstrong County is fairly homogeneous with the majority of residents identifying as being Caucasian and English speaking. Of that population, Family Counseling Center's PATH Program is built to serve adults or emancipated minors that have been diagnosed with a Serious Mental Illness (SMI) and who are experiencing homelessness. Experiencing homelessness is defined as the client being "at-risk of homelessness" or be "literally homeless" at the time of the first contact. Individuals who are "at-risk of homelessness" are those who are doubled up with family or friends and are unable to continue to stay, those who are temporary living situation such as transitional housing that carries time limits, those whose housing was recently condemned requiring them to move, and those who have received an eviction notice. Individuals who are considered "literally homeless" are persons who are sleeping in areas not meant for human habitation (streets, underpasses, parks, and buildings not fit for habitation), and persons who are staying in supervised public or private facilities that provide temporary or emergency living accommodations. Based on the number of contacts from 2018-2019 (30 contacts with 19 enrollments), The PATH Program at FCC estimates additional contacts to be around 40 adults this year, and possibly to enroll 28. Due to the low number of literally homeless in our area, the PATH Program at FCC estimates the percentage of adults to be served using PATH funds to be less than 10%.

Consumer Involvement

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

Health Disparities Impact Statement

Armstrong County's PATH data from fiscal year 2018-2019 shows that the main subpopulations represented included those between the ages of 30 and 50 who have (1) significance mental health challenges, (2) co-occurring disorders (MH/D&A), and (3) those who have a low

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socioeconomic status presenting with little to no income and no employment options. Residents are primarily Caucasian, English speaking individuals. The rural nature of the county and its limited resources has a direct impact on their lives, being impacted by limited employment opportunities, limited transportation options, and limited safe and affordable housing options. The majority of 2019-2020 PATH funding is expected to be used to serve these subpopulations. The PATH eligible YYA disparity population has been defined as individuals whose ages fall within 18-30 years of age that have a serious mental illness (SMI) and/co-occurring substance abuse disorders. Applicable individuals must also be homeless or at imminent risk of becoming homeless. Armstrong County's YYA population is primarily made up of Caucasian, English speaking individuals: however, they have increased difficulty accessing necessities 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 YYA group are significantly worse than the other populations served by the grant.

Once the YYA consumer has been contacted and evaluated by the Housing Liaison/PATH Case Manager, they are able to obtain any of the services that PATH offers as long as they meet the eligibility requirements. PATH expects to serve at least 2 YYA individuals with the PATH funds which is roughly 10% of the total individuals that we plan on serving. To prioritize assistance to the YYA population, the total amount of PATH funds expected to be expended on rental assistance is $750.00, which is utilizing roughly 6% of our rental assistance services budget.

If the consumer does not have an income, the consumer is still eligible for case management services, (creating a budget, goal completion, smart shopping habits, etc.), and referrals can be made to outside agencies (job searches, GED classes, drug counseling, emergency clothing, etc.). Unlike the non- YYA population, most YYA individuals do not have access to transportation to get to necessary services. With this being an issue, the Housing Liaison/PATH Case Manager is working to increase outreach to improve upon assisting the YYA individual with signing up for and or understanding programs as needed. This is very important because many YYA individuals may not have access to necessary items such as their birth certificate, social security card, or photo ID. The Housing Liaison will be available to assist YYA individual with signing up for and/or understanding programs as needed.

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Limited English Proficiency

The Family Counseling Center of Armstrong County collaborates with Armstrong Indiana Behavioral and Developmental Health Program (AIBDHP) to provide translations services to consumers when needed through ARIN IU 28 as well as Indiana University of Pennsylvania (IUP) if further translation services are needed. To date, the PATH Program at FCCAC has not needed to call upon translation services at all. The PATH staff is very intuitive in picking observing cues to access situations for the potential need for a translator.

Budget Narrative

The PATH funding received by Family Counseling Center of Armstrong County (a private nonprofit corporation), includes $7543 in state funding and $22,629 in federal funding. A total of $30,172.00 in PATH funds will be used for providing the following:

Personnel

Behavioral Health Housing Liaison/Path Case Manager (Liaison)
(1 full time staff; 50% funded PATH)
Duties to include the following: Provide outreach and engagement activities, serve as county point person on housing resources, referrals and housing options, provide case management services, and disseminate educational materials
Supervisor of Liaison
Provide minimal oversight (less than 1 hour/week)
The majority of PATH Funds will used to pay applicable portion of personnel costs associated with the above activities. These activities will be performed by the Behavioral Health Housing Liaison/ PATH Case Manager (Liaison), Holly Kamer under the supervision of Kim Clark.
There will also be some funding provided to provide rental assistance.
The position cost alone for the full time Liaison is approximately $52,346.00.

The funding of $30,172.00 will be applied to fund a portion (50% -$26,173.00) of the position. $938.00 will be used to fund a small portion of supervisor position and the remaining $3,061.00 will be used to provide rental assistance funds. Both the Supervisor and Liaison are full time employees of the Family Counseling Center of Armstrong County. The Liaison will be responsible for the operation of the program through working with the PATH clients to secure housing and support services they need.

The breakdown of funding is as follows:

Liaison	*Supervisor*	
Salary:	$16,250.00	$728.00
Pension:	$406.00	$66.00
Work Comp:	$91.00	$4.00
Unemployment:	$146.00	$4.00
FICA:	$1,243.00	$56.00
Medical:	$7,051.00	$75.00
Dental:	$441.00	$4.00
Vision:	$103.00	$1.00
Staff travel:	$442.00*	$0.00
Total:	**$26,173.00**	**$938.00**

*Travel:
Staff will travel to attend PATH Trainings on homeless/housing/mental health issues related to the PATH Program. Travel will be used for outreach, distributing education materials, and attending necessary meetings (i.e. landlords). Transportation will not be provided to transport consumers.

Rental Assistance:
There is one-time rental assistance that is available up to $750.00 a household for a total amount of **$3,061.00** Monthly rental amounts vary in the county area.

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BUDGET TABLE
FAMILY COUNSELING CENTER OF ARMSTRONG COUNTY PATH Program
FY 2019-2020 Budget

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
Supervisor			$728.00	$728.00
Behavioral Health Housing Liaison Case Manager	$32,500.00	50% FTE	$16,250.00	$16,250.00
sub-total			$16,978.00	**$16,978.00**
Fringe Benefits				
FICA Tax			$1,299.00	$1299.00
Unemployment			$150.00	$150.00
Retirement			$472.00	$472.00
Health			$7,126.00	$7,126.00
Dental and Vision			$549.00	$549.00
Workman's Comp			$95.00	$95.00
sub-total			$9,691.00	**$9,691.00**
Travel				
Local Travel for Outreach & Training .445/Mile			$442.00	$442.00
sub-total			$442.00	**$442.00**
Supplies/Equipment				
Consumer-related items				
sub-total				**$0.00**
Other				
Staff training				$0.00
One-time rental assistance			$3,061.00	$3,061.00
Security deposits				
sub-total			$3,061.00	**$3,061.00**
Total PATH Budget				**$30,172.00**

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Armstrong-Indiana County - Indiana County Community Action Agency
300 Indian Springs Road
Indiana, PA 15701
Contact: Sandra Harber

Provider Type: Social service agency
PDX ID: PA-068
State Provider ID: 4268
Contact Phone #: 7244652657

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	none

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**none**
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

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

Estimated Number of Persons to be Contacted: 100

Estimated Number of Persons to be Enrolled: 25

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

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

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Indiana County Community Action Program, Inc.
Local Provider Intended Use Plan
2019-2020

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-three 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 25 full and part-time employees, ICCAP provides a variety of services to thousands of individuals every year.

ICCAP's address: 827 Water St., Indiana, PA 15701
Amount of Grant for Indiana County: $ 30,172
Our PATH PDX provider name is: Indiana County Community Action Program
PDX Number: 068

Collaboration with HUD Continuum of Care (CoC) Program
The Indiana County Community Action Program, Inc. (ICCAP) is under the Southwest Regional Housing Advisory Board Continuum of Care (CoC) and is under PA601. ICCAP has a long history of collaboration with the HUD Continuum of Care. Since 1990 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 PHD (permanent housing for the chronically homeless and disabled) and PHD 2, another supported housing program for the chronically homeless and disabled; which began in October of 2017. In addition, the agency provides Rapid Re-Housing through the Emergency Solution's Grant and operating a similar ESG program under the CoC through a partnership with Fayette County Community Action Program called South West Rapid Re-Housing.

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

Collaboration with Local Community Organizations

NOT FINAL

Primary Health Providers
The importance of information and referral is woven into the fabric of every community action agency. In this spirit, the many county residents Indiana County Community Action provides services to annually are offered information about and assistance in applying for medical benefits. In addition, the agency enjoys a close working relationship with our primary health provider, Indiana Regional Medical Center. The Executive Director is a member of the County Health Advisory Committee.
Mental Health Providers
As a provider of representative payee services for mental health consumers since 1996, ICCAP has a long history of working with mental health providers. Contracted for services by the Armstrong-Indiana Base Service Unit, the payee program provides services to over 200 consumers a year and in this capacity interacts with case management, the sheltered workshops, Indiana and Armstrong (I&A) Residential Services, the Community Guidance Center and the Family Counseling Center. Our Representative Payee Coordinator also sits on I & A's board of directors. Other ICCAP programs including the Pathway Shelter, Homeless Case Management, and our utility programs work closely with mental health providers to provide the best outcomes for consumers; conversely, our familiarity with mental health services allows us to make informed referrals for services, particularly Peer Support services. The Behavioral Health Housing Liaison/PATH Case Managers regularly attend meetings of the Community Support Program (CSP).

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

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

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Service Provision

PATH eligibility determination
The Behavioral Health Housing Liaison/PATH Case Manager is one of the people in our agency that enters clients into the HMIS Coordinated Assessment. When she meets with a client who is either homeless or imminently homeless that discloses mental health and is an Indiana County resident he will explain the PATH program to them to see if the clients are interested in being enrolled in PATH in addition to working with another Homeless Case Manager. We would enroll them into the PATH program if they wish, have them sign a release for medical records and a mental health diagnosis. The client may be enrolled in the PATH program for 90 days before we are required to have a diagnosis. If the client does not wish to be enrolled we would enter it as a pre-enrollment contact in the HMIS system.

Alignment with PATH goals

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

Maximizing use of PATH funds
Indiana County Community Action Program serves as the county's primary point of contact/service provider for the homeless. State and local police, township supervisors and other human service agencies are aware that ICCAP's housing staff is available through the Pathway shelter 24/7. This position in the county continuum of care allows us a unique outreach to the homeless and imminently homeless. The housing staff works with residents of Pathway. Homeless clients are assessed, entered into HMIS Coordinated Entry, and then referred to appropriate housing programs such as Pathway, Alice Paul House (domestic violence shelter), Rapid Re-Housing, Rental Assistance, and Permanent Housing for the Disabled (PHD). Additional outreach is provided through written resources such as flyers, brochures and staff at ICCAP's 17 food pantries. Consumers can contact ICCAP by phone, by referral from other agencies, and/or simply walk into one of our buildings and ask for help. The Behavioral Health Housing Liaison/PATH Case Managers are 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 Direct Services/Shelter Director, three Homeless Case Managers, our Homeless Advocacy Liaison, and the Housing Counselor) occurs as needed. Formal meetings and discussion of specific client issues take place at a more formal bi-weekly housing staff meeting.

ICCAP maximizes use of PATH funds by leveraging our Rental Assistance, Food Bank Warehouse, Representative Payee and Utility Assistance programs.

Co-occurring services available
In addition to the available services listed above, PATH clients with both a serious mental health illness and a substance abuse disorder are referred to the Open Door where they can receive an assessment, counseling, intensive outpatient services, or attend a co-occurring disorder's group, and/or the relapse prevention group. The Open Door also provides a 24 hour crisis line and evaluation for inpatient services.

Gaps in current service system
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 choices and some of the landlords are very reluctant to consider or overlook this. 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

NOT FINAL

because of the need. ICCAP will continue working with the AIBDHP and other human service agencies to address these gaps identified. One of the ways we have started to address these gaps is to start a housing program through Health Choices Re-Investment dollars provided to us by AIBDHP in which the homeless population with a serious mental health diagnosis and a current medical assistance card from Indiana County will be referred to the Re-Investment Housing Program, all approvals for this program are done by AIBDHP to insure the clients diagnosis is serious mental health and their medical assistance is current. We then assist the client find affordable housing that passes an HUD Quality Standards (HQS) inspection with the client paying 30 % of their income towards rent if they have income and the Re-Investment Housing Program will pay the remaining rent for up to 5 years until the client can receive public housing or Section 8 through our local housing authority. If the client does not have income the Health Choices Re-Investment Housing Program will pay their rent until the client obtains income, then the client will pay 30% of their income towards rent.

The Behavioral Health Housing Liaison/PATH Case Managers attend local CSP meetings; and are in the process of being trained as a SOAR advocate, the Direct Services/ Shelter Director is SOAR trained. PATH funding will also be used to provide training to PATH staff on PATH related topics and evidence-based practices.

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

Justice-involved
Of the PATH consumers served by Indiana County 50 % have a criminal history. Because of this relatively high percentage, the Behavioral Health Housing Liaison/PATH Case Managers have spent a good deal of time developing working relationships with local correctional staff, mental health providers, and local landlords'/housing providers. Through these relationships, the liaison/case managers are able to help consumers with criminal histories access benefits, support services, and housing in a timely manner. In working with landlords specifically, the liaison/case managers are able to reassure landlords that someone supporting the consumers, giving them a person to call in times of concern. These relationships have the potential of positively impacting the way landlords see behavioral health consumers who also have involvement in the Criminal Justice System. The overall goal is to use these relationships to develop more safe and affordable housing for the justice involved populations. In addition to this work, the Behavioral Health Housing Liaison/PATH Case Managers will be called upon to work with the AIBDHP in the development of any future Justice Related Service's program in Indiana County.

NOT FINAL

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

Our Behavioral Health Housing Liaison/PATH Case Managers and Direct Services/Shelter Director will continue to be trained on HMIS as training is available. The Behavioral Health Housing Liaison/PATH Case Managers will be responsible for entering client data in the HMIS system and the Direct Services/Shelter Director will be responsible for supervision of the

Behavioral Health Housing Liaison/PATH Case Managers, pulling information for reports, etc.

Alignment with PATH Goals

ICCAP will continue to make outreach and case management a top priority to those who are homeless or at risk of becoming homeless in Indiana County. The Behavioral Health Housing Liaison/PATH Case Managers will work closely with the Peer Specialists to identify individuals in need and begin working on a plan to stabilize their housing and living situation. ICCAP will continue to provide rental assistance as funding permits, limited transportation, referrals and other services needed to help our residents. The Behavioral Health Housing Liaison/PATH Case Managers outreach includes attending local CSP meetings, going to the Drop in Center and Pathway Homeless Shelter. ICCAP fully supports the overall PATH Goals of the Armstrong-Indiana Behavioral and Developmental Health Program.

Alignment with State Comprehensive Mental Health Services Plan

ICCAP, working under Armstrong/Indiana Behavioral and Development Health Program (AIBDHP) will continue to comply with and perform all duties and functions that are outlined and executed in the State Mental Health Services Plan. Also, as a primary point of contact for the homeless in Indiana County, ICCAP will continue to provide services to the homeless. ICCAP's Behavioral Health Housing Liaison/PATH Case Managers, work very closely with our shelter staff and spend one day per week at the shelter to assist eligible consumers. As ICCAP has moved forward into the PA Western CoC's Coordinated Entry Plan and Assessment application process, the Liaisons still continue to help consumers access and apply for needed services; coordinate the delivery of services; provide follow-up and monitor progress of goals. One of the goals to eliminate homelessness is "housing first"; to eliminate a waiting list and for agencies across Western PA to work together to provide "Housing First". Currently, all agencies/organizations having a vacancy in one of their housing programs is pulling a list from the coordinated entry system and contacts each individual across the state to see if they would like to come to our county to fill the housing opening provided they meet the guidelines for the program that has the housing opening. The goal is that those most vulnerable will be housed first. ICCAP and the Behavioral Health Housing Liaison/PATH Case Managers are using the Coordinated Plan and using the Application/Assessment tool for all individuals that are homeless or imminently homeless.

Other Designated Funds

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

Programmatic and Financial Oversight

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

NOT FINAL

SSI/SSDI Outreach, Access, and Recovery (SOAR)
Our Direct Services/ Shelter Director is SOAR trained. ICCAP has two PATH funded staff in the process of being trained in SOAR during the grant year ending in 2019, but had no clients who qualified to be assisted with SOAR.

Housing
Locating safe affordable housing in Indiana County has always been difficult due to a number of factors including the rural nature of the county and inadequate public transportation. While this situation is not new to the county, recent factors have exacerbated the situation: Marcellus shale extraction has been started at over 200 sites in Indiana County; more than 200 temporary workers are needed to bring in each well. This has caused an increase in the demand for housing. According to a study completed by the Center for the Study of Community and the Economy at Lycoming College entitled “Marcellus Natural Gas Development’s Effect on Housing in Pennsylvania” the increased demand for housing caused by the influx of Marcellus Shale workers is “broad-based, but the negative effects are felt heaviest by those living on the economic margins…the impact of the housing shortage are falling heaviest on those whose housing situation was most at risk prior to the growth of the Marcellus Shale industry, namely the non-working poor, seniors, the disabled and, newly, the working poor.” The Pennsylvania Department of Community and Economic Development has indicated in their Marcellus Shale Fact Sheets that the experience of other states suggests that a gas boom will drive up prices for housing and lessen the availability of housing for middle-income as well as lower-income families. ICCAP’s response to this situation takes many forms. First, the agency maintains a current database of safe, affordable rental properties in the county for distribution to clients. Rental assistance in the form of security deposits and/or rents is available through the Housing Assistance Program. Housing programs include the Pathway Homeless Shelter, Bridge Transitional Housing, Project PHD; supportive permanent housing for the disabled, PHD 2 and Homeless Case Management. The Behavioral Health Housing Liaison/PATH Case Manager position has become an added position member of the ICCAP Housing team in April 2013.

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

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

Coordinated Entry
In 1997, PA initiated the Regional Homeless Assistance Process to address homelessness in Pennsylvania’s rural counties known as the “balance of the state”. To cover the participating counties, this process began with the formulation of four separate Regional Continuum of Care:

NOT FINAL

Central-Harrisburg, Northeast, Northwest and Southwest. Each region established a Regional Homeless Advisory Board (RHAB). Over the last few 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 has implemented "Housing First" under the CoC's. Both the Western and the Eastern CoC's are using a Coordinated Assessment Tool and Coordinated Entry tool. The application/tool is completed by ICCAP Staff; the lead agency in the 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.

All homeless individuals along with all PATH clients are entered into HMIS. However, our PATH clients are not chosen from the Coordinated Entry so it does not produce any barriers for services, and we only accept clients from Indiana County. If we have a PATH client that is also homeless, their name may be pulled from the Coordinated Entry for a housing opportunity in Indiana or another surrounding county. If a PATH client's name is pulled from an agency in another county for a housing opportunity, we can assist them in gathering their documentation needed, and refer them to services and to another PATH provider if available.

Justice Involved

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

Staff Information

The program is staffed by a full-time Behavioral Health Housing Liaison/PATH Case Managers, housed in the main office at 827 Water Street, Indiana. PATH program staff is currently 100% Caucasian female. The Behavioral Health Housing Liaison/PATH Case Managers are supervised by the Direct Services/Shelter Director and will be part of the agency housing team. The Behavioral Health Housing Liaison/PATH Case Managers one has a Bachelor's degree and experience in mental health. The second Liaison has a Master's Degree in Adult Education. This experience will be supplemented through supervision. They attend Community Support Program Meetings, and appropriate available trainings. We do not have any PATH staff, that are Certified Peer Specialists or Certified Recovery Specialists.

As our county consists overwhelmingly of English speaking persons of Western European descent, we have little need for expertise in cultural competency; however, we rely on the nearby Indiana University of Pennsylvania and ARIN IU 28 to assist us with language and cultural issues.

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

NOT FINAL

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

Consumer Involvement
We currently do not have a consumer involved. We are in the process of recruiting to replace the consumer that left. Whomever we recruit will play an active role regarding our housing programs: They will review Policies and Procedures for all of our housing programs, gives input on housing programs as well as sit as a member of our Housing Committee who hears the appeal of those who may have been terminated from a program. However our PATH-eligible volunteer will be involved at all levels in the planning, implementation and evaluation of PATH-funded services. We currently have no family members that are involved at an organizational level in the planning, implementation and evaluation of PATH – funded services. We ask each PATH client to submit a satisfaction survey of how we can improve services to them on a yearly basis.

Health Disparities Impact Statement
Within our PATH population one of the disparities we found while focusing on the subpopulations were that out of 13 clients who identified as having a Co-occurring Disorders 9 were female and 4 were male.

It is projected that 33% of clients served through PATH funds will be Youth and Young Adult (YYA) 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 YYA consumers are due to their lack of income, and rental history. Also compared to older consumers who have had a mental health diagnosis, YYA consumers don't know what services are available. ICCAP's Behavioral Health Housing Liaison/PATH Case Managers will continue to educate this population about resources and services available as well as coordinating services.

- The unduplicated number YYA individuals who are expected to be served using PATH funds: 18.
- The total amount of PATH funds expected to be expended on services for the YYA population: $9,956.
- The types of services funded by PATH that are available for YYA 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 YYA population and in comparison to the general population: Most of our YYA 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.

NOT FINAL

	Total	FY1	FY2	FY3	FY4
Direct Services: **Number to be served**	18	4	4	4	6
By Race/ Ethnicity					
African American	<8	<2	<2	<2	<2
American Indian/Alaska Native	<8	<2	<2	<2	<2
Asian	<8	<2	<2	<2	<2
White	<40	<10	<10	<10	<10
Hispanic or Latino	<8	<2	<2	<2	<2
Native Hawaiian/Other Pacific Islander	<8	<2	<2	<2	<2
Two or more Races	<8	<2	<2	<2	<2
By Gender					
Female	8	2	2	2	2
Male	8	2	2	2	2
By Sexual Orientation/Identity Status					
Lesbian	unknown	unknown	unknown	unknown	unknown
Gay	unknown	unknown	unknown	unknown	unknown
Bisexual	unknown	unknown	unknown	unknown	unknown
Transgender	unknown	unknown	unknown	unknown	unknown

NOT FINAL

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

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

Personnel:
The funding amount of $21166.00 is being requested to provide from the full-time salary (70% of the time) of the Indiana County PATH/Behavioral Health Housing Liaison position. This position will be located at the Indiana County Community Action Program, Incorporated's office located at 827 Water Street, Indiana, PA. The housing liaison work concentrates on increasing and creating housing resources for those who are homeless or at imminent risk of becoming

homeless and have a behavioral health illness.

Fringe Benefits:
The funding amount of $3703.00 is being requested to provide for the full-time fringe benefits of ICCAP's Behavioral Health Housing Liaison/PATH Case Manager. Fringe benefits include the following costs: FICA ($1619.00), Workers Compensation ($81.00), Pennsylvania Unemployment ($249.00), Health Insurance ($1659.00), Vision Insurance ($45.00) and Life Insurance ($52.00).

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 $ 1700 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 5-7 individuals experiencing homelessness or at imminent risk at approximately $400 each, not to exceed $2400; $ 1,400 would be a one-time assistance to help consumers maintain housing and 1,000 for security deposits. Total request for other expenses: $2,400.00.

As mentioned above Indiana County Community Action Program, Inc.(ICCAP) is the Local Lead Agency on Housing for Indiana County and provides numerous housing programs. In addition, although ICCAP is continuing a PATH program to specifically expand existing housing and increase new housing programs for homeless/near homeless mental health individuals, ICCAP provides housing components of $672,228.04 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.

NOT FINAL

BUDGET TABLE
Indiana County Community Action Program, Inc.
PATH Program
FY 2019-2020 Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Housing Case Manager/ Admin costs	30237	.7 FTE	21166.00	21166.00
sub-total			**21166.00**	**21166.00**
Fringe Benefits				
FICA Tax			1619.00	1619.00
Unemployment			249.00	249.00
Workman's Compensation			81.00	81.00
Health Insurance			1659.00	1659.00
Vision Insurance			45.00	45.00
Life Insurance			51.00	51.00
sub-total			**3703.00**	**3703.00**
Travel				
Local Travel for Outreach			1700.00	1700.00
Travel to training and workshops			100.00	0.00
sub-total			**1800.00**	**1800.00**
Equipment				
(list individually)				
sub-total				
Supplies				
Office Supplies			252.00	252.00
Consumer-related items			850.00	850.00
sub-total			**1102.00**	**1102.00**
Other				
Staff training				
One-time assistance to maintain housing			1400.00	1400.00
Security deposits			1,000.00	1,000.00
Postage				
sub-total			**2400.00**	**2400.00**
Total PATH budget				**$30,172**

NOT FINAL

Blair County - Home Nursing Agency
500 E Chestnut Avenue
Altoona, PA 16601
Contact: Kelly Williams

Provider Type: Community mental health center
PDX ID: PA-029
State Provider ID: 4229
Contact Phone #: 8149430414

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	none

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

NOT FINAL

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 47,087**	**$ 15,696**	**$ 62,783**	

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 47,087	$ 15,696	$ 62,783	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**none**
l. Grand Total (Sum of j and k)	$ 47,087	$ 15,696	$ 62,783	

Source(s) of Match Dollars for State Funds:

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

Estimated Number of Persons to be Contacted: 100

Estimated Number of Persons to be Enrolled: 80

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

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Blair County Human Services Office – PATH Intended Use Plan

UPMC Behavioral Health of the Alleghenies
500 East Chestnut Ave.,
Altoona, PA 16601
PDX: PA 029 Home Nursing Agency
2019-2020

Local Provider Description

UPMC Behavioral Health of the Alleghenies (UPMC BHA), formally the Home Nursing Agency (HNA), was established in 1968 as a home health care organization. In 1975 mental health services were initiated with a Blair County contract to provide housing support and case management to residents discharged from the local state mental health institution. HNA offers a full outpatient continuum of services for adults and well as children and adolescents. In addition to behavioral health services, the agency provides home care, hospice, private duty, maternal and child services, day and community services for individuals with intellectual disabilities, WIC and Adult Day services. In 2014 HNA was acquired by the University of Pittsburgh Medical Center (UPMC) and is now a part of the UPMC system, undergoing our official name change to UPMC BHA in 2018.

Quality is important to UPMC BHA 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 UPMC BHA provides includes Outpatient Mental Health Therapy, Acute Mental Health Partial Hospitalization, Blended Case Management, Resource Coordination, Certified Peer Support Services, Permanent Supportive and Transitional Housing, Outpatient Drug and Alcohol Therapy and Licensed Clubhouse Psychiatric Rehabilitation Services. Our philosophy is co-occurring capable with a "no wrong door policy" that is person centered, recovery oriented and practices a housing first philosophy.

It is currently estimated that the PATH program will receive $62,783 during 2019-2020 via contract with the Blair County Department of Social Services. A budget table is attached and budget justification information is in this IUP. PATH funds will provide for 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 when possible. This case management position will be a full-time case manager working within the PATH program. Case Management is an effective model to work within our existing housing structures to assess, screen, locate appropriate housing and assist with other needs the individual may have. We realize that ensuring a steady income and locating housing is not the end to homelessness. Individuals have many factors that play a significant role in homelessness and we work to give the individual the tools they need to be self-sustaining and successful. Funds will also supplement the salary of a Housing Manager who will provide for an increased level of customer contact, customer satisfaction and community integration of our services

NOT FINAL

Collaboration of HUD Continuum of Care Program
UPMC BHA participates in the South Central RHAB and PA Eastern Continuum of Care Collaborative meetings. We also work closely with and consult Diana T. Myers and Assoc. on a regular basis. Our Continuum of Care works frequently with Department of Community and Economic Development and participate in any trainings they have to offer regarding HMIS utilization.

We are active in our local CoC Coordinated Entry program. We work closely with our local Blair County Community Action Agency which is one of our access sites. PATH staff regularly monitor the Coordinated Entry Queue in the HMIS system for referrals.

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 have also worked closely with the County of Blair Redevelopment and Housing Authority in conjunction with our Housing Assistance Rental Program (HARP) which is our HUD awarded program. However, our agreement for the HARP program ended in April of 2019 due our funding coming to and end in July 2019.

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.

UPMC BHA has letters of agreement with the following community resources:

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

Mental Health: Blair County Department of Social Services contracts with UPMC Altoona and UPMC BHA 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.

NOT FINAL

Community Psychiatric Inpatient	UPMC Altoona
Blended Case Management	UPMC Behavioral Health of the Alleghenies Alternative Community Resource Program Nulton Diagnostic Inc. Cen Clear
Resource Coordination	UPMC Behavioral Health of the Alleghenies And UPMC Altoona
Outpatient Mental Health Psychiatric Clinics	UPMC Behavioral Health of the Alleghenies Nulton Diagnositic Inc. ACRP, Family Services Primary Health Network
Crisis Center	UPMC Altoona
Community Employment	The Skills Group, Office of Vocational Rehabilitation
Certified Peer Support	UPMC Behavioral Health of the Alleghenies PeerStar Inc. Cen Clear Alternative Community Resource Program

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

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

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

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

NOT FINAL

Juniata House – permanent SRO	UPMC Behavioral Health of the Alleghenies
Blair House – transitional & permanent	UPMC Behavioral Health of the Alleghenies
Tartaglio Personal Care Home	UPMC Behavioral Health of the Alleghenies
Twin Mountains-permanent housing	The Skills Group
Union Avenue Apartments-permanent	Improved Dwellings-Altoona
County Housing Emergency Fund	Blair Senior Services
Mental Health Housing Fund	The Skills Group
PATH Project	UPMC Behavioral Health of the Alleghenies
Rapid Re-Housing	Blair Co. Community Action Agency

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

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

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

Sheltered employment	The Skills Group
Transitional employment	UPMC Behavioral Health of the Alleghenies The Skills Group
Competitive training and employment	The Skills Group Office of Vocational Rehabilitation Goodwill Industries

NOT FINAL

Service Provision

PATH eligibility determination

The PATH Case Manager meets with individuals at emergency and transitional sites or anywhere in the community in order to engage people in service. UPMC BHA 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.

Alignment with PATH goals

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

Gaps in current service system
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 participate on the 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.

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

UPMC BHA'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

NOT FINAL

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.

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

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.

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

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

42 CFR Part 2 regulations
UPMC BHA 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. Yearly trainings are provided on confidentiality, fraud, compliance and risk.

NOT FINAL

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

Data
UPMC BHA has been utilizing HMIS for at least 10 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.

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

UPMC BHA continues to have paper records for all services. Monthly and yearly data is sent to the County electronically. 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
UPMC BHA'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. UPMC BHA's PATH staff are located in the same building as our mental health and drug and alcohol services allowing us quick and efficient access to treatment for our individuals experiencing homelessness or who are at-risk of homelessness. We are able to work collectively with Blended Case Managers and Resource Coordinators to help homeless individuals' secure safe and stable housing while assisting to improve their health and live a self -directed and purposeful life.

UPMC BHA believes in treating the whole person and not just a mental health issue, which is why we implemented our Behavioral Health Home Plus Expansion (BHHPE) in 2014. This is a program that is designed to assist individuals in eight dimensions of wellness. We have case managers, peer specialists, counselors and housing staff trained in wellness coaching. The BHHPE has a wellness nurse/health navigator that provides support and resources for the

NOT FINAL

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.

UPMC BHA's PATH program goal is to increase access to permanent housing. We have had a HUD funded permanent housing program within our own agency's continuum of care that we could refer PATH individuals to that meet the HUD definition of homeless and who are Chronically Homeless. However, these funds will not be renewed as of July 1st 2019, we are applying for other funding to continue housing the individuals in that program and expanding our housing services. Our PATH case manager works closely with individuals to first meet their housing and basic needs. Once housing is attained, we assist individuals with employment. We can refer to various employment programs in the Blair County system such as the Skills Group, the Office of Vocational Rehabilitation, Goodwill Industries and Career Link. Staff also assist with obtaining, completing and submitting applications to employers. We are in contact with our local DPW office who regularly provide us with a list of businesses that are hiring. Staff also work closely with our Criminal Justice system, who also can provide a list of employers that will hire individuals who have a criminal record that are a difficult population to find employment for.

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

Alignment with State Comprehensive Mental Health Services Plan

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

Other Designated Funds

Currently, UPMC BHA 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. We have applied through the City of Altoona for a CDBG grant to assist with rental assistance.

Programmatic and Financial Oversight

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

SSI/SSDI Outreach, Access and Recovery (SOAR)

NOT FINAL

UPMC BHA is prioritizing to have the PATH Housing Coordinator complete the online SOAR training in 2019-2020 along with UPMC BHA's Housing Coordinator. Once trained, our PATH Housing Coordinator will be primarily responsible for the screening of individuals to determine eligibility for SOAR and then to assist in the development of an application.

Housing

Providing a Housing First Model of case management services is the main objective of the UPMC BHA's PATH project. UPMC BHA's Blair House is an SRO facility that has 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.

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). UPMC BHA 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 UPMC BHA (7 beds). This is a facility for homeless individuals in the mental health system that are literally or chronically homeless.

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

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

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

Housing projects within the system, like private landlords, are wrestling with the issues of drug abuse, intoxication, drug induced acting out, illegal behavior and disturbances of the peace. UPMC BHA staff continues to seek ways to help individual's access treatment and avoid the harmful physical, emotional, social and legal consequences of abuse and addiction. PATH staff

NOT FINAL

is working with our Local Housing Options Team (LHOT), which should lead to more housing options for individuals with co-occurring disorders.

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

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

Coordinated Entry

Blair County's Coordinated Entry program was up and running in January of 2018. UPMC BHA currently participates in monthly meetings to review our local HMIS Queue for the South Central RHAB. PATH staff are regularly checking the Queue in HMIS for referrals. UPMC BHA keeps all of their housing program information up to date in HMIS so that other areas are aware of what housing services we provide, including our PATH program.

Justice Involved

UPMC BHA'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 Social Services, Blair County Prison, UPMC BHA 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.

NOT FINAL

Staff Information

The PATH staff is comprised of one Caucasian female Housing Coordinator and one Caucasian female Housing Supervisor. All PATH staff participated in cultural competency training, limited English proficient training and person centered training. PATH staff understand the importance of considering one's cultural or personal preferences when providing services and locating housing. UPMC BHA 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
UPMC BHA has served the mental health population of Blair County for the past 50 years. Blair County has a population of about 123,457, primarily Caucasian (96%) and Black or African American (2%), Two or more races (1.4%). The mental health population mirrors the racial breakdown of the county. Rarely do we encounter a person in need of mental health services who does not communicate in English; local professionals are available should a translator be needed. Additionally our staff is reflective of the demographics of the area. The primary cultural diversity of the area is a large rural population surrounding the City of Altoona.

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

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

Consumer Involvement
UPMC BHA 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, UPMC BHA implemented a Certified Peer Support Program. The Peer Specialists use their personal experience to provide support and guidance to individuals who are going through the recovery process. One of our Certified Peer Specialists was promoted to a housing management position.

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

Blair County and UPMC BHA 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 UPMC BHA Behavioral Health Advisory Committee. This committee welcomes the involvement of PATH individuals and families as opportunities are presented. Many individuals have benefits for

NOT FINAL

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.

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

At this time, UPMC BHA does not have a particular dollar amount set aside specifically for TAY, 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 UPMC BHA PATH program does not currently provide services that are funded specifically for TAY individuals. We plan to collect and monitor data over the next fiscal year on the TAY that we come in contact with through our PATH program, to determine what strategies we need to implement to decrease the disparities in access, service use and outcomes for this population.

Limited English Proficiency

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

NOT FINAL

Budget Narrative

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

Fringe Benefits:

Total for benefits is budgeted at $10,608 of the personnel expenses.

Travel:

Staff are reimbursed at .55 per mile, which we anticipate spending $482 for travel in the fiscal year.

Equipment:

PATH will provide a smart phone for the PATH staff at $482.. Record retention is the cost of preserving records per HIPAA regulations for the PATH program. Laptop expense for new staff for employer requirements and HMIS data entry.

Other:

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

Total PATH Allocation $62,783.

NOT FINAL

BUDGET TABLE
Blair County PATH Program
FY 2019-2020 Budget

PERSONNEL Position	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Housing Coordinator	$30,506	1	$30,506	$30,506
Housing Supervisor	$44,008	.31	$13,642	$13,642
sub-total	$74,514		$44,148	$44,148
FRINGE BENEFITS				
FICA Tax	$5,700		$3,377	$3,377
Health Insurance	$13,785		$7,231	$7,231
sub-total	$19,485			$10,608
TRAVEL				
Local Travel for Outreach				$450
Travel to training and workshops				
sub-total				$450
SUPPLIES/EQUIPMENT				
Consumer-related items				
Office supplies				
Cell Phone				$482
sub-total				$482
Other				
Administrative Expenses			$7,095	$7,095
Staff training				
One-time rental assistance				
Security deposits				
Client transportation				
sub-total			$7,095	$7,095
Total PATH Budget			**$62,783**	

NOT FINAL

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	none

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 51,680**	**$ 17,227**	**$ 68,907**	

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

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 51,680	$ 17,227	$ 68,907	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**none**
l. Grand Total (Sum of j and k)	$ 51,680	$ 17,227	$ 68,907	

Source(s) of Match Dollars for State Funds:

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

Estimated Number of Persons to be Contacted: 250

Estimated Number of Persons to be Enrolled: 175

Estimated Number of Persons to be Contacted who are Literally Homeless: 115

Number staff trained in SOAR in grant year ending in 2018: 3

Number of PATH-funded consumers assisted through SOAR: 1

NOT FINAL

Penndel Mental Health Center
PATH Intended Use Plan
FY 2019-2020

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

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

The address as listed in the PATH PDX:

PA-041
Penndel Mental Health Center
2005 Cabot Blvd West
Suite 100
Langhorne PA 19047.

The Housing Continuum of Care- Bucks County and is identified as PA-511
Bristol/Bensalem/Bucks County CoC
PATH will receive 68,907.00 in federal and state funds for fiscal year 2019-2020.

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

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

NOT FINAL

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

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

Mental Health Services

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

Housing and Shelter

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

NOT FINAL

- The Way Home
- Christmas Gala – Provides funding for move in assistance and motels

Substance Abuse Treatment

- Aldie Counseling Center
- Livengrin
- Gaudenzia House
- Pro-Act/Southern Bucks Recovery Community Center
- Bucks County Drug and Alcohol Commission
- Penn Foundation Village of Hope
- Family Service Association of Bucks County – Center of Excellence (Opioid Addiction)

Other Community Agencies and Programs

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

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

One example of collaboration between agencies is the work that PATH has done as a partner with the Housing Link, which is Bucks County's Coordinated Assessment and Entry process for residents who are experiencing homelessness. The PATH program will receive a referral (though HMIS) for individuals who present as having a mental illness or co-occurring substance abuse disorders. A PATH worker will meet the client in the community, verify their homeless status and do a brief assessment to ascertain the individual's housing service eligibility. PATH will make referrals to the Bucks County Emergency Shelter, the Bucks County Opportunity Council, MH residential programs and various other housing programs.

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The PATH program has continued to provide support to the Code Blue shelters, when a Code Blue is called. On nights when code blue shelter is open, PATH provides a case manager to work with the individuals that are at the shelter for the evening. This is an opportunity to assist shelter guests with gathering and completing paperwork for entitlement programs, such as health insurance, food stamps, and Social Security benefits.

The COC has a number of committees, one of which is the Outreach Committee. This committee focuses on improving coordination and collaboration between the various homeless outreach groups and improving services that support individuals who are homeless. The Outreach Committee is comprised of agencies who have a designated role with community and includes PATH, The Bucks County Opportunity Council, Valley Youth House, which has the Synergy Project, which targets homeless youth, and multiple veteran street outreach programs.

A recent refocus of the Street Outreach Workgroup is to utilize the by name list in HMIS to ensure all individuals requiring street outreach have an assigned SO worker. Routine conference calls are currently being coordinated.

Service Provision

PATH eligibility determination
The eligibility requirements for PATH are that the individual be homeless or in imminent danger of becoming homeless and have a mental illness or co-occurring disorder, the client also needs to be a resident of Bucks County. The primary process for PATH to receive a SO referral is generated through HMIS, though PATH workers do have the occasion of meeting someone experiencing street homelessness. The PATH worker can begin the process of engagement and enroll this individual into HMIS if the person is in agreement without the person having an initial call to Housing Link. Typically, an outreach worker will go out and interview the potential client to see if they meet the above criteria, if they do, the client will complete an intake which includes a statement that they agree to work with the PATH program, at this point the client is considered to be enrolled in the PATH program. Any documentation relating to eligibility is placed in the clients chart. Participants are also enrolled in HMIS.

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 homelessness with individuals with serious mental illness or co-occurring serious mental illness and substance abuse disorders who in imminent risk of becoming homeless”

Locating individuals who are homeless in Bucks County can be a daunting task. Unlike many urban areas where the face of homelessness can be quite visible, Bucks County is largely rural. Individuals who are homeless may be living in encampments, abandoned buildings, cars, or moving from couch to couch. The challenge is to identify the locations where these individuals

NOT FINAL

can be found and begin engagement services with PATH and offer available resources and service connections.

PATH case managers are mobile and will 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 PATH and the individual, rather than the individual being offered something he/she may not want or be ready for. PATH will also ensure that access for shower and laundry facilities, food and clothing are offered when available.
Once an individual is identified as meeting the PATH eligibility criteria, the PATH team of outreach workers/case managers can provide linkage to emergency housing, assistance in the acquisition of benefits, debt counseling, mental health, substance abuse treatment, health care and employment supports.

Maximizing use of PATH funds
PATH maximizes the use of PATH funds by collaborating with other agencies when it comes to funding for move in costs, or prevention of an eviction. PATH will often partner with the Bucks County Opportunity Council, Salvation Army, Advocates for the Homeless and Those in Need, and Christmas Gala in obtaining funding for these costs. Additionally, the Bucks County Department of Mental Health/Developmental Programs, has funding available in the form of Contingency Funding to assist with this. Participants enrolled into HMIS through the Coordinated Intake process are also assessed for eligibility with shelter diversion resources and or housing outside the PATH program.

Gaps in current service system
There has historically been a lack of affordable housing in Bucks County, and the cost of living in the region is high. Many individuals living on a fixed income or considered working poor cannot afford the rent on most apartments. Cultivating landlord relationships who are willing to work with tenants utilizing rental subsidies when the vacancy rate of rental properties in Bucks County is less than 2% is another challenge. Additionally, many individuals involved with PATH have poor credit histories or criminal justice involvement so, even when they can afford the rent, there is great difficulty in finding a landlord that will lease to them.

Another issue is the lack of resources for people who have a co-occurring disorder. Bucks County accesses Penn Foundation's Village of Hope program, which serves this population, but the program only has a total of 16 beds (8 male/8 female). PATH workers will utilize Recovery Houses when appropriate, but not all of these houses are able to work with individuals that present with mental health challenges.

There is also a lack of housing options for Transition Aged Youth, especially those who have aged out of residential placement. These young adults may or may not be appropriate for

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available supported housing depending on the skills they've developed to live independently and some aren't interested in the available structured programs to gain these skills.

When prioritizing the most vulnerable in Bucks County, the experience of adult singles is that single males without a co-occurring vulnerability are typically rated the least vulnerable. This can leave some individuals experiencing homelessness feeling that there is no assistance for them.

Co-occurring services available
Provision of integrated mental health and substance abuse disorders continues to be a challenge in Bucks County. We continue to have only one housing program that serves individuals who have a MH/D&A diagnosis. This is the Village of Hope residential program at Penn Foundation. PATH has developed relationships with others substance abuse providers in the area and has been working closely with The Center of Excellence program. The provider for this program is Family Services Association of Bucks County and they assist participants in accessing treatment, resources and support. The Center of Excellence targets those diagnosed with addiction to opioids.

42 CFR Part 2 regulations
At present PMHC does not follow CFR Part 2 regulations.

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

PATH is a program of the Penndel Mental Health Center, which also oversees the Forensic Support Program, so there is coordination with that program when appropriate. This program is described as a Forensic Community Treatment team. Additionally, Bucks County MH/DP has applied to OMHSAS and has been approved for their PRA, which will include high levels of coordination with the Bucks County Prison, Adult Probation and other human service agencies, with a focus on re-entry and diversion. Under the advice of the HCoC-BC, the Bucks County Opportunity Council and Family Service Association made application to the statewide PHARE grant focusing on forensic housing. While these grants are not directly under the PATH program it is evident that these resources will positively impact these collaborating agencies and the individuals being supported in Bucks County.

NOT FINAL

Data
PATH is a full participant in HMIS and the HMIS lead for the county is available to provide any technical assistance and ongoing training. The PATH program currently uses ClientTrack and utilizes the ClientTrack training manuals and videos. All manuals are printed out and serve as our reference materials.

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

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

NOT FINAL

Other Designated Funds
PMHC PATH program does receive additional State and county funding through block grant funding. This is further outlined under the budget section of this plan.

Programmatic and Financial Oversight
Department of MH/DP provides fiscal oversight, which includes reviews of annual budgets, monthly invoicing, quarterly expenditure reports, the PATH IUP and audited financial reports. MH program staff meet bi-monthly with the PATH program to review caseloads and discuss challenges and needs. Over the past year MH/DP has had ongoing and increased coordination

with Housing Services/Housing Link to ensure effective utilization of resources and increased coordination among PATH and other Street Outreach and Housing partners.

SSI/SSDI Outreach, Access, Recovery (SOAR)
Given staff turnover, PATH presently has one staff trained in SOAR, which is a decrease of one staff. During this past fiscal year only one application was submitted. Countywide statistics for SOAR for FY 18/19 are (3) applications have been submitted and received approvals thus far. There was also (1) appeal that was approved. There are 4 applications with protective filing dates but have not yet been submitted. The average day to decision is 82 days.

The SOAR workgroup has experienced more active more active involvement with our Shelter staff, with the Shelter Director attending the SOAR Summit in spring 2019. This person will be attending The Soar Leadership Academy in September 2019.

Housing
Once a PATH case manager has engaged with an individual, the PATH worker will do an assessment of the individual's situation to ascertain what residential or housing options might be most suitable. PATH will typically suggest the individual calls the Bucks County Housing Link, which is the county's centralized intake and referral for those experiencing homelessness or risk of homelessness. The PATH case manager will then work with the individual and Housing Link partner agencies to locate housing, which may be emergency housing at a shelter, application for Rapid Re-Housing, subsidized housing through HUD, or rental assistance through other county programs. If the individual is in need of and agrees to a MH residential or supported living program, a referral will be made to a Community Residential Rehabilitation or Supported Living program. In some cases PATH has assisted individuals with placement into Personal Care Boarding Homes. PATH also uses short term placements, such as a motel as a bridge to a more permanent housing situation, which is typically no more than three days. Below are several agencies and providers of housing are as follows:

- The Bucks County Emergency Homeless Shelter
- The Lenape Valley Foundation Acute Respite Care Program
- The Penn Foundation Village of Hope
- Recovery Houses
- MH/DP CRR and SLP programs
- The Rodeway Inn
- Bucks County Opportunity Council
- Bucks County Housing Group
- Private Landlords

NOT FINAL

Coordinated Entry
The PATH program works very closely with Bucks County's coordinated entry program, The Bucks County Housing Link. Residents experiencing homelessness or risk of homelessness may contact the Housing Link via a 1-800 number. The Housing Link staff screen all callers with a brief interview to determine the households general eligibility for housing assistance. The results are then entered into the Housing Link centralized referral database (HMIS) and if unable to divert the individual/family, an in person assessment will be scheduled at the nearest regional assessment center. During the in person appointment, the level of housing assistance needed to resolve the crisis is determined and referral will be made to available resources and housing options. Agencies involved in the Housing Link include the Family Services Association, the Bucks County Housing Group, the Bucks County Opportunity Council, and Keystone Opportunity Council.

Additionally, PATH also supports the Housing Link assessment process by completing homeless verifications and the vulnerability assessments in the field and forwarding this information to the assessment center. This is often needed as a homeless individual may not have transportation or even a reliable telephone where they can be contacted. One recent change to the assessment process has been for the availability of open access hours for individuals who have difficulty with planning and keeping appointments. Over time the Housing Link partners anticipate seeing a decrease in the drop off rate of engagement following the initial assessment.

Justice Involved
Please indicate if Crisis Intervention Team training is being used in your County/joinder. If so, please provide approximate percentage of law enforcement that has been CIT trained and any feedback on effectiveness.

The Bucks County CIT Task Force has trained all but one law enforcement department in the county, which is a huge gain over the past year. In a typical year the CIT Taskforce would hold two trainings with a classroom of 30 participants in each training. In FY 18-19 the goal is to add one additional training and this was achieved. Also being added to the CIT infrastructure is the identification of a CIT Coordinator within each Police Department. This officer will be invited to participate in a quarterly workgroup led by the CIT Taskforce, with the intention of problem solving and challenges faced by officers and identifying improvements when using this approach in the community. The CIT training initiative began in Bucks County in 2009.

Staff Information
The PATH staffing is consistent with client demographics and consists of a 50 year old Caucasian male, a 60 year old African-American male and a 49 year old female. One of the PATH case managers is a certified peer specialist who has experienced homelessness. In keeping with PMHC policy, all individuals are to be treated with dignity and respect and all Penndel Mental Health Center employees have been given training in trauma informed care. PATH case managers are required to have 20 hours of training annually which will include

NOT FINAL

training in cultural competence and health disparities. A number of recovery focused trainings are available in Bucks County throughout the year and are free of charge.

Client Information

According to the PATH Annual Report Survey for FY 2018, for Bucks County, 81% of the individuals who were served were Caucasian, 21% of the individuals served were Black or African-American, 5% of those served were Hispanic or Latino. In terms of age 2% of the clients were between the ages of 18 and 23; 23% were 24-30; 15% were 31-40; 25% were 41-50; 27% were 51-60 and 8% were over 62. The majority of the PATH eligible consumers are on fixed incomes, usually SSI or SSDI, many of them have poor credit histories and many have been involved with the criminal justice system. In terms of gender, 54% were female, 45% were male and 1% were transgender. It is estimated that more than half of those enrolled with enrolled will be literally homeless.

Consumer Involvement

Describe how individuals who experience homelessness have serious mental illnesses, and family members will be meaningfully involved organizational level in the planning, implementation, and evaluation of PATH funded services. For example, indicate whether individuals who are PATH eligible are employed as staff or volunteers or serve on governing or formal advisory boards. See Appendix 1 “Guidelines for Consumer and Family Participation”.

Penndel Mental Health Center has a Board of Directors that includes a member with mental illness and also includes family members of individuals who are receiving behavioral health services. The Board is regularly apprised of the activities of the PATH program. Presently one of the PATH case managers is a Certified Peer Specialists and use their lived experiences to better serve PATH clients. PATH is also a member of the Bucks County Community Support Program and chairs a subcommittee on homelessness. The goal of this subcommittee is to improve coordination and communication between agencies providing outreach and referral of homeless individuals to the Housing Link. Sub-committee members, by providing feedback on the coordinated entry process have been able to improve and streamline the process of moving homeless individuals from the street into safe stable housing. These changes have resulted in improved communication to the applicant and the referring agency.

The Executive HCoC-BC Committee continues to have a committee member who has the designation of being formally homeless.

Health Disparities Impact Statement

At present in the current fiscal year PATH has served 4 TAY individuals, or about 4% of the total. It is expected that PATH will spend 4 to 5% of its funds on TAY individuals. The types of services and programs available to TAY who access the PATH program are the same as any service provided adults. Currently PATH does not specifically seek out the TAY population and

NOT FINAL

serves them alongside the adult population. As it is with the adult homeless population, the most difficult aspect of serving them is often finding them. PATH has developed relationships with community organizations and law enforcement to help in identifying the locations where the homeless youth might be. This strategy of "in reach" has allowed PATH to serve those whom we might not otherwise know about. In the future PATH hopes to work more closely with organizations that serve youth such as the Synergy Project that works with homeless youth in the county and the Valley Youth House which offers a dedicated shelter for homeless youth and runaways.

Programs that specifically support TAY in bucks County include the TIP (Transition to Independence Program) and the recently available TAY Peer Support Program through Child and Family Focus. TIP provides case management services to youth between the ages of 16 and 26. Bucks County has one CRR program with a set aside of 9 beds for TAY individuals.

Limited English Proficiency

Penndel Mental Health Center keeps a list of employees who speak various languages to assist in case there is a client who does not speak English, in addition Penndel Mental Health Center has access to translation services in the event we need to serve a non- English-speaking client.

The Bucks County Department of MH/DP contracts with Magellan Health Services, Inc. for our HealthChoices medical assistance population. Magellan has in-network provider linguistic competencies, which reflect the county's minority populations. Additionally, Bucks County MH/DP contracts with three translation services to support intake and monitoring needs across the Department. MH/DP contracted providers are also required to have translation services available to meet the needs of linguistic minorities.

Budget Narrative

Personnel:

This component of the budget is **$102,254**. The personnel costs that are supported by PATH dollars represent 6% of the Director's salary, 12% of the Coordinator's salary, and 36% of two FTE Case Manager salaries, and a Certified Peer Specialist.

Federal Share - $30,870 State PATH Share - $9,000 County Share - $62,384

Fringe Benefits:

Fringe benefits are calculated at 23.85% of total salaries (equal **$24,388**) and include FICA, unemployment compensation, health and dental benefits, accidental death & disability/life insurance as well as short term/long term disability.

Federal Share - $7,362 State PATH Share - $2,147 County Share - $14,879

Travel:

NOT FINAL

The costs for travel are at $**7,922**. The costs for staff travel include local travel for outreach and travel to training and workshops. Client travel includes the cost of vehicle fuel, insurance, maintenance and repairs.
Federal Share - $1,822 State PATH Share - $634 County Share - $5,466

Supplies:
The total budget for supplies for 2018-2019 is **$475.** This includes $375 for office supplies necessary to run the program. Client-related supplies ($100) include those supplies necessary for clients to be able to occupy housing on a successful basis.
Federal Share - $109 State PATH Share - $38 County Share - $328

Other:
The total budget figure includes office expense (rent, utilities, repairs/maintenance/housekeeping communications and property/liability insurance), emergency housing assistance, one time rental assistance, security deposits, move-related travel, assistance in obtaining housing, and staff training. The cost for other expenses for 2018-2019 is **$51,043.**
Federal Share - $9,529 State PATH Share - $2,905 County Share - $ 38,609

NOT FINAL

Indirect Cost:

Administrative cost at 4% of total direct costs for Federal PATH Allocation but 16.5% Agency overall administrative cost. Indirect cost is **$30,534.**

Federal Share - $1,988 State PATH Share - $2,503 County and - $26,043

Total PATH Funding……………….…………$216,616

Federal Share - $51,680 State PATH Share - $17,227 County Share - $147,709

NOT FINAL

Bucks County Department of Mental Health/ Developmental Programs
Penndel Mental Health Center, Inc.
PATH Program –State and Federal PATH MATCH Funding
FY 2019-2020 Budget

	Annual Salary	PATH-State & Federal funded FTE	PATH-State & Federal funded salary	Total
Position				
Dir-Path Program	$ 83,230	.056	$ 4,682	
Coordinator	50,807	.12	6,097	
Case Manager	31,145	.356	11,091	
Case Manager	31,200	.356	11,110	
Certified Peer Spec.-TBH	19,344	.356	6,890	
Subtotal				$ 39,870

Fringe Benefits (@ 23.85%)			$ 9,509	
Subtotal				9,509
Travel				
Staff travel: local travel for case mgrs.			$ 31	
Client travel-motor vehicle/repairs/maint/ins.			2,425	
Subtotal				2,456
Supplies				
Office supplies			$ 116	
Client-related supplies			31	
Subtotal				147
Other				
Office expense, including rent, utilities, bldg. insurance, housekeeping, repair and maintenance, depreciation.			$ 0	
Emergency housing assistance			8,934	
One-time housing rental assistance			1,000	
Security deposits			1,000	
Assistance in obtaining housing-client travel exp.			750	
Staff training			750	
Subtotal				$ 12,434
Total Direct Charges				$ 64,416
Indirect Costs: Administrative Cost @ 4% for Federal share;17.51% for State PATH share - overall Agency administrative rate				4,491
Total				$ 68,907

NOT FINAL

Butler County - Catholic Charities
120 West New Castle St
Butler, PA 16001
Contact: Amber Crowe

Provider Type: Social service agency
PDX ID: PA-049
State Provider ID: 4249
Contact Phone #: 7242874011

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	0.00 %	$ 0	$ 0	$ 0	none

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 81,903**	**$ 27,301**	**$ 109,204**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 81,903	$ 27,301	$ 109,204	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 81,903	$ 27,301	$ 109,204	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 81,903	$ 27,301	$ 109,204	

Source(s) of Match Dollars for State Funds:

Butler Co will receive a total of $109,204 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 180

Estimated Number of Persons to be Enrolled: 140

Estimated Number of Persons to be Contacted who are Literally Homeless: 108

Number staff trained in SOAR in grant year ending in 2018: 1

Number of PATH-funded consumers assisted through SOAR: 5

NOT FINAL

BUTLER COUNTY
2019-2020 PATH INTENDED USE PLAN

CATHOLIC CHARITIES
120 New Castle Street
Butler, PA 16001
PDX Name: PA 049 Butler: Catholic Charities

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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 Catholic Charities to provide specified services to PATH eligible Butler County residents.

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. 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. This organization also began functioning as Butler County's Central Intake for housing and homeless services in October 2014 and became the Coordinated Entry general assessment center for Butler County with the implementation of Coordinated Entry across our continuum in January 2018.

Butler County Human Services' total PATH allocation for 2019-2020 is $109,204 with $81,903 in federal funds and $27,301 in state funds. Catholic Charities will receive $109,204.

Collaboration with HUD Continuum of Care (CoC) Program

Butler County is one of twenty counties to make up the new Western Region Continuum of Care (PA-601) and one of seven counties that make up Pennsylvania's Southwest Regional Homeless Advisory Board (SW RHAB). This advisory board functions as the Department of Housing and Urban Development's (HUD) Continuum of Care for the region and is charged with coordination and oversight of the region's homeless services system.

Butler County Human Services holds the HUD Continuum of Care grant that funds the Path Transition Age Project and Home Again Butler County. These are permanent supportive housing programs, one for youth and the other for families that are administered by Catholic Charities. Catholic Charities has a consistent presence at the semi-annual Western Region Continuum of

Care meetings and is also an active participant of the Coordinated Entry Planning committee designated by the Western Region CoC. The Coordinated Entry committee began meeting in April 2015 and Catholic Charities has been a part of the planning, pilot and implementation.

Locally, Catholic Charities is an active participant in the Butler County Local Housing Options Team (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.

Collaboration with Local Community Organizations

Catholic Charities has built trusting, working relationships with various organizations in the community which has reduced many barriers to quickly and effectively serving homeless individuals and families. Connection to mainstream services is a critical aspect of Coordinated Entry because it is essential to help homeless individuals and families overcome barriers to self-sufficiency. The following list is comprised of the community organizations that Catholic Charities partners with to serve PATH-eligible clients:

- PATH -eligible clients who are unable to secure employment due to their disability are referred to apply for Social Security benefits. Catholic Charities works closely with the SOAR program through Center for Community Resources for clients who would benefit from assistance in completing a SOAR application.

- PATH-eligible clients are offered assistance 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 case managers then work with the program participants to access medical care through a network of primary care physicians throughout Butler County. Mental health treatment services are available to PATH-eligible clients through a number of providers, including SPHS Care Center, Glade Run Lutheran Services and Family Services of Butler Hospital. The services available include residential, assertive community treatment, outpatient, psychiatric rehabilitation and blended case management.

- 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.

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- Services for victims of violence are provided by the Victim Outreach Intervention Center (VOICe). VOICe provides free and confidential services to individuals and families who are survivors of various crimes. VOICe works within our community to bring about social change and provide survivors with the ability to take control of their lives.

- PATH eligible clients that are not able to secure medical coverage are connected with the Community Health Clinic of Butler County. The clinic serves county residents with no health insurance and provides them with free outpatient primary medical care, preventive medical services, referrals for specialized services, and free medications when possible.

- Salvation Army, the Lighthouse Foundation, and five local churches offer free community meals for both lunch and dinner during the week, as well as non-prepared food available through a network of over twenty-six different food cupboards across the county.

- Beyond immediate needs, PATH eligible clients are offered numerous ancillary services ranging from peer support and leisure groups, to assistance with furniture, transportation and clothing.

- Catholic Charities has partnered with the Center for Community Resources, the Grapevine Center and VA Butler Healthcare to provide outreach to individuals and families who are homeless. Individuals from each agency form an outreach team when there are reports of encampments, multiple individuals, safety concerns and for the Department of Housing and Urban Development's annual Point-in-Time Count.

- Individuals and families who are homeless or at risk of homelessness are assessed through Coordinated Entry and determined if they are PATH eligible. Path eligible clients are provided with assistance in accessing other housing in the community, which might involve assisting a client in applying for housing services through another provider within the homeless continuum of care, including the Housing Authority of Butler County, Center for Community Resources, the Lighthouse Foundation, and Victim Outreach Intervention Center.

Examples of other service programs that meet the needs of PATH eligible clients and assist them in becoming self-sufficient and remaining in permanent housing include, but are not limited to:

- Representative Payee Program: The Representative Payee program offers community support service through providing a volunteer to handle participants' Social Security benefits on their behalf. This program assists individuals with disabilities to maintain financial stability in the community.
- Support Groups/Social/Recreational Opportunities: Many homeless individuals, especially the transition-age population, have no experience with, or knowledge of how to access positive and healthy socialization and recreation programs in the community. There are numerous support groups (AA, NA, etc.), as well as socialization and leisure

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activity programs, in the community available and willing to support PATH-eligible clients.

- S.H.O.P Program: The Supportive Housing Opportunities Program (S.H.O.P) helps participants ready to enter the housing market with all the necessary skills and knowledge to become a successful renter.

Service Provision

PATH eligibility determination

PATH eligibility is determined at the time of assessment through Coordinated Entry. Once placed on the prioritization list for housing, individuals are scheduled for an intake where it is determined whether or not the individuals would benefit from PATH enrollment and would be agreeable to this service. Verification of homeless or at risk status is typically obtained at this time along with releases to verify mental health diagnosis if necessary. PATH case managers complete a PATH enrollment sheet and maintain a file that includes intake and enrollment forms, service plans, eligibility verifications and case notes.

Alignment with PATH goals

Butler County Human Services enters into a contractual arrangement with Catholic Charities to provide these specific services to ensure that PATH funds are targeted for street outreach and case management services. Contracted providers are only permitted to provide the services dictated under the terms of their contract. A majority of the PATH funds are used to pay for the salary and benefits of the housing and homeless case managers, who, in addition to providing the various supports that fall under the definition of case management, are also responsible for conducting street outreach on a weekly basis.

Maximizing use of PATH funds

In Butler County, individuals and families who are homeless or at significant risk of becoming homeless are one of the major target populations. Butler County acknowledges that not one agency or one funding stream can effectively serve all the individuals who are facing a housing crisis, As such, significant resources, including funds from PATH, MH Base, HAP, PHARE, Act 137, and HUD, are combined to ensure a comprehensive array of services are available. Our strategy is to utilize PATH funding primarily to support the services within our continuum that focus on engaging homeless people and connecting them with the housing, treatment, and resources they need to gain a greater level of stability.

Gaps in current service system

Safe and affordable housing remains the primary gap in Butler County's homeless system. Units that are desirable quite simply are often unaffordable to the PATH-eligible clients. The units of housing that are available in the private market that are affordable and accessible to the people we serve are often not safe and/or are not conducive to support their continued journey with recovery.

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Co-occurring services available
Butler County recognizes the high percentage of individuals who struggle with dual diagnoses. Statistics pulled from the Coordinated Entry prioritization list in June 2019 show that 100 % of individuals reported having mental health and 42% reported drug or alcohol use. 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, substance abuse and mental health treatment. Butler County is proud to be a Trauma Informed Care Community and is taking the steps necessary to build a trauma informed workforce amongst all the providers. The county also offers several providers who offer dual diagnosis inpatient and outpatient options. These services are often necessary in order to overcome symptoms of their disorders that have likely contributed to their unstable housing situation. In addition, other supportive services are provided that help the target population to build the skills necessary to access and retain permanent housing and also to become productive members of the community. These services include life skills training, personal supports, advocacy, educational/vocational services, socialization, and peer support.

42 CFT Part 2 regulations
Catholic Charities is not required to follow 42CFR Part 2 regulations.

Justice-involved
Catholic Charities has worked to identify and form relationships with landlords who will consider tenancy for some individuals with criminal backgrounds and often time, this can be 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. Referral to a program called Starting Over After a Record or SOAR are also common. This service helps individuals complete a resume and/or employment application, provides coaching for interviewing skills and connections to other community resources that may be beneficial to individuals who are seeking employment.

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Data
Catholic Charities PATH funded staff have been entering all PATH required data into the HMIS system since 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 a minimum of quarterly for accuracy by Butler County Human Services. Butler County is part of the Western Region CoC which utilizes ClientTrack, operated through the Department of Community Economics and Development (DCED). DCED has made numerous online materials, including webinars and quick reference guides that are very beneficial for training purposes and can easily be accessed.

Alignment with PATH goals
Catholic Charities utilizes the PATH funds primarily to support the staff within their Central Intake and Coordinated Entry department as well as fund a portion of the emergency shelter coordinator. These programs serve individuals at risk of homeless, literally homeless and chronically homeless. Catholic Charities is the general assessment center for Coordinated Entry and all individuals who present for housing and homeless services are prioritized based on need and priority populations are the current priorities identified with Opening Doors. PATH also partially funds two case managers of permanent supportive housing programs who target chronically homeless youth and families.

Alignment with State Comprehensive Mental Health Services Plan
PATH funds received by Catholic Charities are consistent with the State Comprehensive Mental Health Services Plan because funds are targeted for outreach, engagement and case management of homeless and at risk individuals with a mental health or co-occurring diagnosis. Outreach to known and unknown areas where homeless reside is also completed on a bi-weekly basis. PATH funded staff provide case management to coordinate housing and mental health services as priorities and then work to connect the individuals to other mainstream services.

Other Designated Funds
Butler County participates in the Human Services Block Grant, which includes Mental Health Base Funds and funds from the Drug and Alcohol system. The Block Grant represents 30% of Butler County Human Services' base funding. Other than the PATH funds that are administered by Butler County Human Services, additional funding from the Block Grant is designated for individuals who are experiencing homelessness and have serious mental illness in the community. These funds are contracted to Catholic Charities to serve the target population and funds are used to support the provision of rental assistance, case management and permanent supportive housing.

In Butler County, we do not view PATH services as a stand-alone program, but a part of larger, integrated service system. Many additional resources are directed toward serving the homeless population in our community; however, many of the programs are designed to be able to serve anybody who is homeless, not limiting the service just to individuals who have serious mental illness.

Programmatic and Financial Oversight
Butler County Human Services conducts programmatic and financial oversight of Catholic Charities in several different capacities which include:

- PATH invoices are reviewed monthly and signed off on by the Director of Integrated Services and expenditures are also reviewed quarterly in conjunction with PATH quarterly reporting by the Housing Development Coordinator

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- HMIS data is reviewed for accuracy a minimum of quarterly by the Housing Development Coordinator
- Quarterly outreach reporting is submitted by Catholic Charities to the Housing Coordinator
- Annual monitoring is conducted by the Housing Coordinator
- Technical Assistance is provided by the Housing Coordinator as needed

SSI/SSDI Outreach, Access, Recovery (SOAR)

Currently, Catholic Charities has one full time staff member trained in SOAR. She completed the training in October 2018. The goal is to meet with the individuals who are prioritized with the highest needs through the Coordinated Entry System and work with those individuals to obtain income. Butler County Human Services, recipient of the PATH grant, is responsible for tracking the outcomes of those applications in the OAT system. At this time, two applications have been submitted. Of those, one was denied and is being appealed and the other is still under review. The SOAR case manager currently has 3 other applications in processing.

Housing

The Western Pennsylvania Continuum of Care fully implemented Coordinated Entry in January 2018. Therefore, all PATH eligible clients are assessed and placed on the prioritization list based on need in accordance with the Department of Housing and Urban Developments definition of homeless and with the goals identified in Open Doors, the Federal Strategic Plan to Prevent and End Homelessness. PATH eligible clients are also connected to mainstream resources and referred to such programs as the Housing Choice Voucher through the Housing Authority. The ability to obtain and maintain income is identified and plans to find employment or a referral to SOAR is started shortly after enrollment. In addition, a factor identified as a priority in the Human Services Block Grant plan is housing. As such, initiatives such as landlord engagement, incentive plans and pursuit and obtainment of funding to increase safe, affordable housing options are in progress.

Butler County and its housing and homeless providers, adhere 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.

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Coordinated Entry
The Western Pennsylvania Continuum of Care fully implemented Coordinated Entry in January 2018. Therefore, all individuals who are homeless or are imminently at risk are placed on the prioritization list based on need in accordance with the Department of Housing and Urban Development's priorities. Both Butler County Human Services and Catholic Charities are voting members on the Coordinated Entry Committee who currently meets monthly. Although it is early in its implementation, with improvements to made, we have not noticed any significant barriers to housing PATH eligible consumers.

Justice Involved
Butler County began participating in Crisis Intervention Team training in 2011. The Crisis Supervisors help organize and implement the week long training that is held twice a year, in the spring and fall. Butler County has trained approximately 20 law enforcement personnel along with numerous other first responders and individuals from both prison and probation. In 2017, the crisis team completed a mobile crisis intervention with a first responder approximately 80 times and we have received excellent feedback from the first responders regarding the effectiveness of the training in guiding them to interact differently with people exhibiting mental health symptoms.

Staff Information
Butler County is a primarily rural county located in the southwestern section of the state of Pennsylvania with a population of approximately 187,000 residents. Although there is only a very small percentage of racial mix within our borders, 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.

PATH staff attends annual training at on cultural competence and health disparities and all programs implemented through Catholic Charities adhere to a non-discrimination policy. 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 does not have any PATH funded staff who are Certified Recovery Specialists or Certified Peer Specialists.
Catholic Charities serves PATH-eligible clients of all ages, ethnicities, religions, abilities, sexual orientations, etc. The staff serving program clients include the Path Transition Age Project Case Manager, which is currently vacant, the Home Again Butler County Project Case Manager who is a Caucasian female between the ages of 20 and 30, the Safe Harbor Coordinator who is a Caucasian female between the ages of 40 and 50, and two homeless case managers who are Caucasian females between the ages on 30 and 40 and 50 and 60.

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Client Information
In 2018, Catholic Charities had over 1,000 new intakes through their intake department and 70% of those individuals self-reported as having mental health or mental health and drug and alcohol diagnosis. Participants were 88% Caucasian and 12% Hispanic/Latino. Approximately 58 % of PATH eligible clients were female, with the remaining 42% male. Of the adults served, 14% are between the ages 18-23, 35 % are between 24 -30, 28% are 31-40, 20% are 41-50, and 3% are 50 and older.

It is projected that Catholic Charities will use PATH funds to contact 180 adult clients and 140 will become enrolled. It is projected that approximately 60% of the adults served with PATH funds will be "literally" homeless. The remaining 40% will be at imminent risk of homelessness.

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. Participants are also 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
After review of HMIS data, the following subpopulations are vulnerable to behavioral health disparities:

- Male
- Youth

Please identify efforts to support the current disparate population of Youth and Young Adult by providing the following:

The unduplicated Number of YYA individuals who are expected to be served using PATH funds.

It is anticipated that Catholic Charities will serve approximately 80 YYA individuals this year who are PATH eligible.

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

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The total amount of PATH funds expected to be expended on the YYA population for Catholic Charities is approximately 57 % of the grant total or $62,246.28

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

PATH funds distributed to Catholic Charities are used specifically for street outreach and case management services. Youth and young adults who are at risk or literally homeless will be outreached to and ideally engaged to enroll in case management services.

A data driven improvement plan to decrease the disparities in access, service use, and outcomes both within the Youth and Young adult population and in comparison to the general population.

Based on the general population who will receive services from this grant, the behavioral health outcomes for male youth are worse than other groups. We have prioritized the service needs of this population and will arrange services and activities to be consistent with the needs of the individuals enrolled in the program. Butler County is a rural community and statistically, residents in rural areas do not have health care coverage, proper access to health care needs and often face food insecurity. Outreach and case management will target this population and focus on referrals for these services.

Limited English Proficiency
Catholic Charities is in compliance with Executive Order 13166, having taken reasonable steps for LEP individuals to access services. Catholic Charities proportion of LEP persons served is >1% and it is extremely infrequent that LEP individuals come into contact with the program. Butler County consists of a primarily Caucasian population; 96.3% according to the 2017 Census. Catholic Charities does contract with an interpretation agency, Stratus Audio, to contact when needed and has a policy in place on how to use this service.

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BUTLER COUNTY
CATHOLIC CHARITIES
2019-2020 PATH INTENDED USE PLAN

Budget Narrative

Butler County Human Services' total PATH allocation for 2019-2020 is $109,204 receiving $81,903 in federal funds and $27,301 in state funds. Catholic Charities will receive $109,204. It is projected that Catholic Charities will use PATH funds to contact 180 adult clients and 140 will become enrolled. It is projected that approximately 60% of the adults served with PATH funds will be "literally" homeless. The remaining 40% will be at imminent risk of homelessness.

Personnel (Positions and Fringe Benefits)- PATH funds in the amount of $99,928.00 will be utilized to partially fund five positions at Catholic Charities, equaling 2.24 FTE. PATH funds in the amount of $70,049.30 will be used for salaries and $29,878.83 will be used for benefits. The five partially funded staff includes two homeless and housing case managers, the Safe Harbor Project Coordinator and the two permanent supportive housing case managers.

Travel- PATH funds in the amount of $1,335 will be used to fund staff travel for outreach and travel that is required to assist 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. Outreach is conducted twice a month and other travel is completed on an as needed basis.

Supplies-PATH funds in the amount of $225.00 will be used to fund supplies needed in the office and field for the five partially funded positions.

Occupancy- PATH funds in the amount of $3,230.23 will be used to partially pay for the office space used for the five partially funded positions.

Staff Development and Contracted Services- PATH funds in the amount of $117.64 will be used toward staff training and audit fees. Staff training includes cultural competency and motivational interviewing.

Administrative- PATH funds in the amount of $4,368 will be used to partially pay the administrative costs that are incurred as a result of operating the PATH program. This is 4% of the total PATH funds awarded to Butler County.

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Butler County Catholic Charities
PATH Program
FY 2019 Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Housing and Homeless Case Manager	$23,769.93	.61	$14,499.68	$14,499.68
Housing and Homeless Case Manager	$28,947.12	.66	$19,105.10	$19,105.10
Home Again PSH Case Manager	$24,568.58	.35	$8,599.00	$8,599.00
Housing and Homeless Case Manager	$23,769.93	.12	$2,852.39	$2,852.39
Safe Harbor Project Coordinator	$49,986.25	.5	$24,933.13	$24,933.13
sub-total				**$70,049.30**
Fringe Benefits				
Housing and Homeless Case Manager	6537.31	.61	$3,987.76	$3,987.76
Housing and Homeless Case Manager	$18.421.87	.66	$12,158.43	$12,158.43
Home Again PSH Case Manager	$5,469.87	.35	$1,914.45	$1,914.45
Housing and Homeless Case Manager	$4,968.26	.12	$596.19	$596.19
Safe Harbor Project Coordinator	32,086.02	.5	$11,222.00	$11,222.00
sub-total				**$29,878.83**
Travel				$1335.00
Equipment				
Supplies				$225.00
Other				
Staff Development and Contracted Services				$117.64
Occupancy				$3230.23
Administration				$4368.00
Total PATH Budget	**$109,204**			

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NOT FINAL

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 64,421**	**$ 21,474**	**$ 85,895**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 64,421	$ 21,474	$ 85,895	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 64,421	$ 21,474	$ 85,895	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**Detailed budgets and narratives are included in individual provider IUPs.**
l. Grand Total (Sum of j and k)	$ 64,421	$ 21,474	$ 85,895	

Source(s) of Match Dollars for State Funds:

Cameron/Elk Counties will receive a total of $85,895 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 80

Estimated Number of Persons to be Enrolled: 50

Estimated Number of Persons to be Contacted who are Literally Homeless: 52

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

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CAMERON ELK BEHAVIORAL AND DEVELOPMENTAL PROGRAMS
PATH Intended Use Plan
2018-2019

Local Provider Description

PA-027 Cameron-Elk: Cameron-Elk-McKean MH/MR

Cameron & Elk Counties Behavioral and Developmental Programs receive the PATH funds for Cameron, Clearfield, Elk, Jefferson, McKean, and Potter Counties, all located in rural Northwest Pennsylvania. Services are provided directly from this County Office, located at 2070 Court St. Ridgway, Pa. 15853; PATH services are not sub-contracted with a local provider.

The program continues to employ two full-time PATH Liaisons who work with homeless adolescents between the ages of 17-30, diagnosed with a serious mental illness that are homeless or at risk of being homeless. The PATH Liaisons assist consumers in accessing safe affordable housing and identify, as well as, attempt to address gaps in services. One PATH liaison primarily covers Elk, Clearfield and Jefferson Counties while the other covers McKean, Potter and Cameron counties. Territory is divided between the two.

CE Behavioral and Developmental Programs PATH allocation for fiscal year 2018-2019 is $85,895 ($64,421 federal and $21,474 State match). 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-Elk is part of the PA-601- Northwest PA COC.
Collaboration takes place with attendance at all CoC events by the CE Housing Specialist, as well as, PATH Liaison's when available.

In addition, Cameron and Elk Counties PATH Program has a representative in attendance at the following meetings to satisfy the above mentioned criterion. This helps planning, coordination and access to services and activities within the continuum of care and to continue to make others aware of our services. CE Housing Specialist applied to sit on the Regional Housing Advisory Board (RHAB) to continue gaining knowledge of the assessment tool the CoC has used since its inception in January 2018. That application was denied and Cameron-Elk continues to be the only county program not represented on that board. CE will continue to attempt to gain a seat on the RHAB.

CE works with various counties in an effort to seek new funding to increase our ability to house and serve our individuals.

Participants Include:

NOT FINAL

McKean County Housing Stability Coalition
Cameron/Elk Counties LHOT
Clearfield County LHOT
Jefferson County Shelter Task Force
Clarion County Shelter Task Force by invitation
Western Region Housing Option Coalition
Consortium Housing Committee
Youth Consortium/Transition Cameron Elk
Youth Consortium/Transition McKean
Youth Consortium Dubois
Youth Consortium Clearfield
Youth Consortium Jefferson
Youth Consortium Potter
Transition Council Clearfield/Centre Counties
Appeal Hearings at Housing Authorities
IEP upon invitation
Family Group Decision Making sessions and referral meetings
McKean County Collaborative Board
Cameron County Collaborative Board
Elk County Family Resource Network Collaborative Board
Potter County Collaborative Board
Clearfield County Collaborative Board
Jefferson County Collaborative Board – COFAC
Independent Living meetings by invitation
Community Connections Dual diagnosis by invitation
Pennsylvania's Homeless Children's Initiative
Recovery in the Stix
Clearfield Jefferson CSP Day
Local Health Fairs
Community Support Programs
WRHOC-Biennial Summit/Conference
NW Landlord Association
Point-In-Time Counts
Homes within Reach Conference
Continuity of Care
Forensic treatment teams at County Prison
Forensic treatment teams in the community
Clearfield/Jefferson Provider Resource Meeting
Continuum of Care
Criminal Justice Advisory Board
Strengthening Families
Western Region CoC Youth sub-committee

Collaboration with Local Community Organizations

NOT FINAL

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

ELCAM Transition Apartment
Cenclear Transitional Housing Program
The Public Housing Authorities and Section 8 programs
Shelter + Care Rental Assistance through the DuBois Housing Authority
Housing Plus, Permanent Supported Housing, Elk & Cameron Counties
AHEAD Permanent Supported Housing Elk County
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/sex offenders)
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 (Beacon Light/Helpmates)
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)
Catholic Charities
Agape
Mobile Psych Rehab
COPE Drop-In Center
The Cove Drop-In Center
School Districts and Intermediate Units 6, 9, and 10

NOT FINAL

Center for Community Resources
Workforce Investment and Opportunities Act – Youth Consortia at North Central Regional Planning and Development Commission
Social Security Administration
Goodwill Industries of North Central PA
New Choices/New Options
Drug & Alcohol Counseling and treatment facilities
Local jails and Probation/Parole
Children & Youth Agencies
Children's placement facilities such as Residential Treatment Facilities and Therapeutic Foster Care
Project Rapport serves pregnant and parenting youth.
Nurse Family Partnership offers services for first time pregnant youth
Recovery Supports
Employment Support Services
Family Group Decision Making Process
Veteran's Affairs
Transition Age Support Services Program (TASS)
Community Guidance

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

A brief description of how PATH eligibility is determined, when enrollment occurs and how eligibility is documented for PATH enrolled clients
PATH eligibility is determined through proof of homelessness or risk of homelessness and a Mental Health diagnosis which is documented through Psychological/Psychiatric evaluations and self-reporting.

Enrollment occurs when required documentation confirms eligibility.

Alignment with PATH goals
As we continue to strengthen relationships with landlords in an effort to utilize resources, we continue to gain knowledge of new housing initiatives, trainings, webinars, as well as, keeping current with housing regulation changes, such as, new definitions, coordinated entry, and Housing First.

The building of relationships with shelter staff, church groups, police, hospitals, and County Assistance offices remains a priority. PATH in collaboration with CAPSEA's Housing Coordinator will be conducting a sheltered count in January 2019 to increase the numbers for our

NOT FINAL

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.

Maximizing of PATH funds
CE PATH funding supports wages of liaisons. We constantly refer to other available funds for client services. WE have access to PHARE dollars, HAP money, and Department of Human Services (CAO) funding along with several other small funding streams in our rural communities.

Gaps in current service system
Gaps in services that arise while working with this population are as follows:

- Applications to Housing Authorities are not accepted prior to the individual turning 18 at which time they are placed on a waiting list of 6-12 months. This holds true for the majority of public housing programs.
- 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 only a men's shelter. Jefferson County has a men's and 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, as well as, coordinated entry, has created a barrier making it more difficult to house individuals. This is a large problem for the rural areas.
- There are only two transitional housing project in any of the counties that can address the limited independent living skills of this population. There continues to be a need for a "step down" program for the population that is aging out of placements such as Residential Treatment Facilities, foster care or Juvenile Justice Placements. The program offered in Jefferson County is not supervised 24/7 and does not offer services specific to the population.
- Accessing identification (i.e. Photo I.D., Birth Certificate, and Social Security Card) for individuals has also been difficult; and now there is an increased cost to obtain them as well. Yet, without it, consumers cannot apply for other needed benefits, such as public assistance, social security, and housing.
- An individual over 19 or out of school has difficulty qualifying for any benefit program.
- Skepticism of landlords willing to rent to young people with limited independent living skills. Some landlords raise rents to avoid working with the programs. In addition, landlords are unwilling to include water and sewage in the monthly rent amount.
- Difficulty in coordinating employment opportunities through OVR.
- Difficulty finding employment for youth who often have limited skills and experience.
- Lack of transportation, especially during non-traditional hours and weekends coupled with very limited county to county routes.
- Young people leaving a Children & Youth placement upon turning 18 while still enrolled in High School.

NOT FINAL

- Lack of natural supports. These individuals have burned bridges with family, friends, and agencies.
- Accessing services and housing for individuals with a history of sexual offending.
- Accessing housing for individuals with a history of felony convictions and sometimes even misdemeanors
- Very limited psychiatric time makes it difficult to get evaluations and prescriptions in a timely manner especially for those leaving jail.
- Medical Assistance Transportation Programs discontinue the service for individuals that have missed rides without cancelling.
- Local Behavioral Health and Physical Health providers will close individuals after too many missed appointments.
- Changes in medical coverage at the CAO level that leaves some people without coverage for behavioral health services.

Co-occurring services
Although services are available to dually diagnosed individuals, access is not always immediate. Throughout the six counties the following programs are available:

Bradford Recovery Systems Inpatient Psychiatric Unit.
Maple Manor short term residential facility
Recent expansion of Alcohol and Drug Abuse Services Cameron, Elk, McKean and Potter Counties
Erie City Missions
Community Guidance
Clearfield Jefferson Drug and Alcohol Program
Pyramid Healthcare
Penn Highlands DuBois Behavioral Health
DCI
CenClear Services
The Guidance Center
Blue Dog Counseling
Beacon Light Behavioral Health
Mental Health services in the county prison
Service Access Management

42 CFR Part 2
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.

Justice-involved
- Frequent communication with County Prison Staff and Forensic Treatment Team, which include Probation to address building upon current strengths, barriers that exist with the transition age population.
- Development of a community reentry plan at start of incarceration.

NOT FINAL

- Collaboration with County Assistance to ensure more immediate access to benefits, psychiatric time and medications after release from prison.
- Funding of a Forensic Blended Case Manager to assist with completing county assistance applications prior to discharge, as well as ensuring appointments are scheduled with County Assistance on the day of release.
- Enhanced housing/supported services available to reduce/divert individuals from entering the Criminal Justice System.
- Commitment of CHIPP Dollars to continue supporting the Forensic Program to ensures individuals have access to Mental Health Services while incarcerated. This includes but is not limited to Psychiatric time, Outpatient Therapy and Medication Management provided by an RN. In addition, case management, peer specialists, employment support and drug and alcohol services connect with this population prior to reentry into the community.
- Continued active participation in Criminal Justice Advisory Board (CJAB) meetings to address the needs of the Forensic population, which includes the transition age.

NOT FINAL

Data

- CE is actively participating in HMIS using ClientTrack.
- Housing Specialist and PATH Liaisons participate in monthly Coordinated Entry System training webinars.
- Attendance at update trainings when available.
- Data is updated at least bi-monthly.
- CE utilizes reference materials and on-line support stored on the HMIS website.

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 needed services. CE is in full compliance with coordinated entry.

Alignment with State Comprehensive Mental Health Services Plan

CE's PATH program follows the Housing First model to stay with the states plan to end homelessness. Our agency has CoC funded HUD dollars to administer a chronic housing program, making chronically homeless a priority. This is applied to all of our housing programs in an effort to reduce/eliminate homelessness.

Other Designated Funds

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

CE MH funds are utilized to provide services to the MH population. PATH funding will consist of $64,421 federal allocation, $21,474 state match, and $2,386 local match for a total of $88,281.

Programmatic and Financial Oversight
PATH services are provided by CE. Programmatic oversight is provided by the CE MH Program Director. Referrals, enrollments, goals, etc occur on a regular basis through bi-weekly staffing or sooner if needed. Financial oversight is completed internally by CE's Fiscal Department and is reviewed quarterly prior to the submission of the quarterly PATH reports.

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 Provider Agencies. Since both PATH workers have been trained, we have no plans for additional trainings in the 2017 grant year.

To date, we have had 5 SOAR eligible consumers, with 3 being awarded within a 90 day period. As a requirement of the SOAR training, a county lead had to be identified. CE's Housing Specialist was chosen to be designated the SOAR lead to provide technical assistance with SOAR applications on an as needed basis.

Currently, at CE, there are, as part of their job responsibilities, 2 FT staff dedicated to do SOAR applications.

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
- Housing Plus-CAPSEA
- Lawrence County Phase I & Phase II-LCCAP
- Home Again- Cameron/Elk Behavioral and Developmental Programs
- Housing for Homeless and Disabled Persons-Jefferson/Clarion Community Action

NOT FINAL

- Transitional Housing Program- Cenclear
- Transition Apartment-ELCAM
- PHARE Housing Stability Project-Cameron-Elk Behavioral & Developmental Program/CAPSEA

Coordinated Entry

CE has been following the Western CoC coordinated entry plan since its inception in January 2018 and is in full compliance. Any homeless PATH individual is immediately added to the coordinated entry list by the CE Housing Specialist, as well as, a PATH Liaison that has been trained in that system for back-up.

PATH individuals that are "at risk" for homelessness cannot be added to the coordinated entry list because they are not chronically homeless. In addition, individuals that are aging out of Foster Care or any other residential placement cannot be considered homeless and added to the coordinated entry list.

Justice Involved

Utilizing grant dollars awarded to a provider agency specific to CIT, Cameron-Elk is currently in the planning stages of hosting such training in the Fall of 2018.

A steering committee has been developed with its first meeting being held in July 2018.
The goal is to train approximately 20 individuals that are first responders.

PATH counties currently are not utilizing specialized courts (i.e. veteran courts, drug courts). Our county MH program has funding for in- jail services to decrease recidivism in our forensic population. PATH Liaisons work to connect consumers to these services. PATH workers are also kept abreast of CJAB meetings and planning. Approximately 47% of PATH individuals being served 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 –Partial Hospitalization Program staff, inpatient D&A treatment counselor, inpatient mental health treatment counselor, face to face evaluator in an ER, domestic violence volunteer, Children and Youth Services County Caseworker, YWCA Housing and Employment Services Caseworker, Recovery worker, Forensic case manager, Forensic Mental Health Specialist and Blended Case manager. This experience gives them a broad based understanding of the population served and knowledge of how to relate and engage these young adults.

Once a referral is received by the PATH Program, the Liaison meets with the individual to assess their needs. PATH has been successful in linking individuals with services to deal with racism, language barriers, sexuality, and other stereotypes. In this rural area there has been an increase in

NOT FINAL

diversity among our population. All our youth are treated with respect and sensitivity. We have contacts with the Self-Determination housing Project through our Regional Housing Coordinator. We also have contacts in the Fair Housing realm.

Staff of the PATH Program attends training in Cultural Competency (most recent training held in April 2018) 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. Staff will continue to participate in any Webinars that help us better serve our population.

The PATH staff are not certified peer/recovery specialists.

Client Information

CE Behavioral and Developmental Program's PATH Project serves homeless and at risk of homelessness adolescents between the ages of 17 and 30 diagnosed with a serious mental illness, however, until they turn 18 years of age, they are not eligible to apply for housing assistance programs. If an individual is eligible for PATH at age 17, Liaisons' will assist them in preparing applications, assist with referrals to needed services, compiling needed documentation required to apply for housing, which includes but is not limited to, photo ID, proof of Social Security and Birth Certificate.

The majority of individuals carry a diagnosis of Major Depression, Anxiety, or Bipolar Disorder. The population served last fiscal year was 29% male and 71% female and the majority was Caucasian. At the time of referral 53% had graduated from High School or received their GED. Of that, 12% had some post secondary education. Our youth usually have little or no income. At the time of referral 39%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 39% 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 75 new individuals during FY 19-20 and continue to serve at least 60 individuals who are already in the program for a total of 158 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 approximately 45% 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.

NOT FINAL

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 natural supports and options available to them. These include but are not limited to connections with other services in the community as well as connections with family and friends for support. All PATH services are voluntary and these individuals choose what they feel will best meet their needs.

Currently the budget does not allow for PATH eligible people to be hired by the program. If employment is what they seek we can refer them to Employment Support Services or our local Career Links.

We encourage volunteering and participation on formal or governing boards. We continue to have a PATH consumer on our Local Housing Options Team (LHOT), as well as, participate in the Community Support Program (CSP). 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 YYA individuals who are expected to be served using PATH funds.

  We expect to serve 158 YYA 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 YYA; therefore, all funds serve this population. We continue to see a need for assistance in this population and plan to continue serving only YYA with our PATH funds.

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

  PATH funding covers 6 counties in this rural area of Pennsylvania. These dollars are used to fund 2 PATH Liaisons to assist individuals with housing, as well as, connect them with services and supports within the community. In addition, when individuals have no payment resources for services, CE MH Base and CHIPP dollars can be requested for said service.

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

NOT FINAL

Recovery
Mobile Psych Rehab
Outpatient
Peer Support
Employment Support Services
Food banks
Transportation
Med Clinics
Security Deposits
Utility Assistance
TASS
Medication Management
Other housing stability needs

Although PATH does not fund these services directly, we encourage their use and can have them authorized through other funding sources.

- A data driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the YYA population and in comparison to the general population.

  As previously mentioned, our PATH allocation is only for YYA. In serving this population we are continuously reaching out to area providers regarding their policies and terms of services. In some instances, their policies have a negative effect by increasing these disparities. We do have a county mental health plan in place that addresses some of these issues on a larger scale. However, for PATH, we address these issues as they arise with the providers as necessary. For example, some of our providers have a no show policy that if you miss 3 appointments you can only re-enter services after attending 3 consecutive group sessions at their site. This creates a hardship for some of our consumer's schedules. CE will continue to have discussions with Provider agencies to ensure the quality and quantity of service delivery remains consistent.

  Moving forward, a quality improvement plan will be put in place which will be data driven. For example, data will be collected on a quarterly basis to try and determine patterns for missed appointments, such as, transportation issues, lack of medical assistance benefits, no shows, etc.

Limited English Proficiency
Cameron –Elk has limited resources for LEP individuals. Because the need is minimal in our area, on an as need basis, we will access the following:

- Local Public Libraries reading program.
- Cameron and Elk County Assistance offices as a resource to translation services.
- Utilize, on an as needed basis, via phone/video, *Language Line Solutions*.

NOT FINAL

FY 2019-2020 Cameron/Elk Counties PATH Budget Narrative

Our PATH funding will consist of: $ 64,421 federal allocation, $ 21,474 state match, and $2,386 local match for a total of $88,281.
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 2019/2020 will be $85,895 which will be funded by the Federal and State allocation dollars. The accompanying Budget will total this amount.
Personnel - We have 2 case managers who provide PATH services. The case managers spend 70% of their time on the program and will be paid 70% 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 $1,134 for the year. Aside from this expense which will cover gas and a $0.40 per mile reimbursement when necessary, another $638 has been added for incidental vehicle maintenance according to our cost allocation plan.
Supplies - Projected expenditures for this category total $266. Included are expenses for office supplies, $222, and for the cost of copies for various files, $44. 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 $2,335 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 $1,137 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 $881. 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 $35 from prior year comparisons to send out various correspondence.
Staff Training - $172 for various Training opportunities that's may benefit the program throughout the year.
Computer Expense - $76 for Internet, updates, upgrades, etc.

NOT FINAL

Cameron Elk County Behavioral and Developmental Programs
PATH Program
FY 2019-2020 Budget

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
Position				
Case Manager	$ 43,582	.7	$ 30,507	$ 30,507
Case Manager	$ 31,765	.7	$ 22,236	$ 22,236
sub-total	**$ 75,347**		**$ 52,743**	**$ 52,743**
Fringe Benefits				
FICA Tax	$ 5,536	.7	$ 3,875	$ 3,875
Health Insurance	$ 25,020	.7	$ 17,514	$ 17,514
Retirement	$ 5,501	.7	$ 3,851	$ 3,851
PA Unemployment	$ 478	.7	$ 335	$ 335
Worker's Compensation	$ 520	.7	$ 364	$ 364
Life Insurance	$ 770	.7	$ 539	$ 539
sub-total	**$ 37,825**		**$ 26,478**	**$ 26,478**
Travel				
Clients/Outreach	$ 1,134		$ 1,134	$ 1,134
Vehicle Exp	$ 638		$ 638	$ 638
sub-total	**$ 1,772**		**$ 1,772**	**$ 1,772**
Supplies				
Office Supplies	$ 222		$ 222	$ 222
Copies	$ 44		$ 44	$ 44
sub-total	**$ 266**		**$ 266**	**$ 266**
Other				
Occupancy	$ 2,335		$ 2,335	$ 2,335
Insurance	$ 1,137		$ 1,137	$ 1,137
Telephone	$ 881		$ 881	$ 881
Postage	$ 35		$ 35	$ 35
Staff training	$ 172		$ 172	$ 172
Computer Exp	$ 76		$ 76	$ 76
sub-total	**$ 4,637**		**$ 4,637**	**$ 4,637**
Total PATH Budget				**$ 85,895**

NOT FINAL

Clarion County - Center for Community Resources
214 South 7th Avenue
Clarion, PA 16214
Contact: Sarah Knepper

Provider Type: Social service agency
PDX ID:
State Provider ID:
Contact Phone #: 8142261080

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◯ No ◉

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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

NOT FINAL

	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 34,814**	**$ 11,605**	**$ 46,419**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 34,814	$ 11,605	$ 46,419	Detailed budgets and narratives are included in individual provider IUPs.

	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 34,814	$ 11,605	$ 46,419	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 34,814	$ 11,605	$ 46,419	

Source(s) of Match Dollars for State Funds:

Clarion Co will receive a total of $46,419 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 105

Estimated Number of Persons to be Enrolled: 20

Estimated Number of Persons to be Contacted who are Literally Homeless: 35

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Clarion County
Center for Community Resources
FY 2019-2020 PATH Program 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. 7th Ave., Clarion Pa 16214. The services they provide in Clarion include the base service unit functions, crisis services, the mental health Drop-In Center, transitional/supported housing services, Early Intervention Service Coordination, Intellectual Disabilities Supports Coordination and Representative Payee. The Clarion County Mental Health Administration is the pass-through agent for PATH funding and monitors the services provided.

The PATH program is located in the MH/DD Program's Mental Health Base Service Unit (BSU), located at the above listed address. The BSU serves as a point of intake and referral for mental health related services, information and resources.

The services and programs available in Clarion County are available to persons with serious mental illness, including those with serious mental illness who are homeless or at imminent risk of homelessness.

NOT FINAL

Collaboration with HUD Continuum of Care (CoC) Program
Clarion County is a partner in the Northwestern Region Continuum of Care, Regional Housing Collaborative, Local Housing Options Team, and the Clarion County Shelter Task Force. Currently the Shelter Task Force is working to establish additional emergency housing options in Clarion as well as sharing resources and ideas in a collaborative effort to secure a better solutions to the chronic homeless situation in Clarion County. Clarion County participates in the point-in-time homeless counts. Locally we work closely with the Housing Authority to assess homelessness, monitor housing availability and costs, and coordinate housing for the homeless and at risk of homelessness population. We also work with the Housing Authority to help clients meet HUD eligibility requirements and to maintain them in permanent housing. Both programs keep each other informed of needs and opportunities. The Housing Coordinator also utilizes Behavioral Health Alliance of Rural Pennsylvania (BHARP) to assist individuals financially with their housing needs in an effort to keep individuals from becoming homeless and to collaborate on getting more help to those in need through referral resources. To date the Housing Coordinator has been granted $38, 492.94 through BHARP funds.

Collaboration with Local Community Organizations
The County does have a Local Housing Options Team (LHOT) in conjunction with Jefferson

County. We continue to have active representation at team meetings, which includes representatives from HUD, Community Action, domestic violence shelter (SAFE), Haven House, local ministries, Salvation Army, and other human services agencies such as CYS and Adult Services/Housing Assistance Program.

The Shelter Task Force of Clarion collaborates to explore funding and programming options for emergency and transition housing solutions in Clarion. The Shelter Task Force presents to various groups highlighting the homeless and housing issues in our area. We continue to educate the community about homelessness and create community support for funding and programs to serve the homeless in Clarion. The Task Force is currently working with the Bridge Builders for funding sources, and has held several successful fundraisers including an annual soup luncheon. As a member of the Northwest Regional Housing Alliance (NWRHA), we have two funding slots available for housing in Clarion County. This pays 100% of rent for persons who meet chronically homeless criteria.

The Clarion County Human Services Council serves as a venue to exchange program information and provides opportunities to network and coordinate services among all the public and private social services in the County. Clarion County MH/DD and CCR are active participants in the Council.

A Federally Qualified Health Center (FQHC) operates in Clarion County providing primary care, behavioral health care, drug and alcohol treatment, and dental care. We are active with the Task Force that planned for the FQHC and refer consumers to their services. PATH promotes its services through the FQHC.

PATH refers consumers to the Career Link that serves Clarion County for employment services, Office of Vocational Rehabilitation (OVR), and Workforce Investment Board (WIB) for transition age skill development and employment opportunities. The PATH Administrator attends service organization meetings with representatives from these agencies for updates and for sharing program information.

The PATH Housing Coordinator is also active in the Drop-In Center. This outreach not only helps with identifying and assisting at risk populations, but allows CCR to promote the services, supports and resources available to this population.

Service Provision

The Mental Health Housing Coordinator (HC) contacts the owners of businesses and requests permission to leave information at their sites and to contact him if they believe someone might be in need of our services. Once potential consumers are identified and located, the HC will attempt to make contact and offer case management services and other resources and services. Resources include but are not limited to MH services within the County, Drug and Alcohol Services within the County, transportation, other housing programs, furniture needs, rentals in the community, public housing, churches, food banks, etc.

NOT FINAL

The Housing Coordinator will continue to visit the Drop-In Center and other places such as 24 hour convenience stores and Laundromats, points where homeless people may seek refuge for the night or might be in transition to or from different locations, wherever homeless individuals are likely to be found and engage in a face-to-face contact with potential or current consumers for the purpose of engaging or re-engaging in services.

The services provided with PATH funding include:

1. Screenings – The Housing Coordinator will provide screening to determine the consumer's eligibility for PATH services.

2. Referrals – When appropriate, the Housing Coordinator will provide referrals to primary and behavioral health services, job training, and educational services. The Housing Coordinator will also refer the consumer to other services, resources and supports that will be appropriate in helping them to remain in or access housing.

3. Supportive Services- Designed to stabilize and maintain the individual in a residential setting. The Housing Coordinator provides assistance on a one-to-one basis in those areas which are needed for the individual to be able to maintain their housing. This includes activities such as budgeting, housekeeping skills, self-advocacy skills, scheduling, utilizing community resources, time management and other daily living skills.

PATH eligibility determination
For Clarion County, the eligibility requirements are that the individual has a serious mental health diagnosis as diagnosed by a psychiatrist or psychologist, is homeless or at imminent risk of being homeless, and is a resident of Clarion County. Once the individual agrees to services, enrollment is done through a face-to-face intake within 5 business days of the referral. Eligibility is documented on the intake paperwork and signed by the individual.

Clarion County PATH funds are used to assist with first month's rent, security deposits and moving expenses. We do weekly street outreach by scanning the area for homeless individuals as well as advertising our services on social media and local resource boards (banks, grocery stores, post offices, laundry mats, Drop-In Center). We also do outreach by attending monthly community meetings including: Shelter Task Force, Human Service Meeting, Family Net, Overdose Task Force, D&A Meetings, Human Service Soup, etc. Case management is part of our process and is provided as needed until the individual is successfully housed and is living independently. We also offer follow-up services to ensure that individuals are able to sustain their living situation.

Maximizing use of PATH funds
The Housing Coordinator maximizes PATH funding in several ways. The Housing Coordinator creates a monthly budget with the PATH funds to ensure they will last for the entire fiscal year. The Housing Coordinator will also reach out to other entities for financial assistance before using PATH funds, especially if there is a more appropriate funding source. The Housing Coordinator also works with the individual to come up with a number that will compromise what they can provide towards their housing needs.

NOT FINAL

Clarion County utilizes BHARP (Behavioral Health Alliance for Rural Pennsylvania) funds in addition to the PATH funds. During the 17/18 fiscal year, the Housing Coordinator was able to apply and be approved for over $13,015.74 in contingency funds from BHARP. There were 28 requests for these funds, with an average of $565.90 per request.

The Housing Coordinator also utilizes other agencies to help support homeless individuals in Clarion County. We have utilized SSVF (Supportive Service for Veteran Services) for homeless veterans in Clarion County. We have also utilized Community Action to assist in paying for a hotel for an emergency homeless situation.

The Housing Coordinator leverages PATH funds by utilizing other funds in the community such as assisting individuals with applying for medical assistance, food stamps and utility assistance. This helps alleviate their payout and open up their funds for their housing needs.

Gaps in current service system

- Emergency and transitional housing has been an ongoing issue. The Mental Health Administration, in collaboration with CCR opened a 30 day emergency housing unit to aid homeless individuals and families. However, this is very short term and can only provide assistance to one person/family at a time.

- Ongoing housing assistance on a short and long term basis for people who are temporarily without sufficient income, i.e. those waiting for their social security income (SSI) to begin or those who are unemployed/underemployed.

- There continues to be a gap in services for homeless individuals with a criminal background. NW9 funding has officially ended mid-April 2018. The individuals under NW9 are now responsible for their rent payment in its entirety. The individuals cannot afford to stay in their homes at the full price of rent when they are no longer receiving a subsidy. We have been able to assist these individuals by helping them find more affordable housing that they are able to sustain. This affected about 7 individuals. We have not had any referrals since mid-April with criminal charges looking for subsidized housing.

- Assistance with rent and utilities- available on a limited basis through the Housing Assistance Program (HAP), BHARP and from other community agencies. However, the amount available is considerably less than the need. Sustainable, ongoing assistance is also a need.

Co-occurring services available
Clarion County provides a variety of Mental Health Services and Drug and Alcohol Support for individuals seeking help. For Mental Health, the following services are offered through the County: Blended Case Management, Peer Support, Behavioral Health Court, Psychiatric Rehabilitation, Drop-In Center, Outpatient services, Family-Based Services, Therapeutic Foster Care, Supported Employment, Emergency Housing and Supported Housing. For Drug and

NOT FINAL

Alcohol Services, the following services are available: Outpatient services, Case Management, Group/Individual Counseling, Support Groups and Treatment Court.

Because the PATH Program is an integral part of the MH BSU, access to mainstream MH services is readily facilitated and becomes part of the overall service planning process. Once releases are obtained, the PATH Housing Coordinator works closely with MH case managers and other mental health staff, keeping them informed of the consumer's housing situation.

Substance abuse services include the Armstrong-Indiana Clarion Drug and Alcohol Commission which provides prevention and education programs, case management and referrals to more intensive services, such as detoxification, inpatient or residential treatment and peer support services. Outpatient counseling, intensive outpatient counseling and referral for inpatient treatment is provided by ARC Manor (closing 5/31/2018), a subcontractor located in the Primary Health Network building right off the exit of Interstate 80. Additional drug and alcohol treatment programs are available through a second subcontractor, Cen-Clear which began July 1, 2015. They are providing D&A counseling services, outpatient groups and a partial program.

Coordination of services for those with co-occurring issues is done via collaborations between mental health providers, the BSU, case management and the Armstrong Indiana Clarion Drug and Alcohol Commission, with treatment provided by ARC Manor and Cen-Clear.

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

Justice-involved
Center for Community Resources has a Forensic Liaison in house that works closely with the housing coordinator. When the Forensic Liaison is completing the intake, she is able to assess their housing needs and refer them to the Housing Coordinator as needed. The Housing Coordinator also works closely with probation to ensure that individuals are following their probation guidelines. If our PATH client is released from jail and becomes a resident of Hope Homes, the Housing Coordinator meets with the individual weekly to make sure the individual is meeting their goals. These meetings will include any other agencies that are currently working with the individual.

To better service individuals in the criminal justice system, Clarion County has started up Behavioral Health Court effective April 26, 2018. This provides individuals with intensive case management to assist them with housing, mental health services, drug and alcohol services, support services, employment, etc. Individuals are required to meet with their probation officers and Mental Health Liaison 1-2 per week and meet all of their goals. They also go before the Judge twice a month to discuss their successes and set-backs. This is an 18 month program with 3 phases. The outcome to completing this program would be a lesser sentence and working towards mental health recovery.

Data
PATH liaison is currently using HMIS on a daily basis to enter all enrolled and non-enrolled

NOT FINAL

PATH consumers that are assisted in PATH. PATH liaison will use HMIS program to generate approximately 100% of the annual report for 17/18. 100% of the annual report will be generated from HMIS in year 18/19. Currently PATH liaison utilizes the IT representative for HMIS to troubleshoot any problems he may encounter with HMIS and participates in on-going training provided for HMIS users. The PATH liaison also participates in webinars that are related to HMIS. CCR provides new staff with the HMIS manual and trains the new employee during weekly supervisions and monthly staff meetings.

Alignment with PATH goals

The PATH Liaison will continue to provide outreach by hanging flyers at local laundry mats, fast food restaurants, local libraries, etc. The PATH Liaison will also attend local events to promote PATH services and awareness within the local community. The PATH Liaison will continue to serve as a member of the Shelter Task Force to collaborate with local agencies in an effort to identify adults who are literally and chronically homeless within Clarion County.

Alignment with State Comprehensive Mental Health Services Plan

The PATH Liaison works closely with the Hospital Liaison to support client's being discharged from Mental Health facilities. Once these clients are identified, the PATH Liaison, the MH Deputy Administrator and the Hospital Liaison collaborate with the Mental Health facility to create a "home plan" for the discharge of the client. CCR currently provides transitional housing for clients for up to one year after discharge if there is space available. The PATH Liaison will provide support and put other supports in place to aid in the client's recovery. The PATH Liaison will implement the CCR Emergency Plan in the event of an emergency or disaster. The CCR Emergency Plan is reviewed annually and updated as needed. The CCR Emergency Plan was last updated on 7/1/2016.

Center for Community Resources (CCR) works closely with the Emergency Preparedness Team in Clarion County. CCR is the single point of contact for emergency disasters. The Housing Coordinator is also part of DCORT (Disaster Crisis Outreach and Referral Team) and attends trainings as needed. The Emergency Preparedness Team is in charge of testing the emergency response plan. Should an emergency occur the Housing Coordinator has the contacts available for continuity of care. The Housing Coordinator became CISM (Critical Incident Stress Management) trained on May 7, 8, 2018.

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. The County match is listed at $11,076 which is specifically earmarked for PATH. This money is used to cover any additional costs.

NOT FINAL

Programmatic and Financial Oversight
Center for Community Resources, Inc. (CCR) monitors PATH funds through yearly audits. Clarion County Administration monitors how Center for Community Resources, Inc. uses the PATH funds through quarterly audits performed by the Mental Health Deputy Administrator. CCR is given an improvement plan for areas of concern and a date to make the changes.

SSI/SSDI Outreach, Access, Recovery (SOAR)
The Housing Coordinator is currently refers to Blended Case Managers through other Services Access Management (SAM) and Family Psychological (FP) to assist individuals with the SSI/SSDI application process, and is available to assist consumers as needed with gathering the necessary documentation. These agencies are not SOAR trained but are trained in how to apply for SSI/SSDI. The Housing Authority also offers assistance with SSI/SSDI but are not SOAR trained.

For the grant year 2017-2018, include all of the following data:

- 0 staff are trained in SOAR. The current Housing Coordinator is in the middle of the online SOAR training. We are hoping to have this completed by September 1, 2018.

- 0 staff provide assistance with SI/SSDI applications using the SOAR model. However we have staff in the Base Service Unit that can provide assistance in applying for SSI/SSDI.

- 0 consumers have been assisted through SOAR, therefore we have no results data.

- We currently have 5 staff that have been trained to provide assistance with filling out the SSI/SSDI application. Once we complete the intake with the individual, it is the Blended Case Manager's responsibility to continue assisting them through the process. If an individual does not have a Blended Case Manager, we will continue to provide them with support. The Base Service Unit Staff provide technical support to individual seeking assistance with the application process. We do not have any supportive data on approval rates at this time.

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.

NOT FINAL

- Ten low-income subsidized housing projects located throughout Clarion County. These are available to SMI consumers as long as they meet the income criteria, have a clean credit record, and do not have a history of destructive or criminal behavior.

- Through the Clarion County Housing Authority, there are Section 8 housing vouchers. These are available to SMI consumers based on income and availability.

- Through managed care reinvestment funds and in conjunction with nine other counties, we are able to offer Bridge Housing Subsidies and Master Leasing.

- The Housing Coordinator also works with local landlords to secure and maintain housing for consumers in private rentals.

- If appropriate, personal care or assisted living facilities may also be utilized. There are four personal care/assisted living facilities located in Clarion County.

- Clarion County MH is funding a short term (30 day), transitional apartment for those who are in need of short term emergency shelter.

- HSDF provides emergency funds for a 3 night hotel stay.

- Housing Assistance Program provides rental assistance and payment of security and utility deposits, for those who do not meet PATH criteria.

- Community Action has a four person men's shelter located in Clarion. Availability is limited.

- The MH Administration and CCR have developed a 2 unit apartment building as well as a 3 bedroom unit with shared living space to provide supported housing (up to one year) to consumers with a mental illness who have no or low income. These units are currently full and the program is successful.

NOT FINAL

Coordinated Entry
The Housing Coordinator at Center for Community Resources, makes referrals to the Coordinated Entry point of contact for Clarion County consumers as needed. The Housing Coordinator touches base with the Coordinated Entry point of contact at monthly Shelter Task Force meetings. The only barrier for Coordinated Entry is the amount of time it takes to contact individuals should a home become available. This can be a lengthy process and you could be on the list for several months.

The Housing Coordinator screens all clients to see if they meet the criteria for PATH and it not, refers them to the appropriate agency for assistance. This provides a point of contact so that housing support is easily accessible to people in the community in need. Our goal for 2018/2019 is to create a coordinated entry plan along with other agencies in the community.

The Housing Coordinator plans to attend the Diversion Training in June 2018 and become a trainer. Diversion is a promising practice being used to identify alternatives to entering shelter and the homeless system. Diversion prevents homelessness for people seeking shelter by identifying immediate alternate housing arrangements and connecting them with services and financial assistance so they can return to permanent housing without entering the homeless system.

Justice Involved

The Housing Coordinator has been trained in Crisis Intervention as part of her on boarding. Due to the fact that all of our clientele have mental health, the Housing Coordinator needs to be prepared to keep the individual safe should a crisis arise. We have had instances where the Housing Coordinator had to respond to a crisis in our supported housing so that the individual received the mental health services that she needed.

Clarion County has added Behavioral Health Court to its special courts system. The Housing Coordinator will work closely with the Behavioral Health Court Coordinator should any of the individuals in the program have housing needs. This program began in April 2018.

Local Law Enforcement officers are not currently trained in Crisis Intervention Team. CCR, along with the County, is working on offering a FREE CIT training to a number of law enforcement officers along with a stipend to cover their coverage while they are away from their duties.

Staff Information

There is one staff person, a Caucasian female in her mid-40's who holds a BS in Rehabilitation Service Education and has 20+ years' experience in mental health and drug and alcohol services. Her position is 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 3 months. Her office is located at 214 S. 7th Avenue, Clarion, PA 16214.

Staff members are trained to work sensitively with a wide variety of populations and annual cultural competence trainings are held. The Housing Coordinator is trained on renter- landlord rights and dispute resolution, as well as LGBTQI issues. Our provider is also involved in several PH/BH (physical health/behavioral health) initiatives to address the "whole person" when working with consumers. The Community Support Program made up of consumers, families, and professionals, meets regularly to discuss County mental health programming and concerns or suggestions to improve training and programming. The HC discusses with consumers individual preferences, such as living "in town" versus in a rural setting, lifestyle, access to services and any special needs they may have. Because of the size of the PATH population, services are specifically tailored to the needs and preferences of the consumer as availability allows.

NOT FINAL

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 Human Services – Office of Mental Health and Substance Abuse Service (OMHSAS).”

Staff are required to receive 1 hour of training in cultural competency and health disparities whether it be online or in person.

We have 0 staff trained as Certified Peer Specialists or Certified Recovery Specialists.

Client Information

- The demographics of the client population in Clarion County range in age from 21 through to 60 years old. The client population for Clarion County is comprised of 51% Female, 49 % Male (2016 census).
- Clarion County PATH projects the number of adult clients to be contacted to range from 50 to 100 within the 2018-2019 year.
- Clarion County PATH identifies the expected number of adult clients to be enrolled in PATH for the 2018-2019 year to be 50 to 75 people.
- The estimated percentage of adult clients served using PATH funds to be literally homeless is 10 %

Consumer Involvement

The Mission of Center for Community Resources is to make a positive difference in everyday lives by connecting people to a network of supports and services essential for actively learning, working and living in the community.

The agency’s goal is to coordinate supportive services for individuals and families seeking information & referral for mental health, intellectual disabilities, substance abuse and other human service needs.

We are an integrated point of contact working in collaboration with other human service agencies to identify needs in the community and effectively respond to assist anyone seeking help.

CCR offers free trainings to individuals and families in the community including Youth Mental Health First Aid.

Individuals are given a consent to services to sign and review during each intake to ensure that they understand their right to accept or decline services. Individuals are also given information on the President’s Advisory Commission’s Healthcare Consumer Bill of Rights and Responsibilities: information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and non-discrimination, confidentiality of all services, unless it is a life-threatening situation.

NOT FINAL

Individuals are given satisfaction surveys at initial contact and at discharge. Individuals can also opt to be contacted for a Consumer Satisfaction Survey for any mental health services that were received.

In this case, people who experience homelessness and are seeking funding work on goals to improve their current situation, whether it is finding employment or seeking out help for their mental illness and take an active role in their recovery, and ultimately have a say in their future and their future role in the community. They will do this by actively establishing goals and working on them with community members. Most of the people generally serve their community and the place they are staying by helping others in a peer driven role although they don't usually understand that all of the trails they went through can help them help someone else who is in the same position that they were in.

Family members are seen as a support to individuals in PATH and are sometimes called upon for assistance in housing or moving in certain situations. It is important to surround our PATH individuals with natural supports and family and friends that will support them in their daily living. Family members may be involved in the home search and the moving process. Family members may also provide feedback on what may be best for each individual.

Health Disparities Impact Statement

Please identify efforts to support the Transition Age Youth (TAY) disparity population by providing the following:

- The unduplicated number of TAY individuals who are expected to be served using PATH funds is 11% of the population, or 10 individuals.
- The total amount of PATH funds expected to be expended on services for the TAY population is $4,800.00.
- The types of services funded by PATH that are available for TAY individuals include transitional housing and permanent housing as well as establishing a good rental history for future housing.
- As part of CCR's data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the TAY population and in comparison to the general population CCR has been meeting with Homeless Liaisons in all 7 School Districts to increase homelessness collaboration and provide resources to the schools. CCR is also collaborating with local agencies to provide a youth shelter in Clarion County. With these improvements, our goal is to decrease the TAY population from 11% in Clarion County to 7% or less.

Limited English Proficiency

CCR has a contract with Optimal Phone Interpreters (OPI) that will provide interpretation in any language to engage with individuals via phone. CCR also has contracts with interpreters that are local that are willing to attend intakes and other appointments as necessary with the individual and housing coordinator.

NOT FINAL

Federal allocation	**$34,814.00**
State match	**$11,605.00**
County Match	**$11,076.00**
Total	**$57,495.00**

Budget Narrative

Personnel:

Funding of $19,800 is being requested to provide for the full-time salary, 55% time, of a MH Housing Coordinator. This position will be located through Center for Community Resources, Inc., whose work concentration is to increase and create housing resources in the county for homeless or at imminent risk of homelessness persons with serious mental illness. Total request for salaries is $19,500.

Fringe Benefits:

Funding of $12,755 is being requested to provide for the full-time fringe benefits of a MH Housing Coordinator. Fringe benefits include the following costs: FICA at $1,515 health insurance at $9,416, retirement at $594, life insurance at $960, and state unemployment at $270. Total request for fringe benefits is $12,755.

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 $50, lodging at $0, gas & maintenance of county vehicles at $42. and estimated registration fees of $0. Other costs associated with the PATH program include the MH Housing Program Coordinator's local travel to housing entities, shelters, Shelter Task Force meetings, evaluation meetings and regional housing/homeless meetings at $108. Total travel request: $200.

Supplies:

Funding is requested for supplies necessary to ensure efficient operation of the PATH program and to supply individuals experiencing homelessness with greater access to needed emergency, safety, hygiene, and habilitation resources. The following supplies enable the MH Housing Program Coordinator to efficiently and successfully implement the PATH program: general office supplies—paper, pens, stapler, etc. at $150 and safety/emergency/hygiene/habilitation supplies at $250 for a total of $400 for Supplies.

NOT FINAL

Other:
Other costs include the delivery of case management and support services for consumers in the PATH program; security deposits and one-time rental assistance payments for approximately 35 individuals experiencing homelessness or at imminent risk at approximately $274 each, not to exceed $9,595. Internet/computer service for a year at $777, postage costs at $0; administrative costs are computed at 8.3% of the total budget and include amounts for rent and utilities, with any excess expense amounts to be covered by in-kind funds. Administrative costs included here of 8.3% ($3,850), include the costs of space and utilities to house the PATH staff at $6.24 a square foot in Occupancy (254 sq. ft, with additional amounts for these administrative costs included as an in-kind expense.) Total request for other expenses: $14,222.

In-Kind:
In-kind services provided toward the project include the following items as outlined below at a value of $11,608:

MH Dept. Supv. of MH Housing Program Coordinator @ 1%	$588.00
MH Dept. Fiscal Officer Time @ 1%	$520.00
BSU Housing Coordinator @ 45%	$26,650.00

In addition, although Clarion County MH is continuing a PATH program to specifically expand existing housing and increase new housing programs for homeless/near homeless mentally ill individuals, currently Clarion County MH housing components provide **$297,161.00** in current supportive housing program costs and expenses for mental health individuals, of which, if openings existed, could possibly benefit PATH program eligible individuals in the future. Supportive housing costs and expenses through Clarion County MH and HUD:

NW9 (As Reinvestment funds are available & shared by nine counties)	$144,230.00
Hope Homes	$127,534.00
Emergency Housing Apartment	$25,397.00

NOT FINAL

Clarion County
Center for Community Resources
PATH Program
FY 2018-2019 Budget

Line Item	Annual Salary	PATH-funded FTE	PATH-funded salary	Total
Housing Coordinator	$36,000.00	.55	$19,800	$19,800
Fringe Benefits				$12,755
Travel				$ 200
Equipment				
Supplies				$ 400
Communications				$ 777
Rental Assistance				$ 7,000
Security Deposits				$ 2,095
Consumer Supplies				$ 500
Other				
Admin Fees				$ 3,850
Total				$47,377*

*overage after $46,419 federal and state PATH funding to be covered by county funding identified in budget narrative

NOT FINAL

Crawford County - CHAPS
944 Liberty Street
Meadville, PA 16335
Contact: Lynn McUmber

Provider Type: Consumer-run mental health agency
PDX ID: PA-028
State Provider ID: 4228
Contact Phone #: 8143332924

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 47,087**	**$ 15,696**	**$ 62,783**	

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

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

Source(s) of Match Dollars for State Funds:

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

Estimated Number of Persons to be Contacted: 80

Estimated Number of Persons to be Enrolled: 50

Estimated Number of Persons to be Contacted who are Literally Homeless: 40

Number staff trained in SOAR in grant year ending in 2018: 1

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Crawford County Mental Health Awareness Program (CHAPS)
944 Liberty Street ~ Meadville, PA 16335 ~ (814)333-2924
PATH Grant Intended Use Plan 2019-2020

Local Provider Description

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 a variety of services that were developed to meet the needs of consumers. CHAPS services include:

~ Community Education and Outreach
~ Drop In Center
~ Representative Payee/Money Management
~ Transitional Housing
~ CHIPP Diversionary Shared Housing
~ BRIDGES Housing
~ Emergency Solutions Grant (Rapid Rehousing)
~ Fairweather Lodge
~ Warmline
~ Housing Now
~ Shelter Plus Care
~ Family Housing
~ Clubhouse and Vocational Counseling (Journey Center)
~ McKinney Housing Advocacy
~ Mobile Psychiatric Rehabilitation
~ Certified Peer Support
~ Homeless Outreach
~ Community Support Services

Crawford County Human Services will subcontract with Crawford County Mental Health Awareness Program (CHAPS) to provide all work pertaining to this PATH Award. Crawford County Mental Health Awareness Program, Inc. (CHAPS) will receive $62,783 in federal PATH allocation and state cash match with an additional county cash match of $1,958 for a total of $64,741 for this PATH Project. These funds will be utilized to provide 35 hours per week of Homeless Outreach and case management to eligible participants throughout Crawford County.

The provider name as listed in PDX is Crawford County MH/MR, CHAPS.

Collaboration with HUD Continuum of Care (CoC) Program

CHAPS actively participates in the region's Continuum of Care process in a number of ways. CHAPS staff are board members of the Western PA CoC, and also attend general meetings and trainings. In addition, CHAPS staff is a member of the Coordinated Entry Subcommittee, which is integral in the policies and procedures of the Coordinated Entry System. CHAPS began using the Coordinated Entry system through ClientTrack in January 2018 and is considered the General Assessment Center for Coordinated Entry in Crawford County. CHAPS has a strong partnership with Women's Services, who is the designated Domestic Violence Assessment Center in Crawford County. Staff have attended numerous trainings and webinars pertaining to the topic.

NOT FINAL

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 Housing Authorities, Realtors, Clergy, government representatives, businesses, and persons who represent the low-income and/or disabled population.

Crawford County Coalition on Housing Needs has an established LHOT as a subcommittee of the Coalition. The LHOT focuses on identifying available resources, gaps, and solutions, to meet the housing needs of persons with mental illness.

Numerous agencies in conjunction with the Housing Coalition have worked diligently to establish a system of housing and services which assist persons who are homeless move to stable housing and self-sufficiency. This work has included: development of numerous affordable housing units, homeowner programs for persons with low income and/or disabilities, Transitional Housing, Emergency Shelter, Shelter Plus Care Vouchers, Furniture Closet, Section 811 Housing Units, Housing Counseling and Advocacy Programs, and the expansion and/or creation of various support services. Among the newly expanded services are the Emergency Solutions Program (Rapid Rehousing) and BRIDGES temporary housing program. CHAPS also oversees 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 –
An array of community agencies are involved with providing services to PATH participants in Crawford County. CHAPS works in close partnership with numerous programs to help participants access the supports and resources needed to move forward in their lives and continue on their recovery journey. 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:
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 Coalition on Housing Needs and many provider agencies have worked diligently to ensure there is a continuum of decent housing-first options. CCCHN offers a transitional housing program for families with children. CHAPS offers Shelter Plus Care, Housing Now, Family Housing, and ESG Rapid Rehousing, which are accessible for literally homeless consumers via the Coordinated Entry System. With funding from Crawford County Human Services Mental Health Block Grant, CHAPS was able to develop the BRIDGES Program, which offers temporary emergency housing for mental health consumers experiencing a housing crisis.

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. The Meadville Free Clinic is also available to persons in need of treatment who have no insurance. Meadville Dental Center is also an option for consumers with a Medical Assistance card to receive needed dental services.

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In addition, CHAPS assists individuals with accessing and understanding available medical benefit programs including: Medical Assistance, Medicare Private Insurance, Veteran's Benefits, Medicare Part D, and Medical Assistance for Workers with Disabilities (MAWD).

Mental Health: All Mental Health services are coordinated through the Base Service Unit at Crawford County Human Services. Once an individual accesses the BSU, they can be referred to an array of services including: Outpatient, Partial Hospitalization, Medication Monitoring, Blended Case Management, Mobile Medication Nurses, Mobile Psychiatric Rehabilitation, Site-based Psychiatric Rehabilitation, Housing Advocacy, Rep Payee / Money Management, CHIPP Diversionary Shared Housing, and 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, Meadville Behavioral Health Center, Crawford County Drug and Alcohol Program Executive Commission, CHAPS and the Titusville YWCA.

Substance Abuse: Substance Abuse services are readily available to consumers and are primarily coordinated through Crawford County Drug and Alcohol Executive Commission. Services available include: Intensive Case Management, Resource Coordination, Recovery Specialists, Outpatient, Intensive Outpatient, Dual-Diagnosis Support Groups, access to Detox programs, Halfway Houses, and Residential Treatment Programs. Meadville Medical Center offers drug and alcohol rehabilitation support through a program called Stepping Stones. 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.

Service Provision

PATH eligibility determination

In order to be eligible for PATH services, the consumer must be a single unaccompanied adult residing in Crawford County who has a mental health diagnosis. The consumer must be literally homeless or near homeless. The caseworker provides outreach services and attempts to engage consumers who are homeless. Through motivational interviewing and completion of an intake file, the worker is able to determine eligibility. The worker must obtain homeless documentation and also assists the consumer with connecting to mental health services and obtains documentation of mental illness. Consumers become enrolled once they begin intake paperwork and documentation of homelessness is obtained. Documentation of mental illness is required within 60 days.

Alignment with PATH goals

This program will maximize the use of PATH funds to serve literally homeless adults through the Homeless Outreach/Case Manager position. This worker will provide street outreach services, engage, and support PATH eligible individuals by assisting them with developing the resources and skills needed to access and remain in decent affordable housing. A housing first model will be utilized, with the goal of helping persons move from homelessness to permanent housing as quickly as possible. Also, an emphasis is placed on strong inter-agency collaboration to meet the needs of PATH clients. CHAPS partners with numerous programs in the community to ensure that participants are able to develop the knowledge, resources and skills needed to become responsible and empowered tenants and citizens.

Maximizing use of PATH funds

This program will maximize the use of PATH funds to serve literally homeless or near homeless

NOT FINAL

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. An effort is made to get the homeless person off the street immediately and place them in an emergency shelter, if they are willing. A housing first model is utilized, with the goal of helping persons move from homelessness to permanent housing as quickly as possible. The goal is move from 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 Emergency Solutions Grant (Rapid Rehousing), Family Housing, Fairweather Lodge, Shelter Plus Care, and Housing Now along with support services such as Mobile Psychiatric Rehabilitation, Certified Peer Support, Site-Based Psychiatric Rehabilitation (Clubhouse Model), Drop In Center, and Rep Payee/Money Management Program. The opportunity for affordable housing with strong supports maximizes the chance for success.

Gaps in current service system
There is limited housing for individuals on Megan's Law and individuals with other significant felony offenses. Utilizing community partnerships, we are coming up with creative solutions to house individuals with forensic backgrounds, such as master leasing temporary and permanent housing options. From this housing barrier, the BRIDGES Program was created. BRIDGES is a temporary housing option, funded through the Crawford County Mental Health Block Grant, which consists of four master leased apartments by CHAPS, which are utilized for the hardest to place individuals experiencing a housing crisis (i.e. those who cannot reside in other emergency shelters, those who are exiting an institution, mental health consumers who cannot live in a shared housing environment, etc.).

There are long waiting lists for one bedroom subsidized housing units. CHAPS' utilizes housing voucher programs such as Shelter Plus Care and Housing Now for literally homeless individuals with mental illness. CHAPS' Housing Now voucher is used for chronically homeless individuals (per HUD's definition) with mental illness. In partnership with the Crawford County Planning Office, CHAPS applied for and received Emergency Solutions Grant funding for Rapid Rehousing for 2018 and 2019. CHAPS recently submitted the Intent to Apply form to Lawrence County Community Action Partnership for Regional ESG Rapid Rehousing funding for 2019-2020. CHAPS' has a positive working relationship with the various subsidized housing agencies in the county and work diligently to assist consumers with applying for and obtaining necessary documents to be accepted into subsidized housing.

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

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employers, employment expectations and good practices. The worker will also aid in job search as well. Referrals to the CHAPS Journey Center Vocational Unit can also occur.

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.

Co-occurring services available
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:

~ Dual Illness and the Family
~ Understanding Dual Illness and Recovery
~ How to Benefit from Services in Your Dual Recovery
~ The Role of Medication in Recovery
~ Developing a Dual Recovery / Relapse Prevention Plan
~ Using Support Systems in Dual Recovery
~ Dual Disorders, Understanding: Depression, Borderline Personality, Bipolar Disorder, Panic Disorder, among others

The psycho-therapeutic group series incorporates workbooks and related information. During individual sessions, the Primary Counselor reviews each psycho-therapeutic group attended by the client to confirm the client understands and feels ready to apply 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. If at any time during an individual's treatment episode, a non-treatment need is identified, they will be offered case coordination services to address the need (i.e. health, transportation, child care, housing, employment, life-skills). 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.

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

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 (CJAB), 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 staff members attend Mental

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Health Block Grant meetings and advocate for increasing housing options for the forensic population. Several CHAPS staff recently attended the CJAB Conference in State College, which focused on re-entry strategies.

During the 2018-2019 service year, 43% of our PATH clients had a criminal history. 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).

Data
All homeless data must be entered into ClientTrack, per CoC regulations, in order to utilize the Coordinated Entry System. CHAPS's currently enters all PATH clients into the HMIS system. CHAPS' staff participates in regularly scheduled HMIS trainings, webinars, and conference calls. New staff would be fully trained on HMIS procedures and would also participate in the trainings, webinars, and conference calls. PATH case file forms have been redesigned to capture the information required for data entry in HMIS. CHAPS has a copy of the HMIS manual to be used for reference when needed.

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 Comprehensive Mental Health Services Plan
The PATH Outreach Worker/Case Manager provides weekly street outreach services in order to locate and engage homeless individuals and connect them to permanent housing. A variety of housing options are available, which prioritize individuals with mental illness who meet the chronic homeless definition. CHAPS has a limited number of housing vouchers through Shelter Plus Care, Housing Now, and Family Housing Program. When there is an opening in one of those programs, the Housing Solutions Supervisor utilizes the ClientTrack System through Coordinated Entry to locate the most vulnerable person within the Continuum of Care and is required to offer that individual the housing opportunity. The homeless individual and/or their

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case worker must respond to the offer within three business days. If they accept the offer, the consumer is quickly connected to permanent housing. If they refuse the offer, the Housing Solutions Supervisor follows the same procedure with the next most vulnerable person on the list.

CHAPS was an active participant in the Crawford County Human Services Mental Health Block Grant planning and implementation meetings. Many community stakeholders (i.e. Drug and Alcohol, Educators, Housing Advocates, Shelter Managers, Veteran's Assistance Workers, Child Welfare) presented data and discussed the needs of the underserved residents of Crawford County. It was evident that homelessness was a priority among residents with mental illness. With funding from the Crawford County Human Services Mental Health Block Grant, CHAPS was able to implement the BRIDGES Program, a temporary supportive housing program which serves as a bridge to permanent housing for homeless individuals with mental illness (target population to be served in the PATH Program).

When homeless consumers who are enrolled in PATH Program require more intensive mental health treatment or primary health treatment, the PATH Outreach Worker/Case Manager completes referrals and supports the individual with obtaining the mental health or primary health services. Referrals can be made to the Base Service Unit, and internal referrals at CHAPS can also be made to Mobile Psychiatric Rehabilitation or Certified Peer Support Services.

Other Designated Funds

The Mental Health Block Grant funds various support services including an emergency apartment, Housing Advocates at CHAPS, Drop In Center, Representative Payee/Money Management services, and the BRIDGES temporary housing program. CHAPS is an active participant in the Crawford County Human Services Mental Health Block Grant planning and implementation meetings. Many community stakeholders (i.e. Drug and Alcohol, Educators, Housing Advocates, Shelter Managers, Veteran's Assistance Workers, Child Welfare) presented data and discussed the needs of the underserved residents of Crawford County. It was evident that homelessness was a priority among residents with mental illness. With funding from the Crawford County Human Services Mental Health Block Grant, CHAPS was able to implement the BRIDGES Program, a temporary supportive housing program which serves as a bridge to permanent housing for homeless individuals with mental illness (target population to be served in the PATH Program).

Programmatic and Financial Oversight

PATH funds are monitored through an Internal Compliance Committee and with an Independent Financial Single Audit by a Certified Public Accountant. In addition, CHAPS reports on all aspects of service provision to Crawford County Human Services.

SSI/SSDI Outreach, Access, Recovery (SOAR)

CHAPS recognizes the value of SOAR in assisting homeless consumers with completing applications for Social Security and Supplemental Security Income. All appropriate CHAPS staff and supervisors, including the PATH Outreach Worker/Case Manager participated in SOAR training in September 2013. Updates to SOAR training have been provided through various webinars, which PATH staff continue to attend. Staff has a thorough understanding of SOAR philosophy and procedures. Trained staff serve as SOAR liaisons and assist consumers with completing Social Security and SSI applications. CHAPS continues to build a partnership with the local Social Security Administration, through multiple conversations with John Johnston,

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Public Affairs Specialist at the Social Security Administration. Mr. Johnston met with CHAPS staff in June 2018 to further discuss the SOAR Program and provide valuable training updates, so we are more comfortable utilizing the system to assist our consumers in obtaining benefits. During the 2018-2019 year, zero SOAR applications were submitted. Currently staff assist consumers with applying for benefits via the online Social Security application and/or visiting the local Social Security Office to apply in person.

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.
- BRIDGES Program (Temporary Supportive Housing)

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.
- Transitional Apartment – Child to Family Connections

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

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- 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.
- HUD - VASH vouchers available through the Veterans Administration.
- Emergency Solutions Grant (Rapid Rehousing) – CHAPS – for single persons or families
- SSVF for Veterans

Coordinated Entry
CHAPS has attended all required Coordinated Entry webinars and trainings to be in compliance with expectations of the CoC. PATH eligible client data is entered into ClientTrack and prioritized based on the CoC's most vulnerable populations. The CoC's scoring system prioritizes domestic violence victims, veterans, transition-age youth, and families, which sometimes results in single persons with significant mental illness scoring significantly lower, therefore making it difficult for them to be eligible for an opening in Housing Now or Shelter Plus Care Programs at CHAPS. The Housing Solutions Supervisor is a member of the CoC's Coordinated Entry Sub-Committee and attends monthly meetings to discuss program successes and advocate for changes to the current system, in an effort to better serve homeless consumers.

Justice Involved
CIT training is not being used in our county at this time.

Staff Information
CHAPS has a solid history of hiring qualified consumers for professional positions and will continue to value this position. There are presently 51 CHAPS employees, and 31 individuals or 60% of them have shared that they have a mental illness and receive treatment. Of the 51 staff at CHAPS, 98% are White, and 2% are Hispanic. This is consistent with the diversity of the overall population of Crawford County. Currently, ten staff have received Certified Peer Specialist Training.

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, LGTBQ status. Opportunities for training in racial/ethnic sensitivity, cultural competence, and health disparities will be accessed by staff at least annually. When working with specific groups (such as transitional-age youth or present or previous members of the Amish community), staff will be supported with training and opportunities for more intensive study. In addition, staff would have training and understanding of both persons with mental illness and co-occurring substance abuse disorders. Efforts will be made to assist clients needing any accommodations during the referral and evaluation/intake process. This may include assistance with transportation, reading and writing challenges, language barriers, scheduling conflicts, health disparities and any other unique situations. Access and enrollment in services for the above named subpopulations will be tracked using the PATH Demographic form which has been updated to collect information regarding gender and LGBTQ status, and language disparities in addition to racial and ethnic information already collected on the form.

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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 fiscal year (2018-2019), the Crawford County PATH project has served the following demographics: 20% TAY range, 6% Veterans, 6% were Black, 4% Hispanic and 90% were White, 100% of participants were below poverty level with 36% having no income at entry, 54% of PATH participants were male and 44% were female, 2% were transgender, and 0% didn't identify as male or female. Also one hundred percent of those served had mental illness and 55% had co-occurring disorder (mental illness and substance abuse).

During the 2019-2020 fiscal year it is projected that 80 clients will be contacted using PATH funds. It is projected that 50 individuals will be enrolled utilizing PATH funds. It is estimated that 50% of adult clients served using PATH funds will be literally homeless.

Consumer Involvement
Homeless consumers and their family members will be encouraged to participate in the planning, implementation and evaluation of the PATH program. As previously discussed in Question 8, CHAPS is a consumer-driven organization in all aspects of its operation; CHAPS bylaws require that 60% of Board Members are consumers of mental health services or family members. One board member has previously been homeless. CHAPS currently employs 21 individuals who experience mental illness. Many of these employees were PATH eligible. Also, CHAPS offers an array of volunteer opportunities for participants, which build skills, self-esteem and opportunities for future employment. Many PATH participants are active in volunteer roles at CHAPS.

All CHAPS programs, including the PATH programs, receive ongoing consumer input and are evaluated on a regular basis through focus groups, surveys, suggestion boxes, and open dialogue. CHAPS believes it to be essential for stakeholders to have a significant voice in all programming.

Health Disparities Impact Statement –

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

During the first 11 months of 2018-2019 program year, 10 YYA were served with PATH funds. We anticipate 15 YYA will be served in 2019-2020.

The total amount of PATH funds expected to be expended on services for the YYA population
During the fiscal year 2019-2020, we anticipate spending $24,600.82 of PATH funding on the YYA population.

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

The PATH Outreach Worker/Case Manager will assist YYA individuals in searching for appropriate housing, completing/submitting affordable housing applications,

NOT FINAL

completing/submitting applications for private landlords, applying for SNAP benefits and medical insurance benefits, searching for employment, applying for Social Security/SSI, obtaining security deposit for housing, obtaining furniture and household items, teaching independent living skills, and supporting YYA individuals with maintaining permanent housing. When appropriate, referrals will be made to other service providers for assistance with mental health concerns, physical health concerns, drug and alcohol abuse, education, employment, and trauma. Internal referrals at CHAPS will also be made, if applicable. The PATH Outreach Worker/Case Manager can connect YYA to various CHAPS programs such as Drop In Center, Representative Payee, Certified Peer Support, Mobile Psychiatric Peer Support, Community Support Services, BRIDGES, and Journey Center Clubhouse.

A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the YYA population and in comparison to the general population

CHAPS staff will outreach to common sites where YYA frequently spend time (YMCA, Diamond Park, Downtown Mall, etc) and maintain a positive relationship with schools in order to identify homeless YYA. CHAPS has positive working relationships with agencies that serve youth; such as Children and Youth Services, school guidance counselors, probation, and mental health/behavioral health agencies. We will continue to further foster these relationships. CHAPS staff will refer YYA to relevant services and assist them with attending appointments, if needed. Transportation is often a barrier, so CHAPS will help YYA arrange transportation to appointments. Ongoing staff training on motivational interviewing, engagement techniques, supportive strategies, and addressing special needs of the YYA population will occur. ClientTrack is used to track outcomes for the general population and YYA population. CHAPS staff attend Mental Health Block Grant meetings and express concerns and advocate for the need for additional support for YYA in the community. CHAPS is in the process of creating a YYA Clubhouse and also providing YYA Certified Peer Support Services.

Limited English Proficiency

CHAPS is committed to cultural sensitivity and competency toward the consumers we serve. Ongoing opportunities are provided to ensure staff receives training focusing on cultural competence and health disparities at least annually. Efforts will be made to identify and assist individuals with limited English proficiency or in need of special accommodations during the evaluation process. This may include assistance with transportation, reading and writing challenges, language and cultural disparities, scheduling conflicts, health disparities and any other unique situations. CHAPS makes persons with LEP aware that we will provide an interpreter free of charge for all appointments to make communication meaningful and accurate. CHAPS also allows and encourages friends or family members to serve as an interpreter, if that is what the consumer wishes.

NOT FINAL

Crawford County
Crawford County Mental Health Awareness Program, Inc.
PATH Program
FY 2019-2020 Budget

	Annual Salary	PATH-funded FTE	PATH-funded Salary	Match-funded Salary	TOTAL
	Position				
PATH CaseMan/Outreac	39,591	0.875	25,197	9,446	34,643
Housing Services Coor.	50,765	0.100	3,692	1,384	5,076
Housing Admin Assist.	36,184	0.160	4,211	1,579	5,790
sub-total	**$126,540**	**1.135**	**$33,100**	**$12,409**	**$45,509**
	Fringe Benefits				
FICA Tax/WC/UI			3,979	1,492	5,471
Health Insurance			5,140	1,927	7,067
Retirement			2,317	869	3,186
Staff Development			670	251	921
sub-total			**$12,107**	**$4,538**	**$16,645**
	Other				
Admin			1,880	707	2,587
sub-total			**$1,880**	**$707**	**$2,587**
Total Budget			**$47,087**	**$17,654**	**$64,741**
Total PATH Budget			**$47,087**		
State cash Match				**$15,696**	
County Cash Match				**$1,958**	
Total Allocation			**$47,087**	**$17,654**	**$64,741***

*funds over federal and state allocation total of $62,783 to be covered by county match of $1958

NOT FINAL

Crawford County Mental Health Awareness Program, Inc.
PATH 2019-2020

Budget Narrative

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 4 hours a week of supervision to the PATH Case manager/ Outreach worker and coordinated entry.
The Housing Admin Assistant will provide 6 hours a week of assistance to the PATH program including migrating PATH data into HMIS, referrals and landlord relationships

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 7% of annual salary to a 401K on the employees' behalf. All PATH employees are eligible for retirement benefits.
Staff development for all PATH staff some trainings provided: Cultural Competency, Housing First, Documentation, Motivational interviewing and Ethics and Boundaries.

Admin:

Executive Director	3 hr per month @ 40.17	1,446.12
Financial Director	2 hr per month @ 33.58	805.92
Fiscal Assistant	2 hr per month @ 19.05	457.20
Payroll Taxes		260.63
Benefits		425.78
Audit expense – additional for Single audit		650.00
Total		$4,045.65

In-Kinds Supports

- CHAPS Administrative costs not included on budget page $ 1,459
- HUD Grant for Housing Now $105,980
- County MH base service dollars CHAPS Drop in Center, Clubhouse, $ 33,536
- Mobile Psych Rehabilitation, Representative Payee program will be available to PATH Consumers
- Agencies offering in-Kind support: Housing Authority of City of Meadville, NAMI, Consumer Empowerment Project, Crawford County Assistance Office, PA Career Link , READ Program, Crawford Area Transportation Authority, Penn State Cooperative Extension, Crawford County Drug & Alcohol Executive Commission, Inc., Visiting Nurse Association of Crawford County, Inc., US Dept of Agriculture Rural Development - Crawford office, Court of Common Pleas- Probation/Parole Department, Crawford County Coalition on Housing Needs, Crawford County Human Services.

NOT FINAL

Dauphin County
100 Chestnut Street
Harrisburg, PA 17101
Contact: Rose Shultz

Provider Type: Social service agency
PDX ID:
State Provider ID:
Contact Phone #: 7177807054

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 83,480**	**$ 27,827**	**$ 111,307**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 83,480	$ 27,827	$ 111,307	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 83,480	$ 27,827	$ 111,307	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 83,480	$ 27,827	$ 111,307	

Source(s) of Match Dollars for State Funds:

Dauphin Co will receive a total of $111,307 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

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

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

DAUPHIN COUNTY MH/A/DP
PATH COMPREHENSIVE INTENDED USE PLAN AND CONTINUATION OF FUNDS REQUEST
FY 2019-2020

LOCAL PROVIDER DESCRIPTION

This is verification that there are no substantial changes in PATH providers, services and processes in FY2019-2020. Dauphin County changed the name of the MH/ID Program to Department of Mental Health/Autism/Developmental Programs (MH/A/DP) in early 2019.

The Dauphin County Department of Mental Health/Autism/Developmental Programs (MH/A/DP) 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 MH/A/D Programs 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/A/DP oversees the operations of the PATH services and is the responsible fiscal entity. The contact persons for PATH at the Dauphin County Department of MH/A/DP are:

Rose M. Schultz MSW Deputy MH Administrator 717/780-7054
rschultz@dauphinc.org

Frank Magel MH Program Specialist 2 717/780-7045
fmagel@dauphinc.org

Address: 100 Chestnut Street, First Floor
Harrisburg, PA 17101

With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the County MH/A/DP 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/A/DP and is an important provider of PATH services. The CIP program is most frequent point of first contact for PATH funded services to individuals with a serious mental illness and/or a co-occurring disorder and homelessness. Services include but are not limited to 24-hour, 7 day per week availability via telephone, walk in or mobile outreach to individuals experiencing a crisis. The CIP provides MH assessments, brief counseling, service planning and referral information as well as MH stabilization. CIP is licensed by OMHSAS. 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

NOT FINAL

Base Service Unit. For individuals in which a language is a barrier to services, the CIP utilizes the Language Line to meet linguistic needs and they have one bilingual/bicultural Hispanic staff.

Downtown Daily Bread (DDB) is another point of contact for PATH services contracted by Dauphin County MH/ID. This program provides outreach and homeless case management services, including in reach and street outreach to individuals dealing with homelessness. The program has operated a soup kitchen that provides hot lunches on a daily basis for over thirty (30) years. In FY16-17 forty (40) persons received case management/ housing support. During FY17-18 Dauphin County MH addressed PATH goals not achieved in FY16-17 by the Downtown Daily Bread outreach specialist position with DDB management. A new staff person was hired for PATH services with more human service experience who had been employed in their drop in center program. DDB operates a drop in center during the day. Individuals have access to computers and information regarding resources available in the community. The census ranges from 20-45 persons per day. The center is staffed by a director, activity aides and volunteers to assist individuals in accessing needed services and supports. Crisis and CMU MH case management staff have been on site weekly and work with DDB outreach staff to assist individuals in getting enrolled in case management services and engaging in MH services and supports.

CMU (Case Management Unit) in FY 2017-18 was added as a provider of PATH funds for Housing Support services, specifically to screen and enroll individuals for PATH eligibility and use PATH funds to support the need for security deposits or first/last month rents. This service can provide quicker access to more permanent housing options for individuals. The CMU is also the PATH training fiduciary assuring PATH network has access to Mental health training annually.

Dauphin County is located in the South Central Pennsylvania and it is comprised of 40 scenic municipalities and is a mix of rural, urban and suburban areas. Dauphin County has an estimated population at 275,710 persons in 2017 There are 525 square miles, and the Susquehanna River is one of its borders. Dauphin County includes the City of Harrisburg, a small urban center and is also the State Capitol.

The amount of PATH funds allocated to Dauphin County MH/A/DP by the Department of Human Services (DHS) , Office of Mental Health and Substance Abuse Services (OMHSAS) in FY 2019-20 is $111,307 of which $27,827 consists of State Funds and $83,480 are Federal Funds. Based on data collected in the PATH Annual Report for FY 2017-18 and year-to-date in FY18-19, it is projected that outreach efforts will be made to approximately 400 individuals and approximately 300 individuals will be enrolled in PATH services. The literally homeless population to be served should reach 61%. Table 1 illustrates the projected enrollment and service goals in FY19-20 by provider.

NOT FINAL

Table 1 – Projected PATH Services FY 2019-20

Provider	MH/ID Crisis Intervention Program	Downtown Daily Bread	CMU	TOTAL
Estimated Number Outreach	150	250	Persons are enrolled with CMU	400
Estimated Number Enrolled	125	155	Referrals from Crisis/DDB or new enrollees/ 20	300
Estimated Number Literally Homeless	80	95	10	185 (61%)

NOT FINAL

COLLABORATION WITH HUD CONTINUUM OF CARE

The Dauphin County MH/A/DP 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. The Dauphin Co/Harrisburg CoC number is PA501.

Dauphin County MH/A/DP and PATH providers participate directly in several CACH committees. Dauphin County MH/ID Program collaborates in many CACH activities such as the point in time surveys and networking. CACH is designated the Local Lead Agency (LLA) for Dauphin County by Department of Human Services and PHFA (PA Housing Finance Agency) to assist with the development and monitoring of the HUD 811 PRA demonstration project awarded in 2015. In FY 17-18 17 persons with a serious mental illness were served based upon available project based vouchers and eligibility. Since that time MH/A/DP has been involved with the identification of persons with SMI for the 15 811 HCV and we are in the process of working with CACH on the Mainstream vouchers awarded.

COLLABORATION WITH LOCAL COMMUNITY ORGANIZATIONS

Dauphin County MH/A/DP 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/A/DP or PATH funded through Dauphin County MH/A/DP.

Dauphin County's Medicaid behavioral health managed care organization is PerformCare, a company of AmeriHealth *Caritas.* All of the resources will be available to individuals served as needed and eligible within the limitations of available funding.

The County Department of Drugs & Alcohol Services functions as the Single County Authority (SCA) for the County and is responsible for the provision of prevention, screening, assessment, treatment, case management and recovery support services in Dauphin County for the uninsured. Most services are available and can accessed directly from private-non-profit contracted agencies. PerformCare (BH-MCO) is also responsible for maintaining a network of drug & alcohol services for Medicaid recipients. Collaboration occurs frequently between mental health and drug & alcohol service providers. Dauphin County MH has been working with the Drug & Alcohol Department to establish D&A case management services.

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. Walk-in intake interviews are available four-days per week. These include mental health and financial liability assessments to determine eligibility and the individual's ability to participate in the cost of services, if any, according to State regulations.

The CMU also provides targeted case management services called Blended Case Management for eligible adults and children. Administrative case management is also provided by the CMU. CMU has an administrative case manager specifically to serve the homeless adult population and serves as the SSI/SSDI Outreach, Access, Recovery (SOAR) Coordinator position in Dauphin County. No PATH funded staff were trained in SOAR and there is no plan to do so at this time. SOAR is not funded with PATH dollars. The current Homeless MH case manager has adequately met this demand. Intensive case management services for eligible individuals in Dauphin County are available from Keystone Service System. Merakey offers Assertive Community Treatment (ACT) Team for approximately 120 persons per year.

The Wellspan-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), ACT, psychiatric rehabilitation, employment and social rehabilitation services. There are fourteen (14) employed Certified Peer Specialist. The CMU ended their CPS program in April 2019. MH/A/DP is exploring new CPS providers to serve Dauphin County residents.

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. Many outpatient clinics in Dauphin County offer Tele-Psychiatry to address the demand for psychiatry services.

Some outpatient providers have unique characteristics or serve specific populations of Dauphin County residents. There are also several licensed psychiatric outpatient clinics that have a

NOT FINAL

Medicaid HealthChoices BH-MCO contracts but not a county contract. Two of the clinic have a D&A outpatient clinic license at the same site, and both are operating COD clinics offering integrated MH and D&A treatment. There are clinics that are specialized for the following populations: LGBTQI, HIV/AIDS, homeless, Evidenced based outpatient interventions, sex offenders, open access, older adults, Hispanic, dual MH/ID, and school-based. The Federally Qualified Health Center, Hamilton Health Center also provides some outpatient services.

Merakey, PPI, and Wellspan-Philhaven offer partial hospitalization services. Pennsylvania Psychiatric Institute (PPI) operate partial hospitalization programs for adults, teens and children.

Dauphin County has two (2) social rehabilitation programs: Aurora Social Rehabilitation and a consumer-run drop-in center, Patch-N-Match. Keystone Service Systems operates a licensed Psychiatric Rehabilitation services which are center based and mobile service. Keystone's Psychiatric Rehabilitation program is HealthChoices and County funded.

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. Some programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

Community Residential Rehabilitation (CRR) services offer many choices to individuals to gain independence skills 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 Merakey, Elwyn, Keystone Service Systems and Gaudenzia. Supportive living services are provided by Volunteers of America (VOA) and Keystone.

CAPSTONE, a first episode psychosis program, for person ages 16-30 began services in March 2017. CMU, YWCA and Pennsylvania Psychiatric Institute are the three (3) collaborating agencies. Services include targeted case management, peer support, clinical services and supported employment/supported education.

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/A/DP for specialized CRR services: Merakey's Windows Program in Harrisburg, and Community Services Group (CSG), Crisis and Diversion Program in the Steelton community. Both programs provide short-term 45-day residential support with a capacity of 24 persons and two (2) 5-day crisis beds with 24-hour, 7-day per week staff oversight.

Ongoing collaboration with many of the Dauphin County contracted providers and the homeless provider network, assist in providing the right combination of supportive services with individuals in securing permanent housing for PATH eligible individuals to live successfully in the community.

Dauphin County MH/A/DP has developed a collaborative working relationship with the Housing Authority of the County of Dauphin (HACD) and jointly link individuals to approved landlords

NOT FINAL

that accept HUD funded Shelter + Care and Project Access vouchers. Keystone Service System's Supportive Living Program has a designated housing locator position for individuals that secure HUD or Bridge Rental Subsidy vouchers. MH/A/DP implemented a Bridge Rental Subsidy program with that currently serves eighteen (18) 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.

A Safe Haven (men only) program is operated by Christian Churches United and offers transitional and " housing first" living for up to 25 men. The YWCA transitioned the women's safe haven program in 2015 to a Permanent Supportive Housing Program. This transition has significantly improved the housing services available to eight (8) chronically homeless women by providing permanent housing to women who have been challenged with maintaining housing independence in our community.

HUD 811 projects in Dauphin County for potential PATH enrolled persons include Creekside Village and New Song Village; both are operated by Volunteers of America (VOA). These programs are permanent affordable housing projects for individuals with serious mental illness.

The HUD 811 project-based vouchers are a project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) and have available safe and affordable permanent housing for individuals with disabilities. Dauphin County was approved for two 2 bedroom unit vouchers at Felton Lofts in Steelton PA. Two – two (2) bedroom apartments are currently available in suburban areas. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH). The vouchers will serve a varied group such as individuals with a physical disability, mental illness, intellectual disabilities, Autism and transition age youth with disabilities, with the priorities given to those in institutions, living in congregate living situations and those at risk of being institutionalized. In FY 2017-18 PHFA approved more one (1) bedroom voucher within the Harrisburg City limits.

Sunflower Fields is a capital investment LIHTC housing project in Dauphin County using FY 2013-14 HealthChoices reinvestment funds. There are a total of 35 single family homes of which Dauphin County MH has preference for 5 of the homes. Availability of housing contingency funds and completion of PREP (Pepared Renters program) were positive aspects of assisting individuals and families in this application/approval process. All five (5) units were occupied in FY 2018-19

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals. The employment component is called Paxton Cleaning Solutions with competitive contracts in the surrounding area..

Mission of Mercy provides mobile medical outreach and care to homeless individuals and those who are uninsured or underinsured to obtain appropriate medical and dental care. Catholic Charities continues to provide outpatient therapy services to individuals served by Mission of Mercy.

NOT FINAL

For several years, UPMC-Pinnacle has operated a medical outreach program with a registered nurse conducting outreach to homeless individual on the street to address their medical conditions and assist in obtaining medical care and benefits.

The HELP Office is the primary program for assistance with basic needs and emergency housing and is operated by Christian Churches United. Emergency shelters include: Bethesda Mission, Salvation Army, Shalom House, Interfaith Shelter and the YWCA Domestic Violence services. Several local church organizations run soup kitchens and food pantries to assist individuals in obtaining needed food.

All MH case management entities and the Crisis Intervention Program have access to consumer support and emergency housing funds available to assist individuals with first month's rent and security deposits or back rent and utilities as needed. Dauphin County continues its commitment to improving the wellness of individuals served in the MH system: ongoing information sharing on effective strategies among provider agencies to promote healthy lifestyle choices, team building on how to make lifestyle changes in group living arrangements, in addition to improved communication between primary care physicians and psychiatrists facilitated by outpatient clinics and case managers.

SERVICE PROVISION

A list and description of services to be provided using PATH funds in Dauphin County during Fiscal Year 2019-20 include:

1. Outreach services (partially funded)
2. Screening and assessment for treatment services (partially funded)
3. Staff training (fully funded)
4. Case management (partially funded)
5. Housing services
   - Housing-technical assistance in applying for housing (partially funded)
   - Housing-improving coordination of housing services (partially funded)
   - Housing-security deposits (partially funded)
   - Housing-matching individuals with appropriate housing (partially funded)
   - Housing-rental payments to prevent eviction (partially funded)

A detailed description of the PATH funded services in Dauphin County are listed below:

Outreach Services

Downtown Daily Bread (DDB) has an outreach specialist designed to conduct outreach and in reach services in a location where most homeless individuals frequent. In addition to outreach and case management services, individuals have access to a hot nutritious meal and case management/support which provides information/referrals, lockers for personal storage, mail service, and showers. Outreach is prioritized and conducted routinely on city streets to engage and desensitize individuals to homeless and mental health services that typically decline traditional

NOT FINAL

homeless services. DDB determines PATH eligibility and provides outreach, initial screening, service planning, information and referrals. DDB works collaboratively with the 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/assessment, service planning, information and referrals.

Person enrolled with MH case management services will also be identified as literally homeless and screened for PATH eligibility and homeless assistance needs. These case management functions will not be PATH funds at the CMU.

Screening and Assessment for Treatment Services

Crisis Intervention Program (CIP) performs initial screening/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.

Screening and assessment is a role and responsibility of MH case managers. These functions at the CMU will not be PATH funded.

Staff Training

NOT FINAL

PATH training is selected each year by identifying the needs of PATH providers and the homeless provider network. The CMU serves as the fiduciary for the Annual PATH training. For FY 2018-19 Drexel University provided the training and 30 persons participated.

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 screening/assessment, planning and implementation of treatment services and housing resources. Services are provided to assist individuals in meeting their basic needs including; meals, access to showers, mail service, clothing, applications for entitlements, housing, and other requested services. Case management with individuals experiencing homelessness will develop rapport and build relationships and demonstrate sensitivity to the fears and anxieties in using formal services, stigma associated with mental illness, trauma, recovery, and illness management. The goal of case management at DDB is to engage individuals 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. As previously stated, CMU case management activities will not be PATH funded.

Housing Services

Dauphin County continues to offer a way to individualize our responses to the housing challenges faced by PATH eligible persons.

- Planning of Housing: Efforts are made to keep direct care and support staff informed and knowledgeable about housing opportunities. The information is then used to assist PATH enrolled persons with their housing plans. Dauphin County MH staff are one of many entities that facilitate housing information to aid in planning. The actual planning with the consumer is done by their interagency team and are not funded through PATH.
- Technical Assistance in Applying for Housing Services: Knowledge and understanding of the complex application process and the documents required to apply for subsidized housing, can be difficult for individuals. Assistance is available to PATH eligible individuals in identifying available housing resources, completing applications and accessing the documentation necessary to successfully secure affordable housing subsidies. Case managers 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.
- Improving the Coordination of Housing Services: Ongoing coordination and collaboration within the homeless service network, CACH and mental health providers for PATH enrolled individuals continue to be developed. Relationships with landlords, shelters, other housing programs, churches and community agencies are essential in meeting the needs of individuals or families who are literally homeless, chronically homeless, or at imminent risk of homelessness. Dauphin

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County utilizes the revised landlord-tenant protocol developed by the Dauphin County Local Housing Options Team (LHOT). CACH, the designated LLA, in collaboration with the PHFA Regional Housing Coordinator provides ongoing information regarding newly developed housing projects in the area and alerts providers and individuals they serve in the system on location of the properties and the application process to apply for these available units and maintains MOU's with referring provider agencies.

- Security Deposits: The CMU is contracted to provide PATH funds to assist individuals in securing permanent housing. CIP and case management entities have additional but limited funds to provide this assistance, other than PATH funding. This service can provide quicker access to more permanent housing options for individuals, rather than relying on limited shelter space. The funding assists PATH eligible individuals with securing safe, affordable and permanent housing.
- Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: When individuals secure appropriate housing, there are additional costs associated with that housing other than security deposit or first/last month rent. Some costs may involve rental application fees, furnishings, moving expenses and establishing good credit/reducing or eliminating bad debts. CMU is contracted to provide assistance to prevent eviction and homelessness and assist individuals in securing permanent housing. CIP and all case management entities have access to additional, but limited funds other than PATH funds for transition purposes that result in more stable housing.
- One-time Rental Payments to Prevent Eviction: PATH enrolled individuals can receive a one-time rental assistance to prevent eviction. CMU is contracted to provide limited assistance to prevent eviction and homelessness. CIP and all case management entities have access to additional, but limited funds , other than PATH for preventing eviction on a one-time basis.

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. Merakey operates an open access clinic two-days per week for Medicaid and county funded persons to access intake and psychiatric services. Catholic Charities operates a specific clinic for homeless individuals. 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.

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- Programs continue to be challenged with complex mental health needs and chronic medical conditions among persons with a serious mental illness or co-occurring disorder.
- Individuals being released from the criminal justice settings are not a good fit in shelter settings or are not eligible for subsidized housing due to past criminal charges. Dauphin County has a disproportionate number of persons sent to community correctional centers and halfway houses under early release that are not Dauphin County residents.

Needs of the Co-Occurring Population

Addressing the needs of the co-occurring population has been very challenging and complex in Pennsylvania, including Dauphin County, since the most effective treatment is to offer integrated approaches. Co-occurring training for professionals is essential for staff. The proposed consolidation of State departments under one administrative and licensing entity would significantly help establish co-occurring services without the burden of separate administrative and licensing entities.

Dauphin County mental health system is charged with assuring there are established services to meet the needs of individuals who also have substance use disorders and a serious mental illness. While the regulatory authority of services lies with both the Department of Human Services (mental health) and the Department of Drugs and Alcohol, County administered programs face challenges to implement integrated treatment model services to meet the needs of individuals with co-occurring disorders. Among individuals who are medical assistance eligible, services are administered through the same behavioral health managed care organization, PerformCare.

Individuals with co-occurring disorders have access to the following array of mental health services and supports: outpatient services, partial day programs, residential services, and support services such as targeted case management, supportive living, social rehabilitation, peer support and inpatient care through county /state funding streams and Medicaid managed care. The Drug & Alcohol system is disproportionately funded at the community level and the lack of integrated treatment adds additional barriers to recovery. There are two Co-Occurring Disorder (COD) Outpatient programs developed in Dauphin County and operated by T.W. Ponessa and Pennsylvania Counseling Services.

Evidenced Based and Promising Practices

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) (a function of the CMU) is an essential first step in providing the individual access to the array of services that are available. Once registered with the BSU through walk-in access , an individual will have access to evidence based and promising practices that operate with fidelity throughout the MH system. These services can benefit literally homeless, including chronically homeless individuals and those at imminent risk of homelessness who we are seeking to engage in mental health and co-occurring services. Table 2 represents evidence based and promising practices that are available in Dauphin County currently.

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Table 2 – Evidenced Based and Promising Practices in Dauphin County

Evidenced Based and Promising Practices	Service Available in County	Staff Trained in EBP/PP	Comments
Assertive Community Treatment	Yes	Yes	Urban Team
Supported Housing	Yes	No	Two (2) providers
Supported Employment	Yes	Yes	One (1) provider
Integrated Treatment Co-Occurring (MH/SU)	Yes	Yes	Located with Two (2) OPT D & A Providers
Dialectical Behavioral Therapy	Yes	Yes	Adult and Teen models; two (2) certified providers
Mobile Psychiatric Nursing	Yes	Yes	One (1) provider
Shared Decision Making	Yes	Yes	CAPSTONE (FEP)
Psychiatric Rehabilitation	Yes	Yes	One (1) provider Center based and Mobile
Cognitive Behavior Therapy	Yes	Yes	Multiple providers
Trauma-Focused CBT	Yes	Yes	One (1) MH provider and One (1) D&A provider
Consumer-operated Services	Yes	Yes	Drop-in Center
MHFA Adults and Children	Yes	Yes	Three (3) certified trainers
Illness Management Recovery	Yes	Yes	Four (4) providers
Certified Peer Specialist	Yes	Yes	Two (2) Free-standing and other Embedded CPS services
Parent-Child Interaction Therapy	Yes	Yes	Two (2) certified providers
Guiding Good Choices	Yes	Yes	Parents are facilitators
First Episode Psychosis	Yes	Yes	CAPSTONE
WRAP & WRAP Facilitator	Yes	Yes	Providers have certified trainers
Family Psycho-education	Yes	Yes	NAMI Family-to-Family

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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. Following events, further outreach and engagement activities are provided to individuals linking them to needed /requested services.

Dauphin County and the provider network embraces the Principles of Recovery and Resilience. Most activities include all stakeholders and all individualized teams supporting persons have a common message to be recovery/resiliency oriented, work with a person's strengths, consumer-driven, and emphasize the use of natural, peer, and family support. In Dauphin County, a

Community Support Program (CSP) Committee is actively involved in the system planning as well as improving person involvement in leadership roles and evaluation activities. As a Block Grant County, Dauphin MH/A/DP documents their recovery and resilience priorities and activities.

Dauphin County MH/A/DP 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 to drug & alcohol treatment as needed by PATH funded staff, but they are not involved in any provision of treatment.

Dauphin County has completed the initial data collection and analysis of the STEPPING UP Initiative. The Implementation Phase is underway in MH.

DATA

The Dauphin County Mental Health administration and CIP staff have completed training on the use of the Homeless Management Information System (HMIS). Downtown Daily Bread is already using HMIS to collect data under the CACH umbrella. The Capital Area Coalition on Homelessness (CACH) is the local planning group in Dauphin County and the CACH funds the HMIS training and activities around data collection. Bowman Service Point is the selected HMIS contractor. Dauphin County MH/A/DP and its PATH contracted providers have worked diligently in conjunction with the HMIS Program Director to assure PATH data is successfully entered into the HMIS system. HMIS training was conducted in FY 2017-18 with the CMU staff.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH provider agency staff will be supported on a routine basis by Dauphin County MH administrative staff and the HMIS program administrator. Data entry and reporting issues with HMIS continue to be addressed with HMIS Administrator in Dauphin County. Ongoing technical support is being used to further develop the data quality and integrity of the PATH data entered into HMIS.

The CoC does not have a written HMIS manual. When PATH staff were trained in HMIS they received a PowerPoint presentation. The CoC uses Bowman and the Bowman Library may have an up-to-date user manual but the CoC doesn't use it.

ALIGNMENT WITH PATH GOALS

The Dauphin County MH/A/DP 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

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ongoing and persistent outreach along with building rapport and trust with individuals will has the greatest impact and success in reducing homelessness.

All PATH providers in Dauphin County are trained and supported to identify person in crisis due to mental health issues who are also literally or imminently homeless. OMHSAS identifies adults with a serious mental illness as the priority adult MH population. Our service system and interventions are all focused on meeting the needs of this population and also include adults with an SMI and co-occurring drug & alcohol disorders. The primary child and adolescent priority population are those with a serious emotional disturbance.

ALIGNMENT WITH STATE MENTAL HEALTH SERVICES PLAN

Dauphin County MH/A/DP 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/A/DP has maintained a collaborative relationship with Dauphin County Emergency Management Agency (EMA) and provides a Mental Health Response Team when an incident occurs which requires mental health disaster intervention. Under a collaborative agreement, the EMA will support the efforts of the MHRT and will provide whatever appropriate resources it may have at its disposal to intervene in a disaster incident (including activating ancillary agreements the EMA may have with other resources such as the Red Cross). The County Emergency Management Agency and local EMAs in municipalities will notify the county program by telephone or by fax if any incident has occurred that may, in their opinion, require the mental health response.

Crisis Intervention Program staff also participates in the County-wide TMI disaster preparedness drill, which occurs every other year. The Program staff's role is "rumor control" to the general public and support to the State and local EMA staff. Further, on a daily basis, suicide callers to the EMA 911 Center are routinely patched through to the Dauphin County Crisis Intervention Program. The Program also maintains a mutual aid agreement with the local Red Cross that will be updated in the coming fiscal year. All homeless providers have developed individual emergency preparedness plans to address the needs of the individual they serve.

ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS

As outlined in various sections of the comprehensive Intended Use Plan (IUP) including the individual IUPs for both Downtown Daily Bread and Crisis Intervention Services provide street

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outreach and focus on the most vulnerable population of homeless and chronically homeless persons in Dauphin County. This is consistent with the State's Plan to End Homelessness.

With the adoption of HOME RUN by the County of Dauphin and the City of Harrisburg, and the continued leadership of CACH as the Blueprint Manager, the stage has been set to make homelessness *rare, brief and non-recurring in our community*.

The 2017 Blueprint presents six (6) Primary Objectives with several strategies and action steps to achieve the U.S. Department of Housing and Urban Development's definition of "ending homelessness", where *homelessness is rare, brief, and non-recurring:*

1) Strengthen Leadership to End Homelessness;
2) Achieve a Continuum or County-Wide Coordinated Entry, Assessment and Referral System;
3) Preserve Existing, and Increase Affordable Housing Supply;
4) Ensure Access to and Availability of Supportive Services;
5) Increase Public Awareness and Education about Homelessness, the Coalition, and its resources; and
6) Prevention of Homelessness. Each Primary Objective has outcome measures based on "System Performance Measures" by the US Department of Housing and Urban Development (HUD) on how a continuum or catchment is progressing towards ending homelessness.

<u>OTHER DESIGNATED FUNDS</u>

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 rapid rehousing and HMIS.

Dauphin County's Homeless Assistance Services (HAP) Program serves individuals and families whose income is below 200% of Federal Poverty level and who are homeless, near homeless, and who meet the specific HAP program component requirements. HAP services include; bridge housing, case management, rental assistance, emergency shelter.

Dauphin County uses MH Block Grant funds to support many homeless positions in the provider network not funded by PATH dollars. Medicaid expansion has facilitated the use of HC funds to support the provision of treatment for the homeless population, including families.

<u>SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)</u>

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SOAR training was provided by OMHSAS in coordination with a SOAR Implementation Team. SOAR activities are not PATH funded in Dauphin County. The Dauphin County SOAR coordinator also manages a homeless caseload in the CMU agency. The position continues to work collaboratively with improving ongoing communication with Mid-Penn Legal Services, the Social Security Administration (SSA) and the Bureau of Disability Determination (BDD). All potential SOAR applicants are screened and the process has been used to secure benefits for thirty-five (35) persons since SOAR was introduced to Dauphin County in 2012. The process is very time-consuming, detail oriented and comprehensive. During FY 16-17 five (5) persons were approved through SOAR and in FY17-18 three (3) persons were SOAR approved. 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. FY18-19 7 persons were or are being served: 4- approvals, 1 denial in the appeal process, 1 ready for submission and 1 in early application development.

PROGRAMATIC AND FINANCIAL OVERSIGHT

Dauphin County MH/A/DP receives state and federal funds PATH directly from the Office of Mental Health and Substance Abuse services OMHSAS. These PATH funds are allocated to the subcontracted PATH providers; DDB, CMU, Crisis Intervention Services. Quarterly reviews are conducted by MH program specialist staff of HMIS data. Internal audits are conducted by Dauphin County MH/A/DP Fiscal Officer and PATH Financial quarterly reports are provided to the OMHSAS for review reflecting all contracted PATH funds in Dauphin County. At a minimum quarterly programmatic meetings are held with the Downtown Daily Bread staff regarding service delivery and reporting issues. The CMU has monthly monitoring contacts with MH/A/DP. Crisis Intervention Program has a Compliance Committee for monitoring purposes.

HOUSING

PATH funds continue to assist individuals who are literally homeless, chronically homeless, and at imminent risk of homelessness in securing permanent housing. PATH services continue to remain flexible and sensitive to the unique needs of individuals. Downtown Daily Bread, Crisis Intervention Program and CMU continue to provide outreach to build rapport and engage individuals in accessing appropriate mental health treatment and support services and available housing. Several temporary options are considered first in addressing immediate housing needs and once established can lead to a permanent housing situation, which include the following options:

General shelter/housing programs:

- Bethesda Mission, supplying emergency shelter services for men in some extended stay options, in the city.
- Shalom House, a shelter site available to single women and to women with children in the city.
- YWCA, providing transitional housing services for women, in the city. Provides overnight shelter for homeless women during the winter months

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- Delta Housing, operated by Gaudenzia, provides transitional services in small apartment settings for women and women with children.
- Interfaith Shelter, a facility for intact families operated by Catholic Charities in the Colonial Park suburb area of Harrisburg.

Private and public resources outside the conventional human service agency framework:

- Harrisburg Housing Authority, in Harrisburg city.
- Housing Authority of the County of Dauphin, with units outside the boundaries of Harrisburg city and the balance of Dauphin County.
- Hotel and motel proprietorships, allowing short-term stays with sponsorship for people, both in the city and in the suburbs.
- YMCA Single Room Occupancy for men not limited to city residents.
- Susquehanna Safe Haven, a housing first program for 25 homeless men with serious mental illness.
- YWCA Supportive Housing programs have been recognized for their veteran housing services.

Housing Partnerships: The MH/A/DP 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/A/DP continues to further develop potential partners with whom we need to improve our relationship with such as Dauphin County's Department of Community and Economic Development and the Harrisburg City Housing Authority.

In past few years, Dauphin County developed a Bridge Rental Subsidy program using reinvestment dollars in collaboration with the Housing Authority of the County of Dauphin (HACD). A total of eighteen (18) individuals have received funding through the Bridge Rental program. Changes were made to the Administrative Plan and a procedure was developed to consider persons purged from the Section 8 list to be considered for reinstatement. All applicants were required to complete a PREP (Prepared Renters Program) curriculum and PREP classes are offered to any interested consumer/family in the MH system.

Paxton Ministries developed two (2) Community Lodges which serve a total of eight (8) persons. The lodges are managed by the individuals living in the home. All expenses are paid for by the individuals living there and any decisions made regarding the Lodge are made by its members. There is a part-time Lodge coordinator for oversight. Paxton developed a cleaning company, Paxton Cleaning Solutions, and has contracts with several area businesses.

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COORDINATED ENTRY

CACH has responsibility for the Coordinated System of Entry and Referral for persons seeking homeless services and housing programs in the City of Harrisburg Dauphin County. CACH has developed a Coordinated Entry Referral Tool (CERT) and is used universally by any agency or person in initial contact with a homeless person or family for referral to the first proper and appropriate housing option. Once an homeless individual is identified they are place on the CEAR by names list in HMIS. The VI-SPDAT Vulnerability Assessment tool is used, which is completed by the provider that is in contact with the individual. A priority number ranks the individual's priority for housing is assigned based on the outcome of the VI-SPDAT assessment and data is entered in HMIS. Individuals who are chronically homeless or unsheltered and especially the Transition Age Youth (TAY) population are prioritized. Monitoring is conducted by CACH CEAR Committee until individuals have secured permanent housing.

The CoC's VI-SPDAT assessment tool has streamlined the process of effectively screening and prioritizing individuals to access appropriate housing. The availability of housing, criminal record and interest in securing permanent housing are barriers to immediate housing PATH agencies have encountered. PATH funded agencies and all MH providers work with individuals to address barriers and create solutions to immediate needs.

MH/A/DP is involved with a CEAR Committee examining the CEAR process and making process improvement recommendations to CACH according to HUD guidelines.

Emergency Shelter:

Women and families needing immediate emergency shelter in order to avoid becoming unsheltered are all assessed through the HELP Office and at Dauphin County Crisis during off-hours and weekends. Single (unaccompanied) men access shelter directly through the Bethesda Men's Mission.

Unsheltered Persons who are Homeless (Non-Chronically Homeless):

Those who are unsheltered but do not have a disability or who do not have a recurring history of being unsheltered or in emergency shelter defined as chronically homeless will be referred to Transitional Housing Programs. Such referral TH is often done through informed outreach workers, agency, or self-referral. Immediate referral to ES may be required in the event that TH is not available or requires more time to process.

Persons who are Chronically Homeless:

Those who are unsheltered or in an emergency shelter who have a disability and repeated history of being unsheltered or in shelters (12 months in 3 years) that meet the federal definition of chronic homeless will be referred first and foremost to Permanent Supportive Housing (PSH).

Person who are in Rural Areas and Homeless:

Persons in rural Northern Dauphin County will be assisted by the HELP Office with housing/rental assistance for up to six months, using up to 20% of HP and RRH Dauphin County funds, in coordination with the Dauphin County Human Services Office in Elizabethville.

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Veterans who are Homeless:
Homeless Veterans can be assisted through any program but they should quickly be referred to Veteran specific housing and service programs offered by the YWCA, Shalom House, Volunteers of America, and Lebanon VA Medical Center i.e. VA Per Diem TH, HUD-VASH, Supportive Services for Veteran Families (SSVF), and Homeless Veterans Reintegration Program (HVRP). If a homeless Veteran moves from a non-specific homeless housing program to one dedicated for Veterans only that then releases bed vacancy for non-veterans candidates.

VAWA Victims Immediately Homeless due to Fleeing**:**
Victims who are homeless because they are immediately fleeing domestic violence, dating violence, sexual assault or stalking, or fleeing any actual or threat of violence can access any portal of housing and homeless service, but are immediately referred and transferred where possible to housing and services provided by the VAWA services agency which in Dauphin County is the YWCA of Greater Harrisburg.

JUSTICE INVOLVED

Dauphin County has been developing forensic services for person with a serious mental illness and criminal justice involvement for well over 10 years. During that period, grants for jail diversion, re-entry strategies and a Mental Health Court have brought additional expertise to the mental health system and significantly improved collaboration with some related criminal justice agencies. Police trainings in Mental Health First Aid and CIT have been conducted. A Boundary Spanner position to coordinate MH forensic cases was established and continues to be funded through the MH system. Forensic case management, specialized CRR residential services, ACT and other treatment approaches were implemented. More recently, there has been successes in sustaining strong partnerships with Pre-Trial Services and Adult Probation, using Housing support funds through HealthChoices reinvestment, and expanding co-occurring treatment options. Research now indicates that increasing mental health services and supports may not decrease the number of person in jail with mental illness. The criminogenic risk factors that may be unaffected by MH treatment include:

- History of anti-social behavior
- Anti-social personality pattern
- Antisocial cognition
- Antisocial attitudes
- Family and/or marital discord
- Poor school and/or work performance
- Few leisure or recreational activities
- Substance abuse

Rigorous review and tracking has occurred identifying persons that may be eligible for Jail diversion since January 2017 based upon admission to Dauphin County prison and involving the Pre-Trial Boundary Spanner position and CMU Forensic Blended Case Management Supervisor.

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The Calendar Year 2017 data has been reviewed. Individuals were identified for MH Diversion/Reentry Services if they are currently active with Mental Health Case Management or had been active within the last three (3) years. All individuals were then screened for criteria who may be eligible for diversion from incarceration at Dauphin County Prison. Most referrals came through this screening process and a few referrals for diversion were received were self-referrals or from Dauphin County Prison. The STEPPING UP data collection estimated that 16% of the persons in the Dauphin County Prison have a serious mental illness.

As of December 31, 2017, 1, 018 individuals were screened for MH Diversion/Reentry Services. Of those individuals, 212 (17.68%) met all the criteria and were offered services and 136 individuals (64.2% of 212) were approved and subsequently released from incarceration. By the end of the year, 47 person were sentenced and waiting to be released or were waiting for a court date. Data on the persons sent to DCP among the 1, 018 - there were 806 (79.2%) either not eligible for a diversion plan or not divert during the calendar year. Person not diverted were primarily because they were released before a diversion screening could be conducted. Data for FY18-19 is comparable.

Our data is consistent with national research indicating that MH treatment alone does not reduce criminal justice involvement or reduce recidivism for person with SMI who are involved in the criminal justice system. The challenges ahead are complex and multi-system. Person being released from State Correctional Institutions, particularly those with no connections to Dauphin County (no family/no job/not sentenced here) add to the challenges ahead for the Dauphin County mental health.

Dauphin County has programs that address the needs of justice involved individuals. In 2008 MH/A/DP 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 intends to improve treatment participation and outcomes that promote recovery.

Dauphin County has a Jail Diversion & Reentry program. The Jail Diversion program is beneficial for avoiding or radically reducing jail time by using community-based treatment as an alternative, leading individuals with mental illness or mental illness and substance use problems away from criminal incarceration or cutting it short. The Reentry program works with individuals with a serious mental illness who are court ordered or sentenced to county jail time and connects them to community mental health services prior to or shortly after release from prison.

Dauphin County opened a judicial center for centralized booking several years ago. Pre-Trial staff screen admissions and request a MH assessment from Crisis Intervention Program staff or, if active, targeted mental health case managers. Recommendations are made to Magisterial District Justices in determining bail, release or incarceration.

Dauphin County is not required to and does not collect specific PATH data on individuals that are PATH enrolled and justice involved. However based on the statistics of the general population in Dauphin County that are justice involved, it is estimated the percentage of justice involved persons would be relatively high.

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Dauphin County is renewing CIT training in FY19-20.

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.

None of the staff hired at Crisis Intervention Program and Downtown Daily Bread using PATH funds are Certified Peer Specialists (CPS). Certified Peer Specialist are either funded by a behavioral health managed care program through HealthChoices (Medicaid) or County funded.

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. A newly hired individual for the DDB Outreach Specialist position has some previous experience working with a diverse population of homeless individuals in the drop in center and overnight shelter program. 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 routine meetings and periodic administrative reviews. County MH staff have been involved in orientation/training of the new Outreach Specialist position.

Keystone Mental Health Services, Merakey and the CMU are examples of agencies that continue to cultivate staff sensitivity to cultural and ethnic differences and have many language competencies at particular programs they operate. Mental health agencies may also use contracted interpreter services when needed. Several agencies also periodically offer staff and individuals in service training on cultural topics and skills. The CMU specifically recruits persons that are representative of the communities they serve throughout Dauphin County.

A survey of the demographics of the staff hired in programs that are partially funded by PATH dollars has not been undertaken. Service providers and the County-operated Crisis Intervention Program and contracted PATH providers are encouraged to hire staff representative of the population they serve demographically by age, race/ethnicity and gender while hiring the best qualified candidate for the position.

NOT FINAL

The Crisis Intervention Program is also part of the County's Merit Hire system and County Human Resources Department reviews and monitors staff composition and equal employment opportunity criteria. Dauphin County continues to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

CONSUMER INFORMATION

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 19-20 to be similar to the previous year's PATH annual data. The chart below illustrates the demographics of individuals served in the PATH program for FY 16-17(n=237).

Table 3-PATH Consumer Information Demographics for PATH Planning

Demographic Information	FY16-17 Persons Served	FY16-17 Percentage Persons Served
Age: 18-30 31-61+	62 175	26% 74%
Gender: Male Female	157 79	66.6% 33.3%
Race: African American Caucasian Other/not reported	101 131 5	43% 55% 2%
Ethnicity: Hispanic Non-Hispanic, Non-Latino	27 210	11% 89%
Diagnosis: MH Only COD MH/DA MH and Other	107 121 9	45% 51% 4%
Veteran Status: Yes No Unknown	9 220 8	4% 93% 3%
Housing Status: Emergency Shelter/ Not meant for Habitation Transitional Housing Other	127 74 36	53% 31% 15%

The Capital Area Coalition on Homelessness conducted a 2018 Point in Time Survey of individuals and families who experience homelessness. There were a total of 445 men, women and children experiencing homelessness, which is a 3% decrease from 460 in 2017.

CONSUMER INVOLVEMENT

NOT FINAL

MH/A/DP is committed to having individuals in service take on leadership roles and continue to be involved in all aspects of mental health planning process. The Dauphin County Community Support Program (CSP) Committee is very involved in evaluation as well planning for mental health services and new initiatives. The expertise of the County Quality Assurance staff is utilized to compile and analyze the data received and assists in exploring next steps or recommendations that can be pursued. The survey data outcomes and reports are shared internally with program staff, the Adult MH Committee of the MH/A/DP Board and the Dauphin County Community Support Program (CSP) Committee. Information is incorporated into annual Block Grant Plan and an Annual Report. MH/A/DP has not taken any steps in the past to evaluate the specific PATH funded services by the persons benefiting from them. Concerns about their privacy and guardedness are perceived to interfere with service delivery. The County's Quality Assurance staff is available to investigate complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns.

Downtown Daily Bread has homeless and formerly homeless volunteers that assist with various operations of the homeless services offered, such as with the drop in center operations and with the homeless outreach specialist to provide assistance and to identify locations typically not known by the outreach worker. In allowing volunteers to assist with services has proved beneficial in providing feedback from individuals that receive services offered by the program.

The CMU has an Advisory Committee that reports to their Management Board of Directors. The groups is comprised of representative from the various populations they serve. Recently, the group has been reviewing the paperwork used for intake interviews at the CMU.

Persons enrolled in community-based MH services may also be referred for Certified Peer Specialist services. The RASE Project has employed Recovery Specialists, but many more Recovery Specialists are volunteers. Individuals in service or that have been homeless are encouraged and attend our local CACH coordination meetings on a regular basis to provide insight and input into the direction of homeless service needs.

HEALTH DISPARITIES IMPACT STATEMENT

Health disparities are not new to the Dauphin County mental health system, including for persons who are homeless, chronically homeless, or imminently homeless. Dauphin County is highly committed to addressing disparities within the County using local, State, and federal resources available to us. For the past several years, an examination of subpopulations in the county-funded system as well as in the Medicaid managed care system has been undertaken to improve the overall wellness of persons we serve. Furthermore, the relationship between health and mental health are fully understood and prioritized. The Commonwealth of Pennsylvania provides for a County-operated and managed mental health system for persons who are uninsured. While services exist, current budgetary cuts and prior cost of living increases not tied to real costs continue to impact the availability of services leading to waiting lists and the need to triage care.

The county behavioral health system is also the primary planner and implementer of service supports and rehabilitation services not funded by Medicaid and Medicare. These are typically

NOT FINAL

services which support persons living in communities. In a recovery and resilience based system, these services are as important as treatment to the individual and their family. Many of our efforts have not been solely for the benefit of PATH eligible persons; however this population has benefited from these focused efforts.

The Outreach Specialist position at Downtown Daily Bread specifically was established because we found that persons needed a community-based agency for outreach, including in reach. The County's Crisis Intervention Program was too much associated with inpatient psychiatric assessments to function as the sole outreach program for PATH. A specialty psychiatric clinic for persons who are homeless is monitored for access and the consistent issue has been follow-up appointments and locating unsheltered persons for subsequent appointments.

Alder Health Services provides integrated physical and behavioral health services for individuals they serve. Agencies are encouraged to address coordination and communication with primary care physicians. Hamilton Health Center, a federally qualified health center, provides mental health counseling through staff LCSWs. Case management agencies focus on the referral of insured and uninsured persons to primary care programs and services, such as Mission of Mercy and Hamilton Health Center while attempting to secure benefits and insurance barriers.

MH/A/DP, as well as the Medicaid BH-MCO has in place policies and procedures to support agencies in addressing the language and linguistic support needs of persons in service. This is particularly necessary when the mental health workforce does not represent the cultural, language, and ethnic demographics of the community population. The last comparative survey of workforce demographics to the persons in mental health services occurred in the mid 1990 during a period of cultural diversity efforts across the Commonwealth, especially in children's mental health services.

Wellness activities undertaken include efforts with the BH-MCO PerformCare: Medication Review Toolkit and Natural Supports Toolkits for family, friends and others supporting an individual with a serious mental illness. All the toolkits are available on PerformCare's website. A Nurse Navigator program has been implemented in Dauphin County by Merakey.

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. In FY 2017-18 MH/A/DP updated the Complaint and Grievance Policy and Procedure. MH/A/DP 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 individuals 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.

NOT FINAL

MH/A/DP works collaboratively with Dauphin County Area Agency on Aging on a quarterly basis to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served in both systems.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. SAMHSA PATH includes TAY individuals ranging in ages from 18-30 year old age group. Transitioning young adults have unique challenges at any chronological age since their emotional and social development may have been impacted by socio-economic and mental health factors. PATH annual report data in FY 2016-17 a total of 62 or 26% of the individuals served were between the ages of 18-30 years. In FY 17-18, fifty (50) persons identified as TAY were served. Year-to-date, in FY18-19 forty-five (45) persons identified as TAY have been served.

Dauphin County takes a flexible approach to determining with a person's support system and interagency team which system (child/adolescent or adult) may fit their needs best and how to individualized the transition period to gain the most success and recovery. Persons under the age of 18 may also be involved with a children and youth agency if they require care and supervision. Mental health treatment in Pennsylvania may be accessed by person 14 years of age and older without parental consent, however efforts are made to engage responsible adults in all aspects of treatment. Person under 18 years requiring inpatient psychiatric or medical care will require the involvement of Children & Youth and the Courts, as needed.

The JEREMY Project is operated by the CMU and 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 CMU Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews.– The JEREMY Project is in its 16th year of operation. A review of The JEREMY Project was undertaken in 2017. Recommendations to modify the target population and work with young adults with more significant risk factors will be implemented in FY19-20. Risk factors during transition such as homelessness, criminal activity, isolation, drug & alcohol use, family conflicts and poor peer relationships should be screened for in the eligibility process.

In FY 17-18 marked the first full year of implementation for CAPSTONE, a first episode psychosis (FEP) program funded by OMHSAS with federal Community Mental Health Block Grant dollars for persons ages 16-30 experiencing an initial diagnosis of a psychotic disorder. The partners include: Pennsylvania Psychiatric Institute for Team Leadership and Clinical Services, YWCA of Greater Harrisburg for Supported employment and supported education services and CMU (Case Management Unit) for targeted case management and certified peer support services. A SAMHSA monitoring was completed in March 2018.

LIMITED ENGLISH PROFICIENCY

The Crisis Intervention Program utilizes the Language Line to meet linguistic needs and they have one bilingual/bicultural Hispanic staff. All Dauphin County contracted providers make individual

NOT FINAL

arrangement for interpreter services for languages other than English if they do not have staff that are bilingual/bicultural. All PATH services are provided on an individualized basis and contracted providers respect and are sensitive to the linguistic needs of the homeless population. MH/A/DP and several providers use The International Service Center to assist with various language translations and interpreting to best serve those who are not proficient in English. This agency has a list of interpreters for many frequently spoken languages that we may experience in the region. Providers continue to tailor services based on individual needs as well as accommodating individuals linguistic needs in order to benefit from services provided. Many agencies seek to hire multi-lingual staff that can accommodate and further address the linguistic needs of the population they serve.

FY19-20 DAUPHIN COUNTY COMPREHENSIVE PATH BUDGET NARRATIVE:

Personnel ($ 62,362): $22,362 approximates one-half the salary of the Full-Time Equivalent (FTE) position with the Dauphin County Crisis Intervention Program. The salary amount is 50% of the actual costs for the Crisis Intervention Program's Lead PATH Worker's position. $40,000 is the full-time salary of the Downtown Daily Bread Outreach Specialist position.

Fringe Benefits ($28,566): $ 12,326 or 55.12% references the benefits for one position within the Crisis Intervention Program. $16,240 or 40.6 % are the fringe benefit costs for the Outreach Specialist position at Downtown Daily Bread.

Travel ($2,000): Local Travel at $.54 cents per mile X 80 miles/month X 12 months for the DDB Outreach Specialist position and parking.

Supplies ($3,000): Costs of supplies to be applied to this PATH grant are solely those related to the basic and rehabilitative needs of PATH eligible consumers. Among supplies anticipated are small stocks of non-perishable food items, clothing and blankets, as well as for accessories important to improve prospects for safe and conventional independent living. Costs for bus passes to assist clients to get to housing related services such as supported employment programs, county assistance offices, benefits counseling.

Other ($10,927): **Staff Training (4,480):** This budget line represents costs of speakers, room arrangements, presentation aids, and dining for the PATH training sponsored for the personnel of emergency shelters and other agencies that serve PATH eligible people. Staff conference costs for specialized training. **One-time Rental Assistance ($ 3,223):** This budget line represents costs incurred on behalf of PATH eligible people for whom one-time expenditures can relieve the risk of possible eviction and homelessness. **Security Deposits ($3,224):** 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% @ ($ 4,452): Four (4) percent of the PATH grant is allocated to cover administrative expenses at MH/ID Crisis, Downtown Daily Bread.

Total PATH Request (Federal $83,480 /State $27,827)**……………………………$ 111,307**

NOT FINAL

Dauphin County MH/A/DP
FY 2019-20 PATH Comprehensive Intended Use Plan Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Personnel Position				
Crisis Caseworker	44,723	50%	22,362	22,362
DDB Outreach Specialist	40,000	100%	40,000	40,000
Salary sub-total			62,362	**62,362**
Fringe Benefits (55.12% & 40.6%)				
Crisis (55.12%)				
FICA, Health, Ret, Life			12,326	12,326
DDB Outreach Spec (40.6%)				
FICA, Health, Ret			16,240	16,240
Fringe sub-total			28,566	**28,566**
Travel				
DDB Local Travel & parking			2,000	2,000
Travel sub-total			2,000	**2,000**
Equipment				
(list individually)			0	0
sub-total			0	**0**
Supplies				
Consumer-related items			3,000	3,000
Supplies sub-total			3,000	**3,000**
Other				
Staff training			4,480	4,480
One-time rental assistance			3,223	3,223
Security deposits			3,224	3,224
Other sub-total			10, 927	**10,927**
Indirect Administration @ 4%				**$ 4,452**
Total PATH Budget (Federal $83,481 /State $27,826)				**$ 111,307**

NOT FINAL

Dauphin County - Case Management Unit
100 Chestnut Street, 1st Floor
Harrisburg, PA 17101
Contact: Frank Magel

Provider Type: Social service agency
PDX ID:
State Provider ID: PA
Contact Phone #: 717-780-7045

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

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

Source(s) of Match Dollars for State Funds:

Dauphin County's Case Management Unit will receive a total of $8024 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 20

Estimated Number of Persons to be Enrolled: 20

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

Number staff trained in SOAR in grant year ending in 2018: 1

Number of PATH-funded consumers assisted through SOAR: 7

NOT FINAL

Dauphin County MH/A/DP
CMU (Case Management Unit)
FY 19-20 PATH Intended Use Plan

LOCAL PROVIDER DESCRIPTION

This is verification that there are no substantial changes in PATH providers, services and processes in FY2019-2020. Dauphin County changed the name of the MH/ID Program to Department of Mental Health/Autism/Developmental Programs (MH/A/DP) in early 2019. All updated information requested by OMHSAS has been incorporated in this submission (highlighted).

The Dauphin County Department of Mental Health/Autism/Developmental Programs (MH/A/DP) 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 MH/A/DP 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/A/DP oversees the operations of the PATH services and is the responsible fiscal entity. The contact persons for PATH at the Dauphin County MH/A/DP are:

Rose M. Schultz MSW Deputy MH Administrator 717/780-7054
rschultz@dauphinc.org

Frank Magel MH Program Specialist 2 717/780-7045
fmagel@dauphinc.org

Greg McCutcheon CMU Executive Director 717/232-8761
gmccutcheon@cmu.cc

Address: CMU
1100 South Cameron Street
Harrisburg, PA 17104
PDX: 080

With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the County MH/A/DP office as OMHSAS does not have a contract directly with the Counties' PATH providers.

MH/A/DP added CMU (Case Management Unit) as a provider of PATH funds Housing Support services, specifically to screen and enroll individuals for PATH eligibility and use PATH funds to support the need for security deposits or first/last month rents. This service can provide quicker access to more permanent housing options for individuals.

The CMU will also use PATH funds to assist PATH eligible/enrolled individuals and families with rental application fees, furnishings, moving expenses and establishing good credit/reducing or

NOT FINAL

eliminating bad debts. One-time Rental Payments to Prevent Eviction are provided for PATH enrolled individuals so as to receive a one-time rental assistance to prevent eviction. The CMU has access to limited PATH funds for preventing eviction on a one-time basis.

The CMU will also serve as a fiduciary in the annual Dauphin County PATH Training provided to PATH contracted agencies, staff and the homeless network.

Dauphin County is located in the South Central Pennsylvania and it is comprised of 40 scenic municipalities and is a mix of rural, urban and suburban areas. Dauphin County has an estimated population at 275,710 persons in 2017 There are 525 square miles, and the Susquehanna River is one of its borders. Dauphin County includes the City of Harrisburg, a small urban center and is also the State Capitol.

The amount of PATH funds allocated to Dauphin County MH/A/DP by the Department of Human Services (DHS) , Office of Mental Health and Substance Abuse Services (OMHSAS) in FY 2018-19 is $111,307 of which $27,827 consists of State Funds and $83,480 are Federal Funds. Dauphin County will contract with the CMU for $ 8,024 of PATH funds for these services and 25% will be State Funds and 75% will be Federal funds.

Based on data collected in the PATH Annual Report for FY 2016-17, it is projected that outreach efforts will be made to approximately 400 individuals and approximately 300 individuals will be enrolled in PATH services. Table 1 illustrates the projected enrollment and service goals in FY 19-20 for the CMU.

Table 1 – Projected PATH Services FY 2018-19 for CMU

Provider	MH/A/DP Crisis Intervention Program	Downtown Daily Bread	CMU	TOTAL
Estimated Number Outreach	150	250	Persons are enrolled with CMU	400
Estimated Number Enrolled	125	155	Referrals from Crisis/DDB or new enrollees/ 20	300
Estimated Number Literally Homeless	80 (64%)	85 (58%)	10	175 (58%)

<u>COLLABORATION WITH HUD CONTINUUM OF CARE</u>

CMU actively participates directly in various committees and activities of the Capital Area Coalition on Homelessness CACH, and is actively involved in serving the homeless community.

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CMU has extensive knowledge and expertise and collaborates effectively with traditional and non-tradition MH services.

COLLABORATION WITH LOCAL COMMUNITY ORGANIZATIONS

Dauphin County MH/A/DP 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/A/DP or PATH funded through Dauphin County MH/A/DP. Dauphin County's Medicaid behavioral health managed care organization is PerformCare, a company of AmeriHealth *Caritas*. All of the resources will be available to individuals served as needed and eligible within the limitations of available funding.

The County Department of Drugs & Alcohol Services functions as the Single County Authority (SCA) for the County and is responsible for the provision of prevention, screening, assessment, treatment, case management and recovery support services in Dauphin County for the uninsured. Most services are available and can accessed directly from private-non-profit contracted agencies. PerformCare (BH-MCO) is also responsible for maintaining a network of drug & alcohol services for Medicaid recipients. Collaboration occurs frequently between mental health and drug & alcohol service providers.

The CMU (Case Management Unit) is the MH/ID contracted agency responsible to perform the duties of the Base Service Unit and registers all individuals for county-funded mental health services. By conducting walk-in intake interviews four-days per week, mental health assessments and financial liability assessments determine eligibility and the individual's ability to participate in the cost of services, if any, according to PA regulations. The CMU also provides targeted case management services called Blended Case Management for eligible adults and children. Administrative case management and peer support are also provided by the CMU. CMU has an administrative case manager specifically to serve the homeless adult population and serves as the SSI/SSDI Outreach, Access, Recovery (SOAR) Coordinator position in Dauphin County. SOAR offers quicker access and approval of Social Security benefits and income for individuals who are homeless. SOAR is not funded with any PATH dollars.

Intensive case management services for eligible individuals in Dauphin County are available from Keystone Mental Health Services. Merakey offers an Assertive Community Treatment (ACT) Team.

The Wellspan-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, ACT, employment and social rehabilitation services. The CMU ended their CPS program in April 2019. MH/A/DP is exploring new CPS providers to serve Dauphin County residents.

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

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Medicaid HealthChoices BH-MCO contracts but not a county contract. Two clinics also have a D&A outpatient clinic license for the same site, and both offer integrated MH and D&A treatment. There are clinics that are specialized for the following populations: LGBTQI, HIV/AIDS, homeless, Evidenced based outpatient interventions, sex offenders, open access, older adults, Hispanic, dual MH/ID, and school-based. The FQHC, Hamilton Health Center also provides some outpatient services.

Merakey provides Assertive Community Treatment Team (ACT) services. Merakey, PPI, and Philhaven offer partial hospitalization services. Pennsylvania Psychiatric Institute (PPI) operates partial programs for adults, teens and children.

Dauphin County has two (2) social rehabilitation programs: Aurora Social Rehabilitation and a consumer-run drop-in center, Patch-N-Match. Keystone Service Systems operates a licensed Psychiatric Rehabilitation services which are center based and mobile.

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. Some programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

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 Merakey, Elwyn, Keystone Service Systems and Gaudenzia. Supportive living services are provided by Volunteers of America (VOA), and Keystone.

CAPSTONE, a first episode psychosis program, for person ages 16-30 began services in March 2017. CMU, YWCA and Pennsylvania Psychiatric Institute are the three (3) collaborating agencies. Case management, peer support, clinical services and supported employment/supported education are all offered.

Short-term temporary residential services are available to PATH eligible individuals until a more permanent housing solution is identified. There are two providers contracted with MH/A/DP for specialized CRR services: Merakey'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.

MH/A/DP has developed a strong collaborative working relationship with the Housing Authority of the County of Dauphin (HACD) and jointly link individuals to housing through 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/A/DP implemented a Bridge Rental Subsidy program which currently serves 18 individuals who have a serious mental illness. Through ongoing collaboration and support the

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landlord/tenant relationships have been strengthened, and there is stability in permanent housing options.

A Safe Haven (men only) program is operated by Christian Churches United and offers transitional and " housing first" living for up to 25 men. The YWCA transitioned the women's "housing first" program in 2015 to a Permanent Supportive Housing Program. This transition has significantly improved the housing services available to eight chronically homeless women by providing permanent housing to women who have struggled with maintaining self-sufficiency in our community.

HUD 811 projects in Dauphin County for potential PATH enrolled persons include Creekside Village and New Song Village ; both are operated by Volunteers of America (VOA). The programs are permanent affordable housing projects for individuals with serious mental illness.

The HUD 811 project-based vouchers are a demonstration project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) and have available safe and affordable permanent housing for individuals with disabilities. These vouchers will serve a varied group such as individuals with a physical disability, mental illness, intellectual disabilities, Autism and transition age youth with disabilities, with the priorities given to those in institutions, living in congregate living situations and those at risk of being institutionalized.

Sunflower Fields is a capital investment LIHTC housing project in Dauphin County using FY 2013-14 HealthChoices reinvestment funds. Availability of housing contingency funds and completion of PREP were positive aspects of assisting persons and families in this application/approval process. All five (5) units were occupied in FY 2017-18.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals. The employment component is called Paxton Cleaning Solutions and has competitive contracts with local companies.

Mission of Mercy provides mobile medical outreach and care to homeless individuals and those who are uninsured or underinsured to obtain appropriate medical and dental care. Catholic Charities continues to provide outpatient therapy services to individuals served by Mission of Mercy.

UPMC-Pinnacle has a medical outreach program with a registered nurse that conducts outreach to homeless individual on the street to address their medical conditions and assist in obtaining medical care and benefits.

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.

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All MH case management entities and the Crisis Intervention Program have access to consumer support and emergency housing funds available to assist individuals with first month's rent and security deposits or back rent and utilities as needed. Dauphin County continues its commitment to improving the wellness of individuals served in the MH system: ongoing information sharing on effective strategies among provider agencies to promote healthy lifestyle choices, team building on how to make lifestyle changes in group living arrangements, in addition to improved communication between primary care physicians and psychiatrists facilitated by outpatient clinics and case managers.

SERVICE PROVISION

A description of the PATH funded services provided by the CMU are listed below:

Staff Training
PATH training is selected each year by identifying the needs of PATH providers and the homeless provider network. In FY19-20 CMU will serve as the fiduciary for the Annual PATH training. In May 2019 Drexel University conducted training for 30 participants.

Screening and Assessment for PATH Eligibility and Case Management
The CMU's case management services are not funded with PATH dollars. The Outreach Specialist at Downtown Daily Bread and Crisis Intervention Program staffs work with the CMU to assure a connection is made with the mental health system for referrals for treatment and supports for individuals enrolled in PATH. Person may be referred and homeless or become homeless while already involved with the CMU. Case management services at the CMU will not be paid with PATH funds. CMU staff will screen and assess persons for PATH eligibility and provide case management services with other types of funding. However, case managers will use PATH funds to prevent homelessness or remove persons and families from a homeless circumstance using limited housing services.

Housing Services

- Security Deposits: The CMU is contracted to provide limited PATH funds to assist individuals in securing permanent housing. CIP and case management entities have additional but limited funds to provide this assistance, other than PATH funding. This service can provide quicker access to more permanent housing options for individuals, rather than relying on limited shelter space. The funding assists PATH eligible individuals with securing safe, affordable and permanent housing.
- Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: When individuals secure appropriate housing, there are additional costs associated with that housing other than security deposit or first/last month rent. Some costs may involve rental application fees, furnishings, moving expenses and establishing good credit/reducing or eliminating bad debts. CMU is contracted to provide assistance to prevent eviction and homelessness and assist individuals in securing permanent housing. CIP and all case management entities

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have access to additional, but limited funds other than PATH funds for transition purposes that result in more stable housing.

- One-time Rental Payments to Prevent Eviction: PATH enrolled individuals can receive a one-time rental assistance to prevent eviction. CMU is contracted to provide limited assistance to prevent eviction and homelessness.

MH/A/DP is a department also in the Block Grant and our office also manages MATP, HAP (Homeless Assistance Program) funds and ESG (Emergency Solutions Grant) funds. Dauphin County MH/ID administrator is also an officer in CACH (Capital Area Coalition on Homelessness) which also functions as the Local lead Agency (LLA) The mental health funds are part of the Block grant and are the largest system. Services through contracts account for 95% of the funds managed by the MH program. Administrative costs are only 5% of the MH funding in Dauphin County. The MH program is positioned to understand a wider range of funding than a typical mental health program and persons that may be PATH eligible need to access funds through other components of the homeless network funding prior to using PATH funds. For example, individuals must seek HELP Office resources for assistance with utility bills and though the LIHEAP program before seeking help from PATH providers. Another example is sharing costs of assisting a PATH eligible person in housing by agencies sharing the costs of a security deposit or providing some basic household items to establish housing.

The CMU is Dauphin County's only Base Service Unit which is wholly responsible for registering persons in the public MH system in PA regardless of insurance, etc. In PA the priority adult population group, as determined by OMHSAS, are adults with a serious mental illness or adults with an SMI and co-occurring drug & alcohol disorder. When individuals already registered in the public MH system are at risk of homelessness or are referred to the MH system for registration, CMU staff assess them for PATH eligibility based upon a MH psychosocial assessment, screening for drug & alcohol needs and identification of a working diagnosis. The intake staff and assigned MH case manager work with the person to identify needs and link them with resources both in the MH system and with other services and supports, including basic needs and housing.

CMU screens and verifies that individual is PATH eligible due to being literally homeless or at imminent risk of homelessness. A service plan is developed with the individual. In the cases of literal homelessness, housing resources are identified and the CMU may assist the person with securing housing via assistance with a rental deposit and/or the first month's rent. In the case of a person at imminent risk of homelessness, the person may identify the reason why they are at risk of losing their housing and one time limit rental assistance may help maintain housing as well as the provision of other services and supports.

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. Service gaps identified include:

- Limited availability of emergency shelter space.

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- Limited number of safe and affordable housing units, due in part to rental costs that have risen tremendously in Dauphin County, which makes it very difficult for low income and very low income individuals to afford rent.
- Programs continue to be challenged with complex mental health needs and chronic medical conditions among persons with a serious mental illness or co-occurring disorder.
- Individuals being released from the criminal justice settings are not a good fit in shelter settings or are not eligible for subsidized housing due to past criminal charges. Dauphin County has a disproportionate number of persons sent to community correctional centers and halfway houses under early release that are not Dauphin County residents.

Needs of the Co-Occurring Population

Dauphin County's mental health system is charged with assuring there are established services to meet the needs of the serious mental illness and individuals who also have substance use disorders. While the regulatory authority of services lies with both the Department of Human Services (mental health) and the Department of Drugs and Alcohol, County administered programs face challenges to implement integrated treatment model services to meet the needs of individuals with co-occurring disorders. Among individuals who are medical assistance eligible, services are administered through the same behavioral health managed care organization PerformCare.

Individuals with co-occurring disorders have access to the following array of mental health services and supports: outpatient services, partial day programs, residential services, and support services such as targeted case management, supportive living, social rehabilitation, peer support and inpatient care through county /state funding streams and Medicaid managed care. The Drug & Alcohol system is disproportionately funded at the community level and the lack of integrated treatment adds additional barriers to recovery. There are two co-occurring disorder (COD) Outpatient programs delivering integrated Mental Health and Drug & Alcohol treatment services to address the complex needs of this population.

Evidenced Based and Promising Practices

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) (a function of the CMU) is an essential first step in providing the individual access to the array of services that are available. Once registered with the BSU through walk-in access , an individual will have access to evidence based and promising practices that operate with fidelity throughout the MH system. These services can benefit literally homeless, including chronically homeless individuals and those at imminent risk of homelessness who are seeking to engage in mental health and co-occurring services.

Table 2 represents evidence based and promising practices that are available in Dauphin County currently.

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Table 2 – Evidenced Based and Promising Practices in Dauphin County

Evidenced Based and Promising Practices	Service Available in County	Staff Trained in EBP/PP	Comments
Assertive Community Treatment	Yes	Yes	Urban Team
Supported Housing	Yes	No	Two (2) providers
Supported Employment	Yes	Yes	One (1) provider
Integrated Treatment Co-Occurring (MH/SA)	Yes	Yes	Located with Two (2) OPT D & A Providers
Dialectical Behavioral Therapy	Yes	Yes	Adult and Teen models; two (2) certified providers
Mobile Psychiatric Nursing	Yes	Yes	One (1) provider
Shared Decision Making	Yes	Yes	CAPSTONE (FEP)
Psychiatric Rehabilitation	Yes	Yes	One (1) provider with Center based and Mobile
Cognitive Behavior Therapy	Yes	Yes	Multiple providers
Trauma-Focused CBT	Yes	Yes	One (1) MH provider and one (1) D&A provider
Consumer-operated Services	Yes	Yes	Drop-in Center
MHFA Adults and Children	Yes	Yes	Three (3) certified trainers
Illness Management Recovery	Yes	Yes	Four (4) providers
Certified Peer Specialist	Yes	Yes	Two (2) Free-standing services and other embedded CPS providers
Parent-Child Interaction Therapy	Yes	Yes	Two (2) certified providers
Guiding Good Choices	Yes	Yes	Parents are facilitators
First Episode Psychosis	Yes	Yes	CAPSTONE
WRAP & WRAP Facilitator	Yes	Yes	Providers have certified trainers
Family Psycho-education	Yes	Yes	NAMI Family-to-Family

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Dauphin County relies upon State and County Base MH funds to support the use of evidenced based and promising practices, as well as Medicaid managed care under HealthChoices.

PATH services are available for non-service connected veterans who may also be homeless and their families by accessing the same array of services available to any individual that is PATH eligible. In some cases, due to gaps in services, veterans and their families are served by both the MH and VA systems based on their need and eligibility for services. The County's Veteran Affairs Office annually coordinates a Stand Down program. Follow-up from an event is conducted by the CMU and Crisis Intervention Program through outreach to assist individuals in linking to needed services.

CMU embraces the Principles of Recovery and Resilience. Most activities include all stakeholders and all individualized teams supporting persons have a common message to be recovery/resiliency oriented, work with a person's strengths, consumer-driven, and emphasize the use of natural, peer,

and family support. As a Block Grant County, MH/A/DP documents their recovery and resilience priorities and activities.

MH/A/DP 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 for drug & alcohol treatment.

Dauphin County has completed the data collection and analysis for the STEPPING UP Initiative. The MH implementation phase is underway.

DATA

The Dauphin County Mental Health administration will be responsible for training CMU on the use of the Federal Homeless Management Information System (HMIS). The Capital Area Coalition on Homelessness (CACH) is the local planning group in Dauphin County and the CACH funds the HMIS training and activities around data collection. Bowman is the selected HMIS contractor. The CMU was trained in FY 2017-18.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH provider agency staff will be supported on a routine basis by Dauphin County MH administrative staff and the HMIS program administrator. Data entry and reporting issues with HMIS will continue to be addressed with HMIS Administrator in Dauphin County. Ongoing technical support is being used to further develop the data quality and integrity of the PATH data entered into HMIS.

The CoC does not have a written HMIS manual. When PATH staff were trained in HMIS they received a Powerpoint presentation. The CoC uses Bowman and the Bowman Library may have an up-to-date HMIS manual.

ALIGNMENT WITH PATH GOALS

CMU is committed to PATH goals for literally homeless persons and devotes PATH funds and other funds to this end. CMU staff focus on conducting service by face-to-face contact in any setting, CMU staff work closely and collaboratively with traditional mental health providers and the local homeless provider network as well as other local church and volunteer organizations to assist these individuals. It is clear that the most effective approach in assisting homeless individuals is ongoing and persistent contact along with building rapport and trust with individuals will has the greatest impact and success in reducing homelessness.

All PATH providers in Dauphin County are trained and supported to identify person in need due to a mental health issue who are also literally homeless or imminently homeless. OMHSAS identifies adults with a serious mental illness or an SMI and co-occurring diagnosis as the priority adult population. Our service system and interventions are focused on meeting the needs of this population. The primary child and adolescent priority population are those with a serious emotional disturbance. Dauphin County complies with OMHSAS mandates.

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ALIGNMENT WITH STATE MENTAL HEALTH SERVICES PLAN

MH/A/DP PATH providers, such as the CMU, focus and prioritize the needs of the most vulnerable individuals, especially those who experience chronic homelessness with a serious mental illness and/or co-occurring substance abuse disorder.

ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS

With the adoption of HOME RUN by the County of Dauphin and the City of Harrisburg, and the continued leadership of CACH as the Blueprint Manager, the stage has been set to make homelessness *rare, brief and non-recurring in our community*.

The 2017 Blueprint presents six (6) Primary Objectives with several strategies and action steps to achieve the U.S. Department of Housing and Urban Development's definition of "ending homelessness", where *homelessness is rare, brief, and non-recurring:*
1) Strengthen Leadership to End Homelessness;
2) Achieve a Continuum or County-Wide Coordinated Entry, Assessment and Referral System;
3) Preserve Existing, and Increase Affordable Housing Supply;
4) Ensure Access to and Availability of Supportive Services;
5) Increase Public Awareness and Education about Homelessness, the Coalition, and its resources; and
6) Prevention of Homelessness. Each Primary Objective has outcome measures based on "System Performance Measures" by the US Department of Housing and Urban Development (HUD) on how a continuum or catchment is progressing towards ending homelessness.

CACH is in the process of developing a committee to address the need to have a comprehensive disaster preparedness plan to address individuals identified as homeless and chronically homeless that reside on the streets and places unfit for habitation.

OTHER DESIGNATED FUNDS

Dauphin County has an Emergency Solutions Grant (ESG) Program authorized by subtitle B of title IV of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11371–11378). This program authorizes the Department of Housing and Urban Development (HUD) to make grants to states, units of general purpose local government, and territories for the rehabilitation or conversion of buildings for use as emergency shelters for the homeless, for the payment of certain expenses related to operating emergency shelters, for essential services related to emergency shelters and street outreach for the homeless, and for homelessness prevention and rapid re-housing assistance. Dauphin County uses this funding for rapid rehousing 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

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who meet the specific HAP program component requirements. HAP services include; bridge housing, case management, rental assistance, emergency shelter.

Dauphin County uses MH Block Grant funds to support many homeless positions in the provider network not funded by PATH dollars. Medicaid expansion has facilitated the use of HC funds to support the provision of treatment for the homeless population, including families.

Any of the above mentioned funds could intersect and support a person who is also PATH eligible. This would primarily occur in the area of rental assistance or supports to establish housing to end homelessness and may be configured on an individual basis.

Dauphin County uses MH Block Grant funds to support many homeless positions in the provider network not funded by PATH dollars. Medicaid expansion has facilitated the use of HealthChoices Medicaid funds to support the provision of treatment for the homeless population, including families. None of the programs under ESG or HAP are used for PATH services.

SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)

SOAR training was provided by OMHSAS in coordination with a SOAR Implementation Team. SOAR activities are not PATH funded in Dauphin County. The Dauphin County SOAR coordinator also manages a homeless caseload in the CMU agency. The position continues to work collaboratively with improving ongoing communication with Central Pennsylvania Legal Services, the Social Security Administration (SSA) and the Bureau of Disability Determination (BDD). All potential SOAR applicants are screened and the process has been used to secure benefits for 35 individuals since SOAR was introduced to Dauphin County in 2012. The process is very time-consuming, detail oriented and comprehensive. During FY 16-17 five (5) individuals were approved through SOAR. In FY 17-18, three (3) person were SOAR approved. 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. FY18-19 7 persons were or are being served: 4- approvals, 1 denial in the appeal process, 1 ready for submission and 1 in early application development.

PROGRAMATIC AND FINANCIAL OVERSIGHT

MH/A/DP receives state and federal funds PATH directly from the Office of Mental Health and Substance Abuse Services (OMHSAS) . The PATH funds are allocated to the subcontracted PATH providers; DDB, CMU, Crisis Intervention Services. Quarterly reviews are conducted by MH program specialist staff of HMIS data. Internal audits are conducted by MH/A/DP Fiscal Officer and PATH Financial quarterly reports are provided to the OMHSAS for review reflecting all contracted PATH funds in Dauphin County. At a minimum monthly programmatic meetings are held with the CMU staff regarding service delivery and reporting issues.

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HOUSING

PATH funds continue to assist individuals who are literally homeless, chronically homeless, and at imminent risk of homelessness in securing permanent housing. PATH services continue to remain flexible and sensitive to the unique needs of individuals. CMU provides services to build rapport and engage individuals in accessing appropriate mental health treatment and support services and available housing. Several temporary options are considered first in addressing immediate housing needs and once established can lead to a permanent housing situation.

Housing Partnerships: MH/A/DP has been working collaboratively with the following partners in developing affordable housing options for individuals with serious mental illness: CACH, Housing Authority of the County of Dauphin, Volunteers of America, and Paxton Ministries as well as new developers being established in the County. CACH is the designated Local lead Agency for Dauphin County with key responsibilities including coordination with area service providers and building owners regarding new HUD 811 projects and tax credit housing projects funded through PHFA in assuring there are eligible individuals ready to move into available units when they become available.

Volunteers of America is a longstanding provider of mental health services and a housing provider. The organization has developed two HUD 202s for low- income elderly and two HUD 811s for low-income individuals with mental health diagnoses. VOA's projects are located in Dauphin County provide safe and affordable housing and are fully occupied.

Paxton Ministries developed two (2) Community Lodges for up to eight (8) individuals. The business component is a cleaning company called Paxton Cleaning Solutions with contracts in the surrounding area.

COORDINATED ENTRY

CACH is the PA-501 Harrisburg/Dauphin County Continuum of Care and therefore, the PA-501 coordinated entry process is the same as CACH's process. CACH has the following Coordinated System of Entry and Referral for persons seeking homeless services and housing programs in the City of Harrisburg Dauphin County. CACH has developed a Coordinated Entry Referral Tool (CERT) and is used universally by any agency or person in initial contact with a homeless person or family for referral to the first proper and appropriate housing option. Once a homeless individual is identified, he or she is placed on the CEAR by names list in HMIS. The VI-SPDAT vulnerability assessment tool is used, which is completed by the provider that is in contact with the individual and a priority number is assigned based on the outcome of the VI-SPDAT assessment and data entered in HMIS. Individuals enrolled with the CMU who are chronically homeless or unsheltered and especially the Transition Age Youth (TAY) population are prioritized and entered into the Bowman HMIS system by name list that is monitored by CACH CEAR committee and remain on the list until individual has secured permanent housing.

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The CoC's VI-SPDAT assessment tool has streamlined the process of effectively screening and prioritizing individuals to access appropriate housing. The availability of housing, criminal record and interest in securing permanent housing are barriers to immediate housing PATH agencies have encountered. PATH funded agencies and all MH providers work with individuals to address barriers and create solutions to immediate needs.

MH/A/DP is involved with a CEAR Committee examining the CEAR process and making process improvement recommendations to CACH according to HUD Guidelines.

JUSTICE INVOLVED

Dauphin County has completed the data collection and analysis for the STEPPING UP Initiative. The action planning phase is underway. The stakeholders recently reviewed the recommendations and a Community Forum was held. The Action Plan should be completed in the near future.

Dauphin County has many programs that address the needs of justice involved individuals. CMU operates a Forensic Blended Case Management Unit and works closely with law enforcement, Courts and probation/parole services. Gaudenzia operates a full-care Community Residential Rehabilitation (CRR) program for 16 individuals. They serve those released from Dauphin County Prison who are actively involved in the criminal justice system. Dauphin County operates a Drug Court that has improved treatment participation and has outcomes that promote recovery.

Dauphin County Mental Health has a Jail Diversion & Reentry program. The Jail Diversion program is beneficial for avoiding or radically reducing jail time by using community-based treatment as an alternative, leading individuals with mental illness or mental illness and substance use problems away from criminal incarceration or cutting it short. The Reentry program works with individuals with a serious mental illness who are court ordered or sentenced to county jail time and connects them to community mental health services prior to or shortly after release from prison.

Dauphin County opened a judicial center for centralized booking several years ago. Pre-Trial staff screen admissions and request a MH assessment from Crisis Intervention Program staff or, if active, targeted mental health case managers. Recommendations are made to Magisterial District Justices in determining bail, release or incarceration.

Dauphin County is not required to and does not collect specific PATH data on individuals that are PATH enrolled and justice involved, however based on the statistics of the general population in Dauphin County that are justice involved it is estimated the percentage of justice involved persons is relatively high.

Dauphin County is renewing CIT training in FY19-20.

STAFF INFORMATION

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Cultural Competence is fundamental to a recovery-oriented mental health system in Dauphin County; building competence needs to be deliberate and overt. Dauphin County MH providers continue to pursue cultural competence in each of their respective agencies by utilizing their own diverse staff to conduct training as well as using outside sources to further develop the agencies overall cultural competency. The CMU has a long-standing committee focusing on cultural competence training for staff.

None of the staff hired at CMU are paid for using PATH funds, and therefore, no PATH funds are involved in hiring Certified Peer Specialists (CPS). Certified Peer Specialist are either funded by a behavioral health managed care program through HealthChoices (Medicaid) or County funded with Block Grant funds, if not MA eligible.

The CMU recruits staff representative of the community they service throughout Dauphin County. This includes bilingual/bicultural staff. Keystone Mental Health Services, Merakey, and the CMU are examples of agencies that continue to cultivate staff sensitivity to cultural and ethnic differences and have many language competencies at particular programs they operate. Mental health agencies may also use contracted interpreter services when needed. Several agencies also periodically offer staff and individuals in service training on cultural topics and skills.

A survey of the demographics of the staff hired in programs that are partially funded by PATH dollars has not been undertaken. Service providers and the County-operated Crisis Intervention Program and contracted PATH providers are encouraged to hire staff representative of the population they serve demographically by age, race/ethnicity and gender while hiring the best qualified candidate for the position. Dauphin County continues to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

CONSUMER INFORMATION

The goals for the CMU in number of adults to be PATH eligible and use Housing support services (as CMU conducts no PATH outreach) are documented. An estimated 20 persons will be enrolled by the CMU as PATH eligible and among those enrolled 10 (or 50%) will be literally homeless.

MH/A/DP anticipates the demographic profile of persons served in FY 2019-20 to be similar to the previous year's PATH annual data. The chart below illustrates the demographics of individuals served in the PATH program for FY 2016-17 (n=237).

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Table 3-PATH Consumer Information Demographics for PATH Planning

Demographic Information	FY16-17 Persons Served	FY16-17 Percentage Persons Served
Age: 18-30	62	26%
31-61+	175	74%
Gender: Male	157	66.6%
Female	79	33.3%
Race: African American	101	43%
Caucasian	131	55%
Other/not reported	5	2%
Ethnicity: Hispanic	27	11%
Non-Hispanic, Non-Latino	210	89%
Diagnosis: MH Only	107	45%
COD MH/DA	121	51%
MH and Other	9	4%
Veteran Status: Yes	9	4%
No	220	93%
Unknown	8	3%
Housing Status: Emergency Shelter/ Not meant for Habitation	127	53%
Transitional Housing	74	31%
Other	36	15%

The Capital Area Coalition on Homelessness conducted a 2018 Point in Time Survey of individuals and families who experience homelessness. There were a total of 445 men, women and children experiencing homelessness, which is a 3% decrease from 460 in 2017.

CONSUMER INVOLVEMENT

MH/A/DP is committed to having individuals in service take on leadership roles and continue to be involved in all aspects of mental health planning process. The Dauphin County Community Support Program (CSP) Committee is very involved in evaluation as well planning for mental health services and new initiatives. The CMU hosts the Dauphin County CSP Committee and several staff have served as officers. The CMU acts as their fiduciary agent.

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/A/DP Board and the Dauphin County Community Support Program (CSP) Committee. Information is incorporated into annual Block Grant Plan and an Annual Report. The Dauphin

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MH/A/DP has not taken any steps in the past to evaluate the specific PATH funded services by the individuals benefiting from them. Concerns about their privacy and guardedness are perceived to interfere with service delivery. The County's Quality Assurance staff is available to investigate complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns.

Dauphin County has two (2) 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. MH/A/DP is exploring a new CPS providers to serve Dauphin County residents.

HEALTH DISPARITIES IMPACT STATEMENT

Health disparities are not new to the Dauphin County mental health system, including for persons who are homeless, chronically homeless, or imminently homeless. Dauphin County is highly committed to addressing disparities within the County using local, State, and federal resources available to us. For the past several years, an examination of subpopulations in the county-funded system as well as in the Medicaid managed care system has been undertaken to improve the overall wellness of persons we serve. Furthermore, the relationship between health and mental health are fully understood and prioritized. The Commonwealth of Pennsylvania provides for a County-operated and managed mental health system for persons who are uninsured. While services exist, current budgetary cuts and prior cost of living increases not tied to real costs continue to impact the availability of services leading to waiting lists and the need to triage care.

The county behavioral health system is also the primary planner and implementer of service supports and rehabilitation services not funded by Medicaid and Medicare. These are typically services which support persons living in communities. In a recovery and resilience based system, these services are as important as treatment to the individual and their family. Many of our efforts have not been solely for the benefit of PATH eligible persons; however this population has benefited from these focused efforts.

Alder Health Services provides integrated physical and behavioral health services for individuals they serve. Agencies are encouraged to address coordination and communication with primary care physicians. Hamilton Health Center, a federally qualified health center, provides mental health counseling through staff LCSWs. Case management agencies focus on the referral of insured and uninsured persons to primary care programs and services, such as Mission of Mercy and Hamilton Health Center while attempting to secure benefits and insurance barriers.

MH/A/DP, 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.

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Wellness activities undertaken include efforts with the BH-MCO PerformCare: Medication Review Toolkit and Natural Supports Toolkits for family, friends and others supporting an individual with a serious mental illness. All toolkits are available on PerformCares website. Merakey has implement a Nurse Navigator Program.

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. MH/A/DP excels at finding solutions to access and service use issues within our budgetary limitations.

Information on the individuals in County-funded mental health services, including PATH eligible persons are documented annually in State reporting. PATH reporting is not integrated to the State data system and when an individual becomes registered for the provision of County-funded service there is not currently a PATH designator to track service use even though their homeless status may have improved. The system includes annual data on race, ethnicity, gender, age, income and living arrangement. Continued homelessness has not been a barrier to treatment and support access in Dauphin County while efforts continue on addressing homeless issues/status.

Dauphin County MH/ID works collaboratively with Dauphin County Area Agency on Aging on a quarterly basis to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served in both systems.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. SAMHSA PATH includes TAY persons ranging in ages from 18-30 year old age group. Transitioning young adults have unique challenges at any chronological age since their emotional and social development may have been impacted by socio-economic and mental health factors. According to Dauphin County's PATH annual report data in FY 2016-17 a total of 62 or 26% of the individuals served were between the ages of 18-30. In FY17-18 fifty (50) person were served identified as TAY. Thus far in FY18-19 forty-five (45) TAY identified persons have been served. The types of services funded by PATH for the TAY population are similar to all PATH funded services: outreach, homeless case management, and housing supports.

Dauphin County takes a flexible approach to determining with a person's support system and interagency team which system (child/adolescent or adult) may fit their needs best and how to individualized the transition period to gain the most success and recovery. Persons under the age of 18 may also be involved with a children and youth agency if they require care and supervision. Mental health treatment in Pennsylvania may be accessed by person 14 years of age and older without parental consent, however efforts are made to engage responsible adults in all aspects of treatment. Person under 18 years requiring inpatient psychiatric or medical care will require the involvement of Children & Youth and the Courts, as needed.

The JEREMY Project is operated by the CMU and designed to assist young adults ages 16-22 in transitioning from adolescence to adulthood by focusing on the transitional needs in the domains

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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 CMU Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews.– The JEREMY Project is in its 16th year of operation.

Dauphin County studied the TAY (16-22 years of age) population discharged from The JEREMY Project over the past three years. The purpose of the review was to determine if the persons being referred, served and discharged were individuals with TAY risks: exploitation/victimization, homelessness, criminal activity, not maintaining MH recovery and lacking family or natural support. MH/A/DP intends to implement changes to the eligibility for JEREMY to screen in higher risk young adults. This is a transformation priority in the Block Grant and may lead to strategic changes in the system of care of the TAY population.

Dauphin County is a Block Grant county and as such we have a planning process to determine trends and needs. An assessment of what is working and quality improvements are a daily activity in the County MH program. We are required to work within our budget. Opportunities to use reinvestment, grants and other funding streams are examined and used when appropriate keeping in mind the priority population needs and issues. In 2012 $1.9 million dollars was cut from our budget and has never been restored.

In FY 17-18 marked the first full year of implementation for CAPSTONE, a first episode psychosis (FEP) program funded by OMHSAS with federal Community Mental Health Block Grant dollars for persons ages 16-30 experiencing an initial diagnosis of a psychotic disorder. The partners include: Pennsylvania Psychiatric Institute for Team Leadership and Clinical Services, YWCA of Greater Harrisburg for Supported employment and supported education services and CMU (Case Management Unit) for targeted case management and certified peer support services.

LIMITED ENGLISH PROFICIENCY

All Dauphin County contracted providers make individual arrangement for interpreter services for languages other than English if they do not have staff that are bilingual/bicultural. All PATH services are provided on an individualized basis and contracted providers respect and are sensitive to the linguistic needs of the homeless population. The CMU uses The International Service Center and other community resources certified to assist with various language translations and interpreting to best serve those who are not proficient in English. This agency has a list of interpreters for many frequently spoken languages that we may experience in the region. Providers continue to tailor services based on individual needs as well as accommodating individuals linguistic needs in order to benefit from services provided. The CMU seeks to hire multi-lingual staff that can accommodate and further address the linguistic needs of the population they serve.

NOT FINAL

FY19-20 CMU (Case Management Unit) PATH BUDGET NARRATIVE:

Personnel: ($ 0): No CMU personnel costs are funded with PATH.

Fringe Benefits (0% and $0): No fringe benefits are funded with PATH at the CMU.

Travel ($0): No travel costs are funded by PATH at the CMU.

Equipment ($0): No PATH funds are used in this category by the CMU.

Supplies ($ 0): **Other ($7,703):** Homeless Provider Network Training ($4,480): The CMU will serve as the fiduciary for the Annual PSTH Training. One-time Rental Assistance ($1,612): This budget line represents costs incurred on behalf of PATH enrolled people for whom one-time expenditures can address literal homelessness through the CMU. Security Deposits ($1,611): This budget line represents cost in securing stable housing to resolve conditions of homelessness for enrolled PATH persons also active with the CMU.

Indirect Costs/Administrative Cost 4% @ $ 321): Four (4) percent of the PATH grant is allocated to cover administrative expenses at CMU.

Total CMU PATH Request ($ 2,006 State funds and $6,018 Federal funds) **…......……$ 8,024**

NOT FINAL

MH/A/DP
FY 2019-2020 CMU IUP PATH BUDGET

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Personnel Position				
No CMU Staff			0	0
Salary sub-total			**0**	0
Fringe Benefits (0%)				
No CMU Fringe			0	0
Fringe sub-total			**0**	**0**
Travel				
No CMU travel			0	0
Travel sub-total			0	**0**
Equipment				
No CMU equipment			0	0
sub-total			0	0
Supplies				
No CMU supplies			0	0
Supplies sub-total			0	**0**
Other				
Staff training			4,480	4,480
One-time rental assistance			1,612	1,612
Security deposits			1,611	1,611
Other sub-total				**7,703**
Indirect Administration @ 4%				**$ 321**
Total PATH Budget ($ 2,006 State funds and $6,018 Federal funds)				**$ 8,024**

NOT FINAL

Dauphin County - Downtown Daily Bread
310 N 3rd St
Harrisburg, PA 17101
Contact: Elaine Strokoff

Provider Type: Shelter or other temporary housing resource
PDX ID: PA-063
State Provider ID: 4263
Contact Phone #: 7172384717

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

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

Source(s) of Match Dollars for State Funds:

Downtown Daily Bread will receive a total of $62,229 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 250

Estimated Number of Persons to be Enrolled: 155

Estimated Number of Persons to be Contacted who are Literally Homeless: 95

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Dauphin County MH/A/DP
Downtown Daily Bread
FY 19-20 PATH Intended Use Plan

LOCAL PROVIDER DESCRIPTION

This is verification that there are no substantial changes in PATH providers, services and processes in FY2019-2020. Dauphin County changed the name of the MH/ID Program to Department of Mental Health/Autism/Developmental Programs (MH/A/DP) in early 2019.

The Dauphin County Department of Mental Health/Autism/Developmental Programs (MH/A/DP) 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 MH/A/DP 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/A/DP oversees the operations of the PATH services and is the responsible fiscal entity. The contact persons for PATH at MH/A/DP are:

Rose M. Schultz MSW	Deputy MH Administrator	717/780-7054	rschultz@dauphinc.org
Frank Magel	MH Program Specialist 2	717/780-7045	fmagel@dauphinc.org
Anne Guenin	DDB Church Administrator	717/238-4717	aguenin@pinestreet.org

Address: The Presbyterian Church of Harrisburg
Downtown Daily Bread
Boyd Building 310 North Third Street
Harrisburg, PA 17101

PDX: PA 063

With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the MH/A/DP office as OMHSAS does not have a contract directly with the Counties' PATH providers.

Dauphin County is located in the South Central Pennsylvania and it is comprised of 40 scenic municipalities and is a mix of rural, urban and suburban areas. Dauphin County has an estimated population at 275,710 persons in 2017. There are 525 square miles, and the Susquehanna River is one of its borders. Dauphin County includes the City of Harrisburg, a small urban center and is also the State Capitol.

The Presbyterian Church of Harrisburg, Downtown Daily Bread (DDB) is an emergency food kitchen that has been in operation for over 30 years at the Pine Street Presbyterian Church. There is no cost to the recipient. Lunch is served daily, including weekends and holidays. Downtown Daily Bread estimates that 25% of all the individuals they serve are homeless. The DDB definition of "homeless" describes an individual who has no permanent address and no permanent place of residence. Of these persons, some live on the streets, under bridges, in cars or in abandoned

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buildings. Others live temporarily with a relative, friend, or at a temporary shelter until their allotted time is over.

Downtown Daily Bread assists individuals with homeless needs in accessing many services including food, clothing, health care, and mental health counseling. The DDB Lunch Plus program provides information referral services, housing support, a phone, lockers, and mail service. Individuals increase their self-esteem by presenting not as homeless when applying for jobs or looking for housing. Lunch Plus allows them to present an image of being able to maintain a clean, neat appearance even in the most difficult circumstances. No other agency in Dauphin County provides this type of service. It is crucial for individuals who experience homelessness issues. A Drop-in center was added to their services for 25-40 persons per day.

Forty (40) persons were enrolled in PATH in FY16-17, substantially below PATH goals for the agency. During FY17-18 Dauphin County MH addressed PATH goals not achieved in FY16-17 by the Downtown Daily Bread outreach specialist position with DDB management. A new staff person was recruited for PATH services in FY 17-18 with more human service experience who had been employed in their drop in center program.

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/A/DP will contract with Downtown Daily Bread in FY 2019-20 using a total of $ 62,229 which consists of $ 15,557 in State Funds and $ 46,672 in Federal Funds of PATH funds for the Homeless Outreach Specialist position and related costs.

Based on data collected in the PATH Annual Report for FY 2018-19 it is projected that outreach efforts will be made to approximately 250 individuals and approximately 155 individuals will be enrolled in PATH services. Table 1 illustrates the projected enrollment and service goals in FY 19-20 by provider.

Table 1 – Projected PATH Services FY 2019-20 for Downtown Daily Bread

Provider	MH/ID Crisis Intervention Program	Downtown Daily Bread	CMU	TOTAL
Estimated Number Outreach	150	250	Persons are enrolled with CMU	400
Estimated Number Enrolled	125	155	Referrals from Crisis/DDB or new enrollees/ 20	300

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Estimated Number Literally Homeless	80	95	10	185 (61%)

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, and networking. Persons in other homeless network services may also use resources offered at DDB. CoC PDX is PA501.

COLLABORATION WITH LOCAL COMMUNITY ORGANIZATIONS

Dauphin County MH/A/DP contracts with a network of private non-profit agencies and for-profit agencies in collaboration with the CIP staff and the homeless provider network including Down town Daily Bread for uninsured individuals or services that are not eligible for Medicaid funding. There are also additional community services and supports available that are not contracted by MH/A/DPor PATH funded through Dauphin County MH/A/DP.

The County Department of Drugs & Alcohol Services functions as the Single County Authority (SCA) for the County and is responsible for the provision of prevention, screening, assessment, treatment, case management and recovery support services in Dauphin County for the uninsured. Most services are available and can accessed directly from private-non-profit contracted agencies. PerformCare (BH-MCO) is also responsible for maintaining a network of drug & alcohol services for Medicaid recipients. Collaboration occurs frequently between mental health and drug & alcohol service providers as MH case managers make many referrals for D&A services for individuals with co-occurring issues. Dauphin County MH has been assisting the County D&A Department with establishing intensive case management services.

The CMU (Case Management Unit) is the MH/A/DP contracted agency responsible to perform the duties of the Base Service Unit and registers all individuals for county-funded mental health services. By conducting walk-in intake interviews four-days per week, mental health assessments and financial liability assessments determine eligibility and the individual's ability to participate in the cost of services, if any, according to PA regulations. Downtown Daily Bread is a referral source for CMU and CMU may see enrolled persons at the DDB site.

The CMU also provides targeted case management services called Blended Case Management for eligible adults and children. Administrative case management is also provided by the CMU. CMU has an administrative case manager specifically to serve the homeless adult population and serves as the SSI/SSDI Outreach, Access, Recovery (SOAR) Coordinator position in Dauphin County.

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Intensive case management services for eligible individuals in Dauphin County are available from Keystone Service System.

Wellspan-Philhaven, and Keystone offer Certified Peer Specialist services that are approved by OMHSAS and credentialed by PerformCare (BH-MCO). Certified Peer Specialists are imbedded in Dauphin County's local psychiatric inpatient unit Pennsylvania Psychiatric Institute (PPI), psychiatric rehabilitation, employment and social rehabilitation services. There are fourteen (14) employed Certified Peer Specialist. The CMU closed the CPS program in April 2019. MH/A/DP is exploring a new CPS provider in FY19-20 for Dauphin County residents.

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. Many outpatient clinics in Dauphin County offer Tele-Psychiatry to address the demand for psychiatric services.

Some outpatient providers have unique characteristics or serve specific populations of Dauphin County residents. Two clinics also have a D&A outpatient clinic license at the same site, and both are operating COD clinics. There are clinics that are specialized for the following populations: LGBTQI, HIV/AIDS, homeless, Evidenced based outpatient interventions, sex offenders, open access, older adults, Hispanic, dual MH/ID, and school-based. The Federally Qualified Health Clinic, Hamilton Health Center also provides some outpatient services.

Merakey, PPI, and Wellspan-Philhaven offer partial hospitalization services. Pennsylvania Psychiatric Institute (PPI) operates partial programs for adults, teens and children.

Dauphin County has two (2) social rehabilitation programs: Aurora Social Rehabilitation and a consumer-run drop-in center, Patch-N-Match. Keystone Service Systems operates a licensed Psychiatric Rehabilitation services which are center based and mobile. 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 Merakey, Elwyn, (KMHS) Keystone Service Systems and Gaudenzia. Supportive Living services are provided by Volunteers of America (VOA), Keystone.

CAPSTONE, a first episode psychosis program, for person ages 16-30 began services in March 2017. CMU, YWCA and Pennsylvania Psychiatric Institute are the three (3) collaborating agencies. Case management, peer support, clinical services and supported employment/supported education are all offered.

Short-term temporary residential services are available to PATH eligible individuals until a more permanent housing solution is identified. There are two providers contracted with Dauphin County MH/A/DP for specialized CRR services: Merakey'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.

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Dauphin County PATH agencies have developed a strong collaborative working relationship with the Housing Authority of the County of Dauphin (HACD) and jointly link individuals to approved landlords that accept HUD funded Shelter + Care and Project Access vouchers. Keystone Service Systems Supportive Living Program has a designated staff that acts as a housing locator for individuals that secure HUD vouchers. Dauphin County MH/A/DP implemented a Bridge Rental Subsidy program that currently serves eighteen (18) individuals who have a serious mental illness.

Employment services in Dauphin County are comprised of varying degrees of support and independence. Competitive 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. Some programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

A Safe Haven (men only) program is operated by Christian Churches United and offers transitional and " housing first" living for up to 25 men. The YWCA transitioned the women's "housing first" program in 2015 to a Permanent Supportive Housing Program. This transition has significantly improved the housing services available to eight chronically homeless women by providing permanent housing to women who have struggled with maintaining self-sufficiency in our community.

HUD 811 projects in Dauphin County for potential PATH enrolled persons include Creekside Village and New Song Village; both are operated by Volunteers of America (VOA). These programs are permanent affordable housing projects for individuals with serious mental illness.

The HUD 811 project-based vouchers are a project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) and have available safe and affordable permanent housing for individuals with disabilities. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH).

Sunflower Fields is capital investment LIHTC housing project in Dauphin County using FY 2013-14 HealthChoices reinvestment funds. There are a total of 35 single family homes of which Dauphin County MH has preference for 5 of the homes. Availability of housing contingency funds and completion of PREP were positive aspects of assisting persons and families in this application/approval process. All five (5) units were occupied in FY 18-19.

Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals. The employment component is called Paxton Cleaning Solutions with competitive contracts in the surrounding area.

Mission of Mercy provides mobile medical outreach and care to homeless individuals and those who are uninsured or underinsured to obtain appropriate medical and dental care. Catholic Charities continues to provide outpatient therapy services to individuals served by Mission of Mercy.

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UPMC-Pinnacle operates a medical outreach program with a registered nurse that conducts outreach to homeless individual on the street to address their medical conditions and assist in obtaining medical care and benefits.

The HELP Office is the primary program for assistance with basic needs and emergency housing and is operated by Christian Churches United. Emergency shelters include: Bethesda Mission, Salvation Army, Shalom House, Interfaith Shelter and the YWCA Domestic Violence services. Several local church organizations run soup kitchens and food pantries to assist individuals in obtaining needed food.

All MH case management entities have access to consumer support and emergency housing funds available to assist individuals with first month's rent and security deposits or back rent and utilities as needed.

SERVICE PROVISION

Description of Downtown Daily Bread PATH Programs:

Outreach services, including in-reach at existing lunch and lunch plus programs, free meal sites, churches, shopping centers, food pantries, public government buildings and other sites yet to be identified where homeless individuals 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 individuals are comfortable with allows for sustained contact for rapport and trust building –key factors in working with a populations of individuals who often experience or have experienced fear and distrust of formal community institutions and services.

Screening and Assessment for Treatment at Downtown Daily Bread the Outreach Specialist is trained to screen and identify individuals that have mental health and/or co-occurring drug & alcohol needs and assist the individual with enrolling in case management services and linking them to needed MH and D&A services. The goal is to engage literally homeless individuals in treatment and supports by using engagement and relationship building strategies to identify individuals in need of mental health and/or co-occurring treatment and supports. Supports for meeting immediate needs and referrals to appropriate housing resources are made as needed. Direct face to face interactions in locations that homeless individuals frequent and are comfortable with allows for sustained contacts in order to build rapport and trust. These are key factors in working with a population of individuals who often experience or have experienced fear and distrust of formal community institutions and services. Downtown Daily Bread staff addresses an individual's basic and immediate needs first and then works toward assisting individuals in accessing additional services.

Case management services are intended to sustain the relationship built through in reach and outreach efforts and include assessment, planning and implementation of services and treatment

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in coordination with the behavioral health system and use of housing resources. Case management would be located at the areas where homeless persons frequent. Activities will be provided to assist the individual with meeting basic needs including access to showers, mail service, clothing, applications for entitlements and housing, and representative payee services. Case management will also incrementally address steps toward full use of mental health and drug & alcohol treatment and supports with extended time for processing fears and anxieties in using formal services, stigma associated with mental illness, recovery, and illness management. Additional case management services are needed to support individuals who may drop out of contact or services when scheduled appointments are the norm.

The DDB homeless outreach position will address the volume of requests for planned outreaches. Aspects of the service address problems and gaps such as: 1) the location of in reach and case management services at sites where homeless persons frequent, including outreaches to unsheltered individuals, 2) increased opportunities for rapport and relationship building important factors in post-crisis interventions, and 3) additional staff resources for case management services to conduct the needed follow-up and follow along as individuals use housing, mental health and co-occurring resources.

The DDB is positioned to understand a wider range of funding than a typical mental health program because they have been a provider in the homeless network for more than 30 years. Individuals that may be PATH eligible need to access funds through other components of the homeless network funding prior to using PATH funds. For example, individuals must seek HELP Office resources for assistance with utility bills and though the LIHEAP program before seeking help from PATH providers. Another example is sharing costs of assisting a PATH eligible individual in housing by agencies sharing the costs of a security deposit or providing some basic household items to establish housing.

Outreach in the community and in-reach in the homeless network of Dauphin County is conducted by the DDB Homeless Outreach Specialist. Individuals are screened and assessed to be determined PATH eligible based by being literally homeless or at imminent risk of homelessness and identified as experiencing a serious mental illness and/or co-occurring disorder. During the intake process which includes screening for PATH eligibility and enrollment, if eligible, demographic information, homelessness status, MH and D&A screening for PATH eligibility is completed and documented by Outreach Specialist. If an individual meet eligibility criteria and agrees to working with the DDB staff service needs are identified in MH, D&A and Housing as well as other potential areas. A service plan is developed and appropriate referrals are made. For individuals who decline enrollment or are unwilling to seek treatment services, housing and supports, the outreach worker will continue to build rapport and encourage individual toward future PATH enrollment.

<u>Service Gaps</u>

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. Service gaps identified include:

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- Limited availability of emergency shelter space.
- Limited number of safe and affordable housing units, due in part to rental costs that have risen tremendously in Dauphin County, which makes it very difficult for low income and very low income individuals to afford rent.
- Programs continue to be challenged with complex mental health needs and chronic medical conditions among persons with a serious mental illness or co-occurring disorder.
- Individuals being released from the criminal justice settings are not a good fit in shelter settings or are not eligible for subsidized housing due to past criminal charges. Dauphin County has a disproportionate number of persons sent to community correctional centers and halfway houses under early release that are not Dauphin County residents.

Needs of the Co-Occurring Population

Addressing the needs of the co-occurring population has been very challenging and complex in Pennsylvania, including Dauphin County, since the most effective treatment is to offer integrated approaches. Co-occurring training for professionals is essential for staff. The proposed consolidation of State departments under one administrative and licensing entity would help establish co-occurring services without the burden of separate administrative and licensing entities. Among individuals who are medical assistance eligible, services are administered through the same behavioral health managed care organization PerformCare.

Individuals with co-occurring disorders have access to the following array of mental health services and supports: outpatient services, partial day programs, residential services, and support services such as targeted case management, supportive living, social rehabilitation, peer support and inpatient care through county /state funding streams and Medicaid managed care. The Drug & Alcohol system is disproportionately funded at the community level and the lack of integrated treatment adds additional barriers to recovery. There are two Co-Occurring Disorder (COD) Outpatient programs in Dauphin County delivering integrated Mental Health and Drug & Alcohol treatment services to address the complex needs of this population.

Evidenced Based and Promising Practices

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) (a function of the CMU) is an essential first step in providing the individual access to the array of services that are available. Once registered with the BSU through walk-in access, an individual will have access to evidence based and promising practices that operate with fidelity throughout the MH system. These services can benefit literally homeless, including chronically homeless individuals and those at imminent risk of homelessness who we are seeking to engage in mental health and co-occurring services. Table 2 represents evidence based and promising practices that are available in Dauphin County currently.

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Table 2 – Evidenced Based and Promising Practices in Dauphin County

Evidenced Based and Promising Practices	Service Available in County	Staff Trained in EBP/PP	Comments
Assertive Community Treatment	Yes	Yes	Urban Team
Supported Housing	Yes	No	Two (2) providers
Supported Employment	Yes	Yes	One (1) provider
Integrated Treatment Co-Occurring (MH/SA)	Yes	Yes	Located with Two (2) OPT D & A Providers
Dialectical Behavioral Therapy	Yes	Yes	Adult and Teen models; two (2) certified providers
Mobile Psychiatric Nursing	Yes	Yes	One (1) provider
Shared Decision Making	Yes	Yes	CAPSTONE (FEP)
Psychiatric Rehabilitation	Yes	Yes	One (1) Provider Site and Mobile
Cognitive Behavior Therapy	Yes	Yes	Multiple providers
Trauma-Focused CBT	Yes	Yes	One (1) MH provider & one (1) D&A provider
Consumer-operated Services	Yes	Yes	Drop-in Center
MHFA Adults and Children	Yes	Yes	Three (3) certified trainers
Illness Management Recovery	Yes	Yes	Four (4) providers
Certified Peer Specialist	Yes	Yes	Two (2) Free-standing and Other Embedded CPS providers
Parent-Child Interaction Therapy	Yes	Yes	Two (2) certified providers
Guiding Good Choices	Yes	Yes	Parents are facilitators
First Episode Psychosis	Yes	Yes	CAPSTONE
WRAP & WRAP Facilitator	Yes	Yes	Providers have certified trainers
Family Psycho-education	Yes	Yes	NAMI Family-to-Family

Dauphin County relies upon State and County Base MH funds to support the use of evidenced based and promising practices, as well as Medicaid managed care under HealthChoices.

Downtown Daily Bread has the opportunity to learn more about the formal mental health and substance abuse service system and participates in training or information sessions about evidenced based practices, recovery and resiliency and promising practices which support recovery.

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) is an essential first step in providing the individual access to the array of services that are available. Once open with the BSU, an individual will have access to evidence based and promising practices that have a proven track record of success. These services which may be utilized and can benefit literally homeless individuals and those at imminent risk of homelessness who we are seeking to engage in mental health and co-occurring services.

NOT FINAL

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.

Dauphin County MH/A/DP 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 for drug & alcohol treatment, as needed, by PATH funded programs.

Dauphin County has completed the data collection and analysis for the STEPPING UP Initiative. The action planning phase is underway. The stakeholders recently reviewed the recommendations and a Community Forum was held. The Action Plan should be completed in the near future.

DATA

Downtown Daily Bread is already using HMIS to collect data under the CACH umbrella. The Capital Area Coalition on Homelessness (CACH) is the local planning group in Dauphin County and the CACH funds the HMIS training and activities around data collection. Bowman is the selected HMIS contractor. Dauphin County MH/A/DP and its PATH contracted providers have worked in conjunction with the CACH HMIS staff assuring PATH data is successfully entered into the HMIS system.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH provider agency staff will be supported on a routine by Dauphin County MH administrative staff and the HMIS program administrator. Data entry and reporting issues with HMIS will continue to be addressed with HMIS Administrator in Dauphin County. Ongoing technical support is being used to further develop the data quality and integrity of the PATH data entered into HMIS.

The CoC does not have a written HMIS manual. When PATH staff were trained in HMIS they received a PowerPoint presentation. The CoC uses Bowman and the Bowman Library may have an up-to-date user manual, but the CoC doesn't use it for training purposes.

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

NOT FINAL

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.

All PATH providers in Dauphin County are trained and supported to identify persons in need, including crisis, due to mental health issues or co-occurring MH and D&A issues who are also literally homeless and imminently homeless. OMHSAS identifies adults with a serious mental illness as the primary adult population. Our service system and interventions are all focused on meeting the needs of this population. The primary child and adolescent priority population are those with a serious emotional disturbance. Dauphin County complies with State mandates.

ALIGNMENT WITH STATE MENTAL HEALTH SERVICES PLAN

Dauphin County MH/A/DP PATH providers focus and prioritize the needs of the most vulnerable individuals, especially those who experience chronic homelessness. Street outreach is provided primarily by the Downtown Daily Bread Outreach Specialist and Crisis Intervention Program. Unfortunately, this population is one of the most challenging groups to serve due to the lack of trust with formal services that may be government-sponsored/funded and or religiously based. Dauphin County PATH providers are engaged with the ongoing efforts spearheaded by CACH to increase available resources for the homeless community.

ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS

As outlined in various sections of the comprehensive Intended Use Plan (IUP) including the individual IUPs for Downtown Daily Bread provides street outreach and focus on the most vulnerable population of homeless and chronically homeless persons in Dauphin County. This is consistent with the State's Plan to End Homelessness.

With the adoption of HOME RUN by the County of Dauphin and the City of Harrisburg, and the continued leadership of CACH as the Blueprint Manager, the stage has been set to make homelessness *rare, brief and non-recurring in our community*.

The 2017 Blueprint presents six (6) Primary Objectives with several strategies and action steps to achieve the U.S. Department of Housing and Urban Development's definition of "ending homelessness", where *homelessness is rare, brief, and non-recurring:*
1) Strengthen Leadership to End Homelessness;
2) Achieve a Continuum or County-Wide Coordinated Entry, Assessment and Referral System;
3) Preserve Existing, and Increase Affordable Housing Supply;
4) Ensure Access to and Availability of Supportive Services;
5) Increase Public Awareness and Education about Homelessness, the Coalition, and its resources; and
6) Prevention of Homelessness. Each Primary Objective has outcome measures based on "System Performance Measures" by the US Department of Housing and Urban Development (HUD) on how a continuum or catchment is progressing towards ending homelessness.

Downtown Daily Bread is well linked to supports for persons experiencing homelessness and open to serving person affect by disasters and emergencies. The Dauphin County MH/ID

NOT FINAL

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. The County MH/A/DP Administrator may also direct activation to an incident which smaller EMAs have not yet communicated. The MH/A/DP Administrator will however inform the county EMA's MH/A/DP 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.

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.

NOT FINAL

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 rapid rehousing and HMIS.

Dauphin County's Homeless Assistance Services (HAP) Program serves individuals and families whose income is below 200% of Federal Poverty level and who are homeless, near homeless, and who meet the specific HAP program component requirements. The use of data through HMIS continues to be refined. HAP providers also collaborate with CACH for the annual CACH Project Homeless Connect.

Any of the above mentioned funds could intersect and support a person who is also PATH eligible. This would primarily occur in the area of rental assistance or supports to establish housing to end homelessness and may be configured on an individual basis.

Dauphin County uses MH Block Grant funds to support many homeless services in the provider network not funded by PATH dollars. Medicaid expansion has facilitated the use of HealthChices funds to support the provision of treatment for the homeless population, including families.

SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)

The DDB homeless outreach worker maintains ongoing contact with the CMU Homeless Outreach/SOAR worker, they have the ability to identify individuals that may need assistance in

obtaining SS disability benefits in addition to MH case management services and supports. 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).

PROGRAMATIC AND FINANCIAL OVERSIGHT

Dauphin County MH/A/DP receives state and federal funds PATH directly from the Office of Mental Health and Substance Abuse services OMHSAS. These PATH funds are allocated to the subcontracted PATH providers; DDB, CMU, Crisis Intervention Services. Quarterly reviews are conducted by MH program specialist staff of HMIS data. Internal audits are conducted by MH/A/DP Fiscal Officer and PATH financial quarterly reports are provided to the OMHSAS for review reflecting all contracted PATH funds in Dauphin County. At a minimum quarterly programmatic meetings are held with the Downtown Daily Bread staff regarding service delivery and reporting issues.

HOUSING

PATH funds continue to assist individuals who are literally homeless, chronically homeless, and at imminent risk of homelessness in securing permanent housing. PATH services continue to remain flexible and sensitive to the unique needs of individuals. Downtown Daily Bread continues to provide outreach to build rapport and engage individuals in accessing appropriate mental health treatment and support services and available housing. Several temporary options are considered first in addressing immediate housing needs and once established can lead to a permanent housing situation, which include the following options:

General shelter/housing programs:

- Bethesda Mission, supplying emergency shelter services for men in some extended stay options, in the city.
- Shalom House, a shelter site available to single women and to women with children in the city.
- YWCA, providing transitional housing services for women, in the city. Provides overnight shelter for homeless women during the winter months
- Delta Housing, operated by Gaudenzia, provides transitional services in small apartment settings for women and women with children.
- Interfaith Shelter, a facility for intact families operated by Catholic Charities in the Colonial Park suburb area of Harrisburg.

Private and public resources outside the conventional human service agency framework:

- Harrisburg Housing Authority, in Harrisburg city.

NOT FINAL

- 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: MH/A/DP has been working collaboratively with the following partners in developing affordable housing options for individuals with serious mental illness. CACH is the designated Local lead Agency for Dauphin County with key responsibilities including coordination with area service providers and building owners regarding new HUD 811 projects and tax credit housing projects funded through PHFA in assuring there are eligible individuals ready to move into available units when they become available.

Three permanent housing projects in Dauphin County include: Bridge Rental Assistance program, HUD 811 rental vouchers, and Sunflower Fields, a capital investment project.

Paxton Ministries operates two (2) Community Lodges for eight (8) individuals. The business component is a cleaning company, Paxton Cleaning Solutions, with contracts in the surrounding area.

COORDINATED ENTRY

CACH is the PA-501 Harrisburg/Dauphin County Continuum of Care and therefore, the PA-501 coordinated entry process is the same as CACH's process. CACH has responsibility for the Coordinated System of Entry and Referral for persons seeking homeless services and housing programs in the City of Harrisburg Dauphin County. CACH has developed a Coordinated Entry Referral Tool (CERT) and is used universally by any agency or person in initial contact with a homeless person or family for referral to the first proper and appropriate housing option. Once an homeless individual is identified, they are placed on the CEAR by names list in HMIS. The VI-SPDAT vulnerability assessment is completed by the provider that is in contact with the individual and a priority number is assigned based on the outcome of the VI-SPDAT assessment and data entered in HMIS. Individuals who are chronically homeless or unsheltered and especially the Transition Age Youth (TAY) population are prioritized and entered into the Bowman HMIS system by name list that is monitored by CACH CEAR committee and remain on the list until individual has secured permanent housing. Several priorities are identified as Emergency shelter, chronically homeless, rural homeless, homeless veterans and those experiencing domestic violence.

The CoC's VI-SPDAT assessment tool has streamlined the process of effectively screening and prioritizing individuals to access housing. The availability of housing, criminal record, and interest in securing permanent housing are barriers to immediate housing that PATH agencies have

NOT FINAL

encountered. PATH funded programs and all MH providers work with individuals to address barriers and create solutions to immediate needs.

JUSTICE INVOLVED

Downtown Daily Bread provides PATH funded services to criminal justice involved individuals. Additionally, DDB has a number of contacts 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 completed the data collection and analysis for the STEPPING UP Initiative. The action planning phase is underway. The stakeholders recently reviewed the recommendations and a Community Forum was held. The Action Plan should be completed in the near future.

Dauphin County is renewing CIT Training in FY19-20.

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.

There are no employed Certified Peer Specialists working in any PATH funded services using PATH funds.

Downtown Daily Bread (DDB) has a diverse staff working in their soup kitchen and support program. 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.

During FY17-18 through discussions with Downtown Daily Bread , PATH goals were reviewed and were not meeting standards. Downtown Daily Bread sought out new staff to lead their PATH funded services and a new staff person was hired in April 2018. The newly hired individual, DDB Outreach Specialist, has experience working with a diverse population of individuals experiencing homelessness. The person hired volunteered in the DDB drop-in center.

Dauphin County will continue to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

NOT FINAL

CONSUMER INFORMATION

The Downtown Daily Bread PATH goals reflect a number of adults to be outreached , expected number to be enrolled and percentage to be literally homeless being served with PATH Funds. In FY19-20 DDB projected PATH services are 250 outreached, 155 enrolled and 95 person to be literally homeless.

MH/A/DP anticipates the demographic profile of persons served in FY 2019-20 to be similar to the previous year's PATH annual data. The chart below illustrates the demographics of individuals served in the PATH program for FY 2016-17(n=237)

Table 3-PATH Consumer Information Demographics for PATH Planning

Demographic Information	FY16-17 Persons Served	FY16-17 Percentage Persons Served
Age: 18-30 31-61+	62 175	26% 74%
Gender: Male Female	157 79	66.6% 33.3%
Race: African American Caucasian Other/not reported	101 131 5	43% 55% 2%
Ethnicity: Hispanic Non-Hispanic, Non-Latino	27 210	11% 89%
Diagnosis: MH Only COD MH/DA MH and Other	107 121 9	45% 51% 4%
Veteran Status: Yes No Unknown	9 220 8	4% 93% 3%
Housing Status: Emergency Shelter/ Not meant for Habitation Transitional Housing Other	127 74 36	53% 31% 15%

The Capital Area Coalition on Homelessness conducted a 2018 Point in Time Survey of individuals and families who experience homelessness. There were a total of 445 men, women and children experiencing homelessness, which is a 3% decrease from 460 in 2017.

NOT FINAL

CONSUMER INVOLVEMENT

Downtown Daily Bread has homeless and formerly homeless volunteers that assist with various operations of the homeless services offered, such as with the drop in center operations and with the homeless outreach specialist to provide assistance and to identify locations typically not known by the outreach worker. In allowing volunteers to assist with services has proved beneficial in providing feedback from individuals that receive services offered by the program.

HEALTH DISPARITIES IMPACT STATEMENT

Health disparities are not new to the Dauphin County mental health system, including for persons who are homeless, chronically homeless, or imminently homeless. Dauphin County is highly committed to addressing disparities within the County using local, State, and federal resources available to us. For the past several years, an examination of subpopulations in the county-funded system as well as in the Medicaid managed care system has been undertaken to improve the overall wellness of persons we serve. Furthermore, the relationship between health and mental health are fully understood and prioritized. The Commonwealth of Pennsylvania provides for a County-operated and managed mental health system for persons who are uninsured. While services exist, current budgetary cuts and prior cost of living increases not tied to real costs continue to impact the availability of services leading to waiting lists and the need to triage care.

The County behavioral health system is also the primary planner and implementer of service supports and rehabilitation services not funded by Medicaid and Medicare. These are typically services which support persons living in communities. In a recovery and resilience based system, these services are as important as treatment to the individual and their family. Many of our efforts have not been solely for the benefit of PATH eligible persons; however this population has benefited from these focused efforts.

The Outreach Specialist position at Downtown Daily Bread specifically was established because we found that persons needed a community-based agency for outreach, including in reach. The County's Crisis Intervention Program was too much associated with inpatient psychiatric assessments to function as the sole outreach program for PATH. A specialty psychiatric clinic for persons who are homeless is monitored for access and the consistent issue has been follow-up appointments and locating unsheltered persons for subsequent appointments.

Wellness activities undertaken include efforts with the BH-MCO PerformCare: A Medication Review Toolkit and Natural Supports Toolkits for family, friends and others supporting an individual with a serious mental illness were developed in the past few years. All toolkits are available on PerformCare's website. Merakey has implemented a Nurse Navigator Program.

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.

NOT FINAL

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.

MH/A/DP works collaboratively with Dauphin County Area Agency on Aging on a quarterly basis to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served in both systems.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. SAMHSA PATH includes TAY persons ranging in ages from 18-30 year old age group. Transitioning young adults have unique challenges at any chronological age since their emotional and social development may have been impacted by socio-economic and mental health factors.

Keystone Service Systems operates a 3 bed max-care residential program for Transition Age Adults ages 18-26, which was developed to address the complex needs of this priority population.

According to Dauphin County's PATH annual report data in FY 16-17 a total of 62 or 26% of the individuals served were between the ages of 18-30. The types of services funded by PATH for the TAY population are similar to all PATH funded services: outreach, homeless case management, and housing supports. In FY17-18 PATH reporting, fifty (50) persons identified as TAY were served. A total of forty-five (45) have been served in FY18-19. Downtown Daily Bread in FY 18-19 served 4 TAY identified persons and expended $777 to support them.

The types of services funded by PATH for the TAY population are similar to all PATH funded services: outreach, homeless case management, and housing supports.

Dauphin County is a Block Grant county and as such we have a planning process to determine trends and needs. An assessment of what is working and quality improvements are a daily activity in the County MH Program. We are required to work within our budget. Opportunities to use reinvestment, grants and other funding streams are examined and used when appropriate keeping in mind the priority population needs and issues. In 2012 $1.9 million dollars was cut from our budget and has never been restored.

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.

NOT FINAL

The JEREMY Project is operated by the CMU and 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 CMU Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews.– The JEREMY Project is in its 16th year of operation. A review of The JEREMY Project was undertaken in 2017 and recommended modifications to the eligibility will be implemented in FY19-20 and screen in more at risk young adults. The risk factors during transition such as homelessness, criminal activity, isolation, drug & alcohol use, family conflicts and poor peer relationships may be addressed through The JEREMY Project.

In FY 17-18 marked the first full year of implementation for CAPSTONE, a first episode psychosis (FEP) program funded by OMHSAS with federal Community Mental Health Block Grant dollars for persons ages 16-30 experiencing an initial diagnosis of a psychotic disorder. The partners include: Pennsylvania Psychiatric Institute for Team Leadership and Clinical Services, YWCA of Greater Harrisburg for Supported employment and supported education services and CMU (Case Management Unit) for targeted case management and certified peer support services.

LIMITED ENGLISH PROFICIENCY

All Dauphin County contracted providers make individual arrangement for interpreter services for languages other than English if they do not have staff that are bilingual/bicultural. PATH providers use The International Service Center to assist with various language translations and interpreting to best serve those who are not proficient in English. Providers continue to tailor services based on individual needs as well as accommodating individual linguistic needs in order to benefit from services provided.

FY 19-20 DOWNTOWN DAILY BREAD PATH BUDGET NARRATIVE:

Personnel: ($ 40,000): Salary of the Full-Time Equivalent (FTE) position as an Outreach Specialist for a twelve month period.

Fringe Benefits (40.6%% percent of salary or $16,240): FICA tax, Health insurance, retirement/pension costs are included in the fringe benefit costs for the Downtown daily Bread position.

Travel ($2,000): Travel costs for the Outreach Specialist are factored at 51 cents per mile for 52 miles per month for a total of three hundred and twenty dollars and parking costs.

Equipment ($0): Equipment totals include the purchase of a laptop computer, notebook and software. Office furniture and a locked file cabinet. Office furniture will be all located in a setting where literally homeless persons frequent.

NOT FINAL

Supplies ($ 1,500): Costs of supplies to be applied to this PATH grant are solely those related to the basic and re(habilitative) needs of PATH eligible consumers. Among supplies anticipated are small stocks of non-perishable food items, clothing and blankets, as well as public transportation bus passes.

Other ($0): Staff Training and Homeless Provider Network Training ($0) Training is hosted for PATH contracted providers and the homeless network. One-time Rental Assistance ($0): This budget line represents costs incurred on behalf of PATH eligible people for whom one-time expenditures can address literal homelessness. Security Deposits ($0): This budget line represents a special cost in securing stable housing to resolve conditions of homelessness.

Indirect Costs/Administrative Cost 4% @ $2,489): Four (4) percent of the PATH grant is allocated to cover administrative expenses at Downtown Daily Bread.

Total Downtown Daily Bread PATH Request……………………………………$ 62,229

($ 15,557 State funds and $46,672 Federal funds)

NOT FINAL

Dauphin County MH/A/DP
FY2019-2020 PATH Downtown Daily Bread IUP Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Personnel Position				
DDB Outreach Specialist	40,000	100%	40,000	40,000
Salary sub-total			***40,000***	**40,000**
Fringe Benefits (45.8%)				
DDB Outreach Spec (40.6%)				
FICA, Health, Ret/pens			16,240	16,240
Fringe sub-total			16,240	**16,240**
Travel				
Local Travel for Outreach DDB and parking			2,000	2,000
Travel sub-total			2,000	**2,000**
Equipment				
(list individually)			0	0
sub-total			0	0
Supplies				
Consumer-related items			1,500	1,500
Supplies sub-total			1,500	**1,500**
Other				
Staff training			0	0
One-time rental assistance			0	0
Security deposits			0	0
Independent Living Resource			0	0
Other sub-total			0	**0**
Indirect Administration @ 4%				**2,489**
Total PATH Budget ($ 15,557 State funds and $46,672 Federal funds)				**$ 62, 229**

NOT FINAL

Dauphin County MH/ID Crisis Intervention
100 Chestnut Street
Harrisburg, PA 17101
Contact: Frank Magel

Provider Type: Social service agency
PDX ID: PA-006
State Provider ID: 4206
Contact Phone #: 7177807045

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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

NOT FINAL

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**none**
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Dauphin Co: Crisis Intervention will receive a total of $41,054 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 150

Estimated Number of Persons to be Enrolled: 125

Estimated Number of Persons to be Contacted who are Literally Homeless: 80

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Dauphin County MH/A/DP
Crisis Intervention Program
FY 19-20 PATH Intended Use Plan

LOCAL PROVIDER DESCRIPTION

This is verification that there are no substantial changes in PATH providers, services and processes in FY2019-2020. Dauphin County changed the name of the MH/ID Program to Department of Mental Health/Autism/Developmental Programs (MH/A/DP) in early 2019. All updated information requested by OMHSAS has been incorporated in this submission (highlighted).

The Dauphin County Department of Mental Health/Autism/Developmental Programs 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 MH/A/DP is a department within the County of Dauphin and is the local recipient of the Commonwealth's allocation of PATH funds. MH/A/DP oversees the operations of the PATH services and is the responsible fiscal entity. The contact persons for PATH at MH/A/DP are:

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With all PATH contracted agencies, Dauphin County prefers OMHSAS works through the County MH/A/DP 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/A/DP and is an important provider of PATH services. The CIP program is most frequent point of first contact for PATH funded services to individuals with a serious mental illness and/or a co-occurring disorder and homelessness. Services include but are not limited to 24-hour, 7 day per week availability via telephone, walk in or mobile outreach to individuals experiencing a crisis. The CIP provides MH assessments, brief counseling, service planning and referral information as well as MH stabilization. Agreements are in place with our local case management entities establishing roles and responsibilities in response to emergencies for individuals currently enrolled in services with the Base Service Unit. For individuals in which a language is a barrier to services, the CIP utilizes the Language Line to meet linguistic needs and they have one bilingual/bicultural Hispanic staff.

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Dauphin County is located in the South Central Pennsylvania and it is comprised of 40 scenic municipalities and is a mix of rural, urban and suburban areas. Dauphin County has an estimated population at 275,710 persons in 2017. There are 525 square miles, and the Susquehanna River is one of its borders. Dauphin County includes the City of Harrisburg, a small urban center and is also the State Capitol.

The amount of PATH funds allocated to Dauphin County MH/A/DP by the Department of Human Services (DHS), Office of Mental Health and Substance Abuse Services (OMHSAS) in FY 2019-20 is $111,307 of which $27,827 consists of State Funds and $83,480 are Federal Funds. The amount of PATH funds designated for Dauphin County MH/A?DP's Crisis Intervention Program for FY 2019-20 is $41,054 of which $10,263 is State Funds and $30,791 are Federal Funds.

Based on data collected in the PATH Annual Report for FY 2017-18, it is projected that outreach efforts will be made to approximately 150 individuals and approximately 125 individuals will be enrolled in PATH services. Table 1 illustrates the projected enrollment and service goals in FY 19-20 for Crisis Intervention Program and other PATH providers.

Table 1 – Projected PATH Services FY 2019-20 for Dauphin County MH/A/DP Crisis Intervention Program

Provider	MH/A/DP Crisis Intervention Program	Downtown Daily Bread	CMU	TOTAL
Estimated Number Outreach	150	250	Persons are enrolled with CMU	400
Estimated Number Enrolled	125	155	Referrals from Crisis/DDB or new enrollees/ 20	300
Estimated Number Literally Homeless	80	95	10	185 (61%)

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COLLABORATION WITH HUD CONTINUUM OF CARE

The Dauphin County MH/A/DP 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. CoC PDX # is PA501.

Dauphin County MH/A/DP and PATH providers participate directly in several CACH committees. MH/A/DP collaborates in many CACH activities such as the point in time surveys and networking. CACH is designated the Local Lead Agency (LLA) for Dauphin County by Department of Human Services and PHFA (PA Housing Finance Agency) to assist with the development and monitoring of the HUD 811 PRA demonstration project awarded in 2015. At this present time, we cannot determine how many persons with a serious mental illness in Dauphin County have been successfully served.

COLLABORATION WITH LOCAL COMMUNITY ORGANIZATIONS

MH/A/DP 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/A/DP or PATH funded through Dauphin County MH/A/DP.

Dauphin County's Medicaid behavioral health managed care organization is PerformCare, a company of AmeriHealth *Caritas*. All of the resources will be available to individuals served as needed and eligible within the limitations of available funding. Dauphin County's Crisis Intervention program is a PerformCare network provider and is fully licensed by OMHSAS.

The County Department of Drugs & Alcohol Services functions as the Single County Authority (SCA) for the County and is responsible for the provision of prevention, screening, assessment, treatment, case management and recovery support services in Dauphin County for the uninsured. Most services are available and can accessed directly from private-non-profit contracted agencies. PerformCare (BH-MCO) is also responsible for maintaining a network of drug & alcohol services for Medicaid recipients. Collaboration occurs frequently between mental health and drug & alcohol service providers. Dauphin County MH has been working with the Drug & Alcohol Department to establish D&A case management services.

The CMU (Case Management Unit) is the MH/A/DP contracted agency responsible to perform the duties of the Base Service Unit and registers all individuals for county-funded mental health services. Walk-in intake interviews are available four-days per week. These include mental health and financial liability assessments to determine eligibility and the individual's ability to participate in the cost of services, if any, according to State regulations.

The CMU also provides targeted case management services called Blended Case Management for eligible adults and children. Administrative case management is also provided by the CMU. CMU has an administrative case manager specifically to serve the homeless adult population and serves as the SSI/SSDI Outreach, Access, Recovery (SOAR) Coordinator position in Dauphin County. No PATH funded staff were trained in SOAR and there is no plan to do so at this time. SOAR is not funded with PATH dollars. The current Homeless MH case manager has adequately met this demand. Intensive case management services for eligible individuals in Dauphin County are available from Keystone Service System. Merakey offers Assertive Community Treatment (ACT) Team services for about 120 persons per year.

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Wellspan-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), ACT, psychiatric rehabilitation, employment and social rehabilitation services. There are fourteen (14) Certified Peer Specialist working in Dauphin County.

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.. Many outpatient clinics in Dauphin County offer Tele-psychiatry to address the demand for Psychiatric services.

Some outpatient providers have unique characteristics or serve specific populations of Dauphin County residents. There are also several licensed psychiatric outpatient clinics that have a Medicaid HealthChoices BH-MCO contracts but not a county contract. Two of the clinic have a D&A outpatient clinic at the same site, and both have COD clinics offering integrated MH and D&A treatment. There are clinics that are specialized for the following populations: LGBTQI, HIV/AIDS, homeless, Evidenced based outpatient interventions, sex offenders, open access, older adults, Hispanic, dual MH/ID, and school-based. The Federally Qualified Health Center, Hamilton Health Center, also provides some outpatient services.

Merakey, PPI, and Wellspan-Philhaven offer partial hospitalization services. Pennsylvania Psychiatric Institute (PPI) operates partial hospitalization programs for adults, teens and children.

Dauphin County has two (2) social rehabilitation programs: Aurora Social Rehabilitation and a consumer-run drop-in center, Patch-N-Match. Keystone Service Systems operates a licensed Psychiatric Rehabilitation service that is center-based and mobile services, which is Medicaid funded.

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. Some programs also work with the PA Office of Vocational Rehabilitation (OVR) for employment and training funding.

Community Residential Rehabilitation (CRR) services offer many choices to individuals to gain independence skills 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 Merakey, Elwyn, Keystone Service Systems and Gaudenzia. Supportive living services are provided by Volunteers of America (VOA), Keystone.

CAPSTONE, a first episode psychosis program, for person ages 16-30 began services in March 2017. CMU, YWCA and Pennsylvania Psychiatric Institute are the three (3) collaborating agencies. Case management, peer support, clinical services and supported

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employment/supported education are all offered. CAPSTONE is trying to expand its catchment area to include Cumberland/Perry MH/DD.

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: Merakey's Windows Program in Harrisburg, and Community Services Group (CSG), Crisis and Diversion Program in the Steelton community. Both programs provide short-term 45-day residential support with a capacity of 24 persons and two (2) 5-day crisis beds with 24-hour, 7-day per week staff oversight. Dauphin County's Crisis Intervention Program and case management entities have 24/7 access to these services.

Dauphin County MH/A/DP 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. MH/A/DP implemented a Bridge Rental Subsidy program and currently serves eighteen (18) 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.

A Safe Haven (men only) program is operated by Christian Churches United and offers transitional and " housing first" living for up to 25 men. The YWCA transitioned the women's safe haven program in 2015 to a Permanent Supportive Housing Program. This transition has significantly improved the housing services available to eight chronically homeless women by providing permanent housing to women who have struggled with maintaining self-sufficiency in our community.

HUD 811 projects in Dauphin County for potential PATH enrolled persons include Creekside Village is located in Lower Paxton Township and New Song Village is located in Swatara Township; both are operated by Volunteers of America (VOA). These programs are permanent affordable housing projects for individuals with serious mental illness.

The HUD 811 project-based vouchers are a project in collaboration with Pennsylvania Housing Finance Agency (PHFA) and PA Department of Humans Services (DHS) and have available safe and affordable permanent housing for individuals with disabilities. The referral and eligibility process is monitored by the Local Lead Agency (LLA), Capital Area Coalition on Homelessness (CACH).

Sunflower Fields is a capital investment LIHTC housing project in Dauphin County using FY 2013-14 HealthChoices reinvestment funds. There are a total of 35 single family homes of which Dauphin County MH has preference for 5 of the homes. All five units were occupied in FY17-18. Availability of housing contingency funds and completion of PREP were positive aspects of assisting persons and families in this application/approval process.

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Paxton Ministries supports two (2) Community Lodge programs in Dauphin County for up to eight (8) individuals. The employment component is called Paxton Cleaning Solutions with competitive contracts in the surrounding area.

For several years, UPMC-Pinnacle has operated a medical outreach program which has a registered nurse that conducts outreach to homeless individual on the street to address their medical conditions and assist in obtaining medical care and benefits.

Mission of Mercy provides mobile medical outreach and care to homeless individuals and those who are uninsured or underinsured to obtain appropriate medical and dental care. Catholic Charities also provides outpatient therapy services to individuals served by Mission of Mercy.

The HELP Office is the primary program for assistance with basic needs and emergency housing and is operated by Christian Churches United. Emergency shelters include: Bethesda Mission, Salvation Army, Shalom House, Interfaith Shelter and the YWCA Domestic Violence services. Several local church organizations run soup kitchens and food pantries to assist individuals in obtaining needed food. Dauphin County's Crisis Intervention Program is the link to the emergency resources after hours for the homeless network in Dauphin County.

The Crisis Intervention Program and all MH case management entities have access to consumer support and emergency housing funds available to assist individuals with first month's rent and security deposits or back rent and utilities as needed. Dauphin County continues its commitment to improving the wellness of individuals served in the MH system: ongoing information sharing on effective strategies among provider agencies to promote healthy lifestyle choices, team building on how to make lifestyle changes in group living arrangements, in addition to improved communication between primary care physicians and psychiatrists facilitated by outpatient clinics and case managers.

SERVICE PROVISION

A detailed description of the PATH funded services are listed below specific to Dauphin County Crisis Intervention Program:

Outreach Services

Dauphin County Crisis Intervention Program (CIP) is a licensed Crisis Intervention Program by the Commonwealth of Pennsylvania to provide mobile, telephone, and walk-in services and in the course of their outreach in the community will identify persons with a serious mental illness and/or a serious mental illness and a co-occurring drug and alcohol disorder experiencing literal homelessness or imminent homelessness. PATH eligible individuals may be identified by providers, community hospitals, businesses or residents and referred to Crisis. Individuals may be self-referred or referred by others, including law enforcement, healthcare personnel, and concerned individuals. CIP also conducts homeless outreach unsolicited by referral sources. CIP determines PATH eligibility though a psychosocial interview and provides an initial screening on housing status, mental health status, service planning, information and referrals.

Screening and Assessment for treatment services

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During the outreach contact Crisis Intervention Program (CIP) performs initial assessments of individuals related to their general welfare, mental health status, basic needs, and housing needs. Crisis intervention Program staff undergo a rigorous training which includes an ability to identify mental health disorders, particularly those encompassed in the States priority population of persons with a serious mental illness. Person are engaged to understand about housing resources and MH/D&A treatments and supports. Persons are encouraged to be voluntarily involved in PATH funds services and supports through enrollment with HCIS and PATH service planning. CIP emphasizes having immediate needs met and are referred to other supports and services to have other needs met. Following an outreach and enrollment, many individuals are referred to the CMU to be registered in the MH system and referred for additional supportive services as needed. Individuals needing emergency psychiatric treatment will be assessed by CIP and referred to appropriate settings as needed.

Case Management

Case management services provided by Crisis Intervention Program staff are intended to sustain the relationship built through outreach/in reach efforts through the assessment, planning and implementation of services and treatment and housing resources. Services are provided to assist individuals in meeting their immediate basic needs including; meals, access to showers, mail service, clothing, applications for entitlements, housing, and other requested services. Case management will develop rapport and build relationships with individuals and demonstrate sensitivity to the fears and anxieties in using formal services, stigma associated with mental illness, trauma, recovery, and illness management. The goal of case management at Crisis is to engage persons in meeting their basic needs, as well as addressing mental health and/or drug& alcohol concerns through referrals for treatment and recovery supports. The Crisis Intervention Program staff work with the CMU to assure a connection is made with the mental health system for treatment and supports for individuals enrolled in PATH.

Housing Services

Dauphin County continues to offer a way to individualize our responses to the housing challenges faced by PATH eligible persons.

- Technical Assistance in Applying for Housing Services: Knowledge and understanding of the complex application process and the documents required to apply for subsidized housing, can be difficult for individuals. Assistance is available to PATH eligible individuals in identifying available housing resources, completing applications and accessing the documentation necessary to successfully secure affordable housing subsidies. Case managers and supportive living staff are well-informed about housing resources both public and private, short term and long-term. Their technical knowledge is used with individuals to develop housing plans and put those plans into action. Crisis Intervention Program, Downtown Daily Bread, CMU and other mental health agencies continue to participate in Project CONNECT events. Dauphin County MH staff have been instrumental in improving technical assistance on applying for Housing as well as the Dauphin County LLA.

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- Improving the Coordination of Housing Services: Ongoing coordination and collaboration within the homeless service network, CACH and mental health providers for PATH enrolled individuals continue to be developed. Dauphin County Crisis Intervention program is involved with Housing/Homeless network and CACH. Relationships with landlords, shelters, other housing programs, churches and community agencies are essential in meeting the needs of individuals or families who are literally homeless, chronically homeless, or at imminent risk of homelessness. Dauphin County utilizes the revised landlord-tenant protocol developed by the Dauphin County Local Housing Options Team (LHOT). Crisis Intervention Program is the primarily contact 24/7 for landlords and property managers looking for assistance to prevent homelessness or eviction. CACH, the designated Local Lead Agency, in collaboration with the PHFA Regional Housing Coordinator provides ongoing information regarding newly developed housing projects in the area and alerts providers and individuals they serve in the system on location of the properties and the application process to apply for these available units and maintains MOU's with referring provider agencies.
- Security Deposits: CIP and case management entities have additional but limited funds to provide this assistance with PATH funding. This service can provide quicker access to more permanent housing options for individuals, rather than relying on limited shelter space. The funding assists PATH eligible individuals with securing safe, affordable and permanent housing.
- Costs Associated with Matching Eligible Homeless Individuals with Appropriate Housing Situations: When individuals secure appropriate housing, there are additional costs associated with that housing other than security deposit or first/last month rent. Some costs may involve rental application fees, furnishings, moving expenses and establishing good credit/reducing or eliminating bad debts. CIP and all case management entities have access to PATH funds for transition purposes that result in more stable housing.
- One-time Rental Payments to Prevent Eviction: PATH enrolled individuals can receive a one-time rental assistance to prevent eviction. CIP and all case management entities have access to PATH for preventing eviction on a one-time basis.

Service Gaps

Dauphin County MH/A/DP is a department also in the Block Grant and our office also manages MATP, HAP (Homeless Assistance Program) funds and ESG (Emergency Solutions Grant) funds. Dauphin County MH/ID administrator is also an officer in CACH (Capital Area Coalition on Homelessness) which also functions as the Local lead Agency (LLA). The mental health funds managed through the Block grant constitute the majority of the Block Grant funding. 95% of the MH funds are spent directly on services and administrative costs are only 5% of the MH funding in Dauphin County. The MH Program is positioned to understand a wider range of funding than a typical mental health program and persons that may be PATH eligible need to access funds through other components of the homeless network funding prior to using PATH funds. For example, individuals must seek HELP Office resources for assistance with utility bills and though the LIHEAP program before seeking help from PATH providers. Another example is sharing

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costs of assisting a PATH eligible person in housing by agencies sharing the costs of a security deposit or providing some basic household items to establish housing.

PATH-funded services continue to be flexible and address the unique needs of the homeless individuals served in Dauphin County. However, there are service gaps where capacity does not meet demand. The needs of homeless individuals for psychiatric services are prioritized along with several additional target groups such as persons with forensic involvement and acute inpatient discharges in order to prevent readmissions. Additional service gaps identified include:

- Limited availability of emergency shelter space.
- Limited number of safe and affordable housing units, due in part to rental costs that have risen tremendously in Dauphin County, which makes it very difficult for low income and very low income individuals to afford rent.
- Programs continue to be challenged with complex mental health needs and chronic medical conditions among persons with a serious mental illness or co-occurring disorder.
- Individuals being released from the criminal justice settings are not a good fit in shelter settings or are not eligible for subsidized housing due to past criminal charges. Dauphin County has a disproportionate number of persons sent to community correctional centers and halfway houses under early release that are not Dauphin County residents. The DOC also discharges persons to shelters when the person is not cooperating with discharge planning or really comes from or was convicted in other Counties.

Needs of the Co-Occurring Population

Addressing the needs of the co-occurring population has been very challenging and complex in Pennsylvania, including Dauphin County, since the most effective treatment is to offer integrated approaches. Co-occurring training for professionals is essential for staff. The proposed consolidation of State departments under one administrative and licensing entity would help establish co-occurring services without the burden of separate administrative and licensing entities.

Dauphin County mental health system is charged with assuring there are established services to meet the needs of the serious mental illness and individuals who also have substance use disorders. While the regulatory authority of services lies with both the Department of Human Services (mental health) and the Department of Drugs and Alcohol, County administered programs face challenges to implement integrated treatment model services to meet the needs of individuals with co-occurring disorders. Among individuals who are medical assistance eligible, services are administered through the same behavioral health managed care organization PerformCare.

Individuals with co-occurring disorders have access to the following array of mental health services and supports: outpatient services, partial day programs, residential services, and support services such as targeted case management, supportive living, social rehabilitation, peer support and inpatient care through county /state funding streams and Medicaid managed care. The Drug & Alcohol system is disproportionately funded at the community level and the lack of integrated treatment adds additional barriers to recovery

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Evidenced Based and Promising Practices

In order to receive and have access to most mental health services in Dauphin County, registration with the Base Service Unit (BSU) (a function of the CMU) is an essential first step in providing the individual access to the array of services that are available. Once registered with the BSU through walk-in access, an individual will have access to evidence based and promising practices that operate with fidelity throughout the MH system. These services can benefit literally homeless, including chronically homeless individuals and those at imminent risk of homelessness who we are seeking to engage in mental health and co-occurring services. Table 2 represents evidence based and promising practices that are available in Dauphin County currently.

Table 2 – Evidenced Based and Promising Practices in Dauphin County

Evidenced Based and Promising Practices	Service Available in County	Staff Trained in EBP/PP	Comments
Assertive Community Treatment	Yes	Yes	Urban Team
Supported Housing	Yes	No	Two (2) providers
Supported Employment	Yes	Yes	One (1) provider
Integrated Treatment Co-Occurring (MH/SA)	Yes	Yes	Located with Two (2) D & A Outpatient Providers
Dialectical Behavioral Therapy	Yes	Yes	Adult and Teen models; two (2) certified providers
Mobile Psychiatric Nursing	Yes	Yes	One (1) provider
Shared Decision Making	Yes	Yes	CAPSTONE (FEP)
Psychiatric Rehabilitation	Yes	Yes	One (1) provider Site and Mobile
Cognitive Behavior Therapy	Yes	Yes	Multiple providers
Trauma-Focused CBT	Yes	Yes	One (1) MH provider and One (1) D&A provider
Consumer-operated Services	Yes	Yes	Drop-in Center
MHFA Adults and Children	Yes	Yes	Three (3) certified trainers
Illness Management Recovery	Yes	Yes	Four (4) providers
Certified Peer Specialist	Yes	Yes	Two (2) Free-standing and Other Embedded CPS services
Parent-Child Interaction Therapy	Yes	Yes	Two (2) certified providers
Guiding Good Choices	Yes	Yes	Parents are facilitators
First Episode Psychosis	Yes	Yes	CAPSTONE
WRAP & WRAP Facilitator	Yes	Yes	Providers have certified trainers
Family Psycho-education	Yes	Yes	NAMI Family-to-Family

Dauphin County relies upon State and County Base MH funds to support the use of evidenced based and promising practices, as well as Medicaid managed care under HealthChoices.

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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. Follow up includes: further outreach and engagement activities are provided to individuals to assist linking them to needed and requested services.

Dauphin County Crises Intervention Program embraces the Principles of Recovery and Resilience. Most activities include all stakeholders and all individualized teams supporting persons have a common message to be recovery/resiliency oriented, work with a person's strengths, consumer-driven, and emphasize the use of natural, peer, and family support. In Dauphin County, a Community Support Program (CSP) Committee is actively involved in the system planning as well as improving person involvement in leadership roles and evaluation activities. As a Block Grant County, MH/A/DP documents their recovery and resilience priorities and activities.

Dauphin County MH/A/DP 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. Referrals are made for drug & alcohol treatment services, as needed, by PATH funded programs..

Dauphin County has completed the data collection and analysis for the STEPPING UP Initiative. MH is already implementing

DATA

The Dauphin County Mental Health administration and CIP staff have completed training on the use of the Federal Homeless Management Information System (HMIS). Downtown Daily Bread is already using HMIS to collect data under the CACH umbrella. The Capital Area Coalition on Homelessness (CACH) is the local planning group in Dauphin County and the CACH funds the HMIS training and activities around data collection. Bowman is the selected HMIS contractor. Dauphin County MH/A/DP and its PATH contracted providers have worked diligently in conjunction with the HMIS staff assuring PATH data is successfully entered into the HMIS system. CIP staff are trained and updated routinely.

PATH agencies will be eligible for any Dauphin County CACH trainings on HMIS. PATH provider agency staff will be supported on a routine basis by Dauphin County MH administrative staff and the HMIS program administrator. Data entry and reporting issues with HMIS will continue to be addressed with HMIS Administrator in Dauphin County. Ongoing technical support is being used to further develop the data quality and integrity of the PATH data entered into HMIS.

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The CoC does not have a written HMIS manual. When PATH staff were trained on HMIS they received a PowerPoint presentation. The CoC uses Bowman and the Bowman Library may have an up-to-date HMIS manual.

ALIGNMENT WITH PATH GOALS

The Dauphin County MH/A/DP is commitment to PATH goals for literally homeless persons and person at imminent risk of homelessness. Dauphin County MH has devoted PATH funds and other funds to this end. Dauphin County Crisis Intervention Program (CIP) has a homeless outreach worker who conducts street outreach not funded by PATH. Pennsylvania has identified adults with a serious mental illness or with an SMI and a co-occurring drug and alcohol disorder as a priority population. Children and adolescents with a serious emotional disturbance are also priority populations. PATH provider in Dauphin County are trained and supported to identify person in crisis due to mental health issues who are also literally or imminently homeless.

Crisis Intervention program staff on all three shifts work with persons and families experiencing homelessness. Ongoing efforts by Case Management entities and the homeless outreach specialist at the CMU (not funded by PATH) provide ongoing support and assistance to individuals they serve that are homeless or at risk of homelessness. The Crisis Intervention Program staff and supervisors work closely and collaboratively with traditional mental health providers and the local homeless provider network as well as other local church, law enforcement, and volunteer organizations to assist these individuals. It is clear that the most effective approach in assisting homeless individuals is ongoing and persistent outreach along with building rapport and trust with individuals will has the greatest impact and success in reducing homelessness.

ALIGNMENT WITH STATE MENTAL HEALTH SERVICES PLAN

Dauphin County MH/A/DP 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.

MH/A/DP 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.

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Crisis Intervention Program staff also participates in the County-wide TMI disaster preparedness drill, which occurs every other year. The Program staff's role is "rumor control" to the general public and support to the State and local EMA staff. Further, on a daily basis, suicide callers to the EMA 911 Center are routinely patched through to the Dauphin County Crisis Intervention Program. The Program also maintains a mutual aid agreement with the local Red Cross that will be updated in the coming fiscal year. All homeless providers have developed individual emergency preparedness plans to address the needs of the individual they serve.

ALIGNMENT WITH STATE PLAN TO END HOMELESSNESS

As outlined in various sections of the comprehensive Intended Use Plan (IUP), Crisis Intervention Program services provide street outreach and focus on the most vulnerable population of homeless and chronically homeless persons in Dauphin County. This is consistent with the State's Plan to End Homelessness.

With the adoption of HOME RUN by the County of Dauphin and the City of Harrisburg, and the continued leadership of CACH as the Blueprint Manager, the stage has been set to make homelessness *rare, brief and non-recurring in our community*.

The 2017 Blueprint presents six (6) Primary Objectives with several strategies and action steps to achieve the U.S. Department of Housing and Urban Development's definition of "ending homelessness", where *homelessness is rare, brief, and non-recurring:*
1) Strengthen Leadership to End Homelessness;
2) Achieve a Continuum or County-Wide Coordinated Entry, Assessment and Referral System;
3) Preserve Existing, and Increase Affordable Housing Supply;
4) Ensure Access to and Availability of Supportive Services;
5) Increase Public Awareness and Education about Homelessness, the Coalition, and its resources; and
6) Prevention of Homelessness. Each Primary Objective has outcome measures based on "System Performance Measures" by the US Department of Housing and Urban Development (HUD) on how a continuum or catchment is progressing towards ending homelessness.

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 rapid rehousing and HMIS.

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Dauphin County's Homeless Assistance Services (HAP) Program serves individuals and families whose income is below 200% of Federal Poverty level and who are homeless, near homeless, and who meet the specific HAP program component requirements. HAP services include; bridge housing, case management, rental assistance, emergency shelter.

Dauphin County uses MH Block Grant funds to support many homeless positions in the provider network not funded by PATH dollars. Medicaid expansion has facilitated the use of HC funds to support the provision of treatment for the homeless population, including families. None of the programs under ESG or HAP are used for PATH services.

SSI/SSDI OUTREACH, ACCESS, RECOVERY (SOAR)

Dauphin County Crisis Intervention Program is not involved in SOAR, except to recommend SOAR and refer persons to the CMU for SOAR support. Training was provided by OMHSAS in coordination with a SOAR Implementation Team. SOAR activities are not PATH funded in Dauphin County. The Dauphin County SOAR Coordinator also manages a homeless caseload in the CMU agency.

PROGRAMATIC AND FINANCIAL OVERSIGHT

MH/A/DP receives state and federal PATH funds directly from the Office of Mental Health and Substance Abuse Services OMHSAS. The PATH funds are allocated to the subcontracted PATH providers; DDB, CMU, Crisis Intervention Services. Quarterly reviews are conducted by MH program specialist staff of HMIS data. Internal audits are conducted by the MH/A/DP Fiscal Officer and PATH Financial quarterly reports are provided to the OMHSAS for review reflecting all contracted PATH funds in Dauphin County. At a minimum quarterly programmatic meetings are held with the Downtown Daily Bread staff regarding service delivery and reporting issues. Implementation of HMIS has increased the amount of administrative monitoring conducted by Dauphin County. The Compliance Committee of MH/ID Crisis Intervention Program provides quarterly monitoring of crisis services.

HOUSING

PATH funds continue to assist individuals who are literally homeless, chronically homeless, and at imminent risk of homelessness in securing permanent housing. PATH services continue to remain flexible and sensitive to the unique needs of individuals. The 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.

NOT FINAL

- 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: MH/A/DP including Crisis Intervention Program, has been working collaboratively with the following partners in developing affordable housing options for individuals with serious mental illness: CACH, Housing Authority of the County of Dauphin, Volunteers of America, and Paxton Ministries as well as new developers being established in the County. CACH is the designated Local lead Agency for Dauphin County with key responsibilities including coordination with area service providers and building owners regarding new HUD 811 projects and tax credit housing projects funded through PHFA in assuring there are eligible individuals ready to move into available units when they become available.

In FY 2016-17 Dauphin County developed a Bridge Rental Subsidy program using reinvestment dollars in collaboration with the Housing Authority of the County of Dauphin (HACD) . A total of 18 individuals have received funding through the Bridge program in FY18-19. All applicants were required to complete a PREP (Prepared Renters Program) curriculum and PREP classes are offered to any interested MH consumer/family.

Paxton Ministries developed two (2) Community Lodges which serve a total of eight (8) persons. The lodges are managed by the individuals living in the home. Paxton developed a cleaning company, Paxton Cleaning Solutions, and has contracts with several area businesses.

COORDINATED ENTRY

CACH is the PA-501 Harrisburg/Dauphin County Continuum of Care and therefore, the PA-501 coordinated entry process is the same as CACH's process. CACH has the following Coordinated

NOT FINAL

System of Entry and Referral for persons seeking homeless services and housing programs in the City of Harrisburg Dauphin County. CACH has developed a Coordinated Entry Referral Tool (CERT) and is used universally by any agency or person in initial contact with a homeless person or family for referral to the first proper and appropriate housing option. Once an homeless individual is identified, they are placed on the CEAR by names list in HMIS. The VI-SPDAT assessment tool is completed by the provider that is in contact with the individual and a priority number is assigned based on the outcome of the assessment and data entered in HMIS. Individuals who are chronically homeless or unsheltered and especially the Transition Age Youth (TAY) population are prioritized. Monitoring is conducted by CACH CEAR Committee until persons have secured permanent housing. Dauphin County's Crisis Intervention Program staff is involved in the assessment process.

The CoC's VI-SPDAT assessment tool has streamlined the process of effectively screening and prioritizing individuals to access appropriate housing. The availability of housing, criminal record and interest in securing permanent housing are barriers to immediate housing PATH agencies have encountered. PATH funded agencies and all MH providers work with individuals to address barriers and create solutions to immediate needs.

MH/A/DP serves on a CEAR Committee to review CEAR processes and policies and make improvement recommendations to CACH according to HUD Guidelines.

<u>Emergency Shelter:</u>
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.

<u>Unsheltered Persons who are Homeless (Non-Chronically Homeless):</u>
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.

<u>Persons who are Chronically Homeless:</u>
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).

<u>Person who are in Rural Areas and Homeless:</u>
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.

<u>Veterans who are Homeless:</u>

NOT FINAL

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 been developing forensic services for person with a serious mental illness and criminal justice involvement for well over 10 years. During that period, grants for jail diversion, re-entry strategies and a Mental Health Court have brought additional expertise to the mental health system and significantly improved collaboration with some related criminal justice agencies. Police trainings in Mental Health First Aid and CIT have been conducted. A Boundary Spanner position to coordinate MH forensic cases was established and continues to be funded through the MH system. Forensic case management, specialized CRR residential services, ACT and other treatment approaches were implemented. More recently, there has been successes in sustaining strong partnerships with Pre-Trial Services and Adult Probation, using Housing support funds through HealthChoices reinvestment, and expanding co-occurring treatment options. Research now indicates that increasing mental health services and supports may not decrease the number of person in jail with mental illness. The criminogenic risk factors that may be unaffected by MH treatment include:

- History of anti-social behavior
- Anti-social personality pattern
- Antisocial cognition
- Antisocial attitudes
- Family and/or marital discord
- Poor school and/or work performance
- Few leisure or recreational activities
- Substance abuse

The STEPPING UP data collection estimated that 16% of the persons in the Dauphin County Prison have a serious mental illness. Our data is consistent with national research indicating that MH treatment alone does not reduce criminal justice involvement or reduce recidivism for person with SMI who are involved in the criminal justice system. The challenges ahead are complex and multi-system. Person being released from State Correctional Institutions, particularly those with

NOT FINAL

no connections to Dauphin County (no family/no job/not sentenced here) add to the challenges ahead for the Dauphin County mental health.

Dauphin County has programs that address the needs of justice involved individuals. Dauphin County MH/A/DP funds 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 intends to improve treatment participation and outcomes that promote recovery.

Dauphin County MH has a Jail Diversion & Reentry program. The Jail Diversion program is beneficial for avoiding or radically reducing jail time by using community-based treatment as an alternative, leading individuals with mental illness or mental illness and substance use problems away from criminal incarceration or cutting it short. The Reentry program works with individuals with a serious mental illness who are court ordered or sentenced to county jail time and connects them to community mental health services prior to or shortly after release from prison.

Dauphin County opened a judicial center for centralized booking several years ago. Pre-Trial staff screen admissions and request a MH assessment from Crisis Intervention Program staff or, if active, targeted mental health case managers. Recommendations are made to Magisterial District Justices in determining bail, release or incarceration.

Dauphin County is not required to and does not collect specific PATH data on individuals that are PATH enrolled and justice involved. However based on the statistics of the general population in Dauphin County that are justice involved, it is estimated the percentage of justice involved persons would be relatively high.

Dauphin County is renewing CIT training in FY19-20.

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. None of the staff hired at Crisis Intervention Program using PATH funds are Certified Peer Specialists (CPS). Certified Peer Specialist are either funded by a behavioral health managed care program through HealthChoices (Medicaid) or County funded with Block Grant fund, if not MA eligible.

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.

NOT FINAL

A survey of the demographics of the staff hired in programs that are partially funded by PATH dollars has not been undertaken. Service providers and the County-operated Crisis Intervention Program and contracted PATH providers are encouraged to hire staff representative of the population they serve demographically by age, race/ethnicity and gender while hiring the best qualified candidate for the position. The Crisis Intervention Program is also part of the County's Merit Hire system and County Human Resources Department reviews and monitors staff composition and equal employment opportunity criteria. Dauphin County continues to encourage PATH contracted providers to consider and hire individual staff that are representative of the population served.

CONSUMER INFORMATION

Persons identified through outreach by Crisis Intervention Program (CIP) in FY 18-19 is estimated at 150 and an estimated 125 persons will be enrolled by the CIP as PATH eligible and among those enrolled 80 (or 64%) will be literally homeless.

The Dauphin County MH/ID Program anticipates the demographic profile of persons served in FY 19-20 to be similar to the previous year's PATH annual data. The chart below illustrates the demographics of individuals served in the PATH program for FY 16-17(n=237):

Table 3-PATH Consumer Information Demographics for PATH Planning

Demographic Information	FY16-17 Persons Served	FY16-17 Percentage Persons Served
Age: 18-30 31-61+	62 175	26% 74%
Gender: Male Female	157 79	66.6% 33.3%
Race: African American Caucasian Other/not reported	101 131 5	43% 55% 2%
Ethnicity: Hispanic Non-Hispanic, Non-Latino	27 210	11% 89%
Diagnosis: MH Only COD MH/DA MH and Other	107 121 9	45% 51% 4%
Veteran Status: Yes No Unknown	9 220 8	4% 93% 3%
Housing Status: Emergency Shelter/ Not meant for Habitation	127	53%

NOT FINAL

Transitional Housing Other	74 36	31% 15%

The Capital Area Coalition on Homelessness conducted a 2018 Point in Time Survey of individuals and families who experience homelessness. There were a total of 445 men, women and children experiencing homelessness, which is a 3% decrease from 460 in 2017.

CONSUMER INVOLVEMENT

MH/A/DP is committed to having individuals in service take on leadership roles and continue to be involved in all aspects of mental health planning process. The Dauphin County Community Support Program (CSP) Committee is very involved in evaluation as well planning for mental health services and new initiatives. The expertise of the County Quality Assurance staff is utilized to compile and analyze the data received and assists in exploring next steps or recommendations that can be pursued. The survey data outcomes and reports are shared internally with program staff, the MH Committee of the MH/A/DP Board and the Dauphin County Community Support Program (CSP) Committee. Information is incorporated into annual Block Grant Plan and an Annual Report. MH/A/DP has not taken any steps in the past to evaluate the specific PATH funded services by the persons benefiting from them. Concerns about their privacy and guardedness are perceived to interfere with service delivery. The County's Quality Assurance staff is available to investigate complaints or concerns by individuals receiving PATH services and acts as mediators to resolve the individual's concerns.

HEALTH DISPARITIES IMPACT STATEMENT

Health disparities are not new to the Dauphin County mental health system, including for persons who are homeless, chronically homeless, or imminently homeless. Dauphin County is highly committed to addressing disparities within the County using local, State, and federal resources available to us. For the past several years, an examination of subpopulations in the county-funded system as well as in the Medicaid managed care system has been undertaken to improve the overall wellness of persons we serve. Furthermore, the relationship between health and mental health are fully understood and prioritized. The Commonwealth of Pennsylvania provides for a County-operated and managed mental health system for persons who are uninsured. While services exist, current budgetary cuts and prior cost of living increases not tied to real costs continue to impact the availability of services leading to waiting lists and the need to triage care.

The county behavioral health system is also the primary planner and implementer of service supports and rehabilitation services not funded by Medicaid and Medicare. These are typically services which support persons living in communities. In a recovery and resilience based system, these services are as important as treatment to the individual and their family. Many of our efforts have not been solely for the benefit of PATH eligible persons; however this population has benefited from these focused efforts.

NOT FINAL

Alder Health Services provides integrated physical and behavioral health services for individuals they serve. Agencies are encouraged to address coordination and communication with primary care physicians. Hamilton Health Center, a federally qualified health center, provides mental health counseling through staff LCSWs. Crisis Intervention Program and case management agencies focus on the referral of insured and uninsured persons to primary care programs and services, such as Mission of Mercy and Hamilton Health Center while attempting to secure benefits and insurance barriers.

Dauphin County MH/A/DP, as well as the Medicaid BH-MCO has in place policies and procedures to support agencies in addressing the language and linguistic support needs of persons in service. This is particularly necessary when the mental health workforce does not represent the cultural, language, and ethnic demographics of the community population. The last comparative survey of workforce demographics to the persons in mental health services occurred in the mid 1990 during a period of cultural diversity efforts across the Commonwealth, especially in children's mental health services.

Wellness activities undertaken include efforts with the BH-MCO PerformCare: Medication Review Toolkit and a Natural Supports Toolkit for family, friends and others supporting an individuals with a serious mental illness. All the toolkits are available on PerformCare's website. a Nurse navigator program was implemented in Dauphin County with Merakey.

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. In FY 17-18 MH/A/DP revised the Complaint and Grievance Policy and Procedure and all County contracted providers are in the process of revising their agency Policy & Procedure. Dauphin County MH/A/DP excels at finding solutions to access and service use issues within our budgetary limitations.

Dauphin County MH/A/DP works collaboratively with Dauphin County Area Agency on Aging on a quarterly basis to discuss areas of concern, possible training needs within systems and conducts case reviews/consultations and outreaches regarding individuals that are served in both systems.

Transition Age Youth (TAY) experiencing homelessness are served within the Dauphin County PATH. SAMHSA PATH includes TAY persons ranging in ages from 18-30 year old age group. Transitioning young adults have unique challenges at any chronological age since their emotional and social development may have been impacted by socio-economic and mental health factors.

According to Dauphin County's PATH annual report data in FY15-16, 27% of the individuals served were between the ages of 18-30 years. For FY16-17, 62 or 26% of the individuals served were between the ages of 18-30. In FY17-18, fifty (50) person were served identified as TAY. The types of services funded by PATH for the TAY population are similar to all PATH funded services: outreach, homeless case management, and housing supports. A total of forty-one (41)

NOT FINAL

TAY individuals have been served so far in FY18-19 by Crisis Intervention with a total of $6,257 dollars expended.

Dauphin County is a Block Grant county and as such we have a planning process to determine trends and needs. An assessment of what is working and quality improvements are a daily activity in the County MH program. We are required to work within our budget. Opportunities to use reinvestment, grants and other funding streams are examined and used when appropriate keeping in mind the priority population needs and issues. In 2012 $1.9 million dollars was cut from our budget and has never been restored.

Keystone Service Systems operates a 3 bed max-care residential program for Transition Age Adults ages 18-26, which was developed to address the unique needs of the TAY population.

Dauphin County takes a flexible approach to determining with a person's support system and interagency team which system (child/adolescent or adult) may fit their needs best and how to individualized the transition period to gain the most success and recovery. Persons under the age of 18 may also be involved with a children and youth agency if they require care and supervision. Mental health treatment in Pennsylvania may be accessed by person 14 years of age and older without parental consent, however efforts are made to engage responsible adults in all aspects of treatment. Person under 18 years requiring inpatient psychiatric or medical care will require the involvement of Children & Youth and the Courts, as needed.

The JEREMY Project is operated by CMU and 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 CMU Transition Coordinator assists participants with job searches, preparing resumes, completing and following up on applications, and preparing for interviews.– The JEREMY Project is in its 16th year of operation. A review of The JEREMY Project was undertaken in 2017 and recommendations will be implemented in FY19-20 to screen in more at risk young adults. The risk factors during transition such as homelessness, criminal activity, isolation, drug & alcohol use, family conflicts and poor peer relationships may be met through The JEREMY Project.

In FY 17-18 marked the first full year of implementation for CAPSTONE, a first episode psychosis (FEP) program funded by OMHSAS with federal Community Mental Health Block Grant dollars for persons ages 16-30 experiencing an initial diagnosis of a psychotic disorder. The partners include: Pennsylvania Psychiatric Institute for Team Leadership and Clinical Services, YWCA of Greater Harrisburg for Supported employment and supported education services and CMU (Case Management Unit) for targeted case management and certified peer support services.

LIMITED ENGLISH PROFICIENCY

The Crisis Intervention Program utilizes the Language Line to meet linguistic needs and they have one bilingual/bicultural Hispanic staff. All Dauphin County contracted providers make individual

NOT FINAL

arrangement for interpreter services for languages other than English if they do not have staff that are bilingual/bicultural. All PATH services are provided on an individualized basis and contracted providers respect and are sensitive to the linguistic needs of the homeless population. Dauphin County MH/ID and several providers use The International Service Center to assist with various language translations and interpreting to best serve those who are not proficient in English. This agency has a list of interpreters for many frequently spoken languages that we may experience in the region. Providers continue to tailor services based on individual needs as well as accommodating individual linguistic needs in order to benefit from services provided. Many agencies seek to hire multi-lingual staff that can accommodate and further address the linguistic needs of the population they serve.

FY19-20 DAUPHIN COUNTYMH/ID PROGRAM CRISIS INTERVENTION PROGRAM (CIP) PATH BUDGET NARRATIVE:

Personnel ($ 22,362): $22,362 approximates one-half the salary of the Full-Time Equivalent (FTE) position within the PATH local provider's Crisis Intervention Program. The salary amount is 50% of the actual costs for the Crisis Intervention Program's Lead PATH Worker's position.

Fringe Benefits ($ 12,326): Conforming to methodology for ascertaining personnel costs, or $ 12,326 or 55.12% references the benefits attending one position within the Crisis Intervention Program, with the amount assigned to benefits based on actual costs for the lead PATH Crisis Intervention Worker's position.

Travel ($0): No travel costs under PATH funds for MH/ID Crisis Intervention Program.

Supplies ($1,500): Costs of supplies to be applied to this PATH grant are solely those related to the basic and rehabilitative needs of PATH eligible consumers. Among supplies anticipated are small stocks of non-perishable food items, clothing and blankets, as well as for accessories important to improve prospects for safe and conventional independent living. Costs for bus passes to assist clients to get to housing related services such as supported employment programs, county assistance offices, benefits counseling.

Other ($ 3,224): **Staff Training ($0):** Crisis Intervention program has no costs related to training. **One-time Rental Assistance ($1,612):** This budget line represents costs incurred on behalf of PATH eligible people for whom one-time expenditures can relieve the risk of possible eviction and homelessness. **Security Deposits ($1,612):** 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% @ $1,642): Four (4) percent of the PATH grant is allocated to cover administrative expenses at MH/ID Crisis.

NOT FINAL

Total Dauphin County MH/ID Crisis Intervention Program PATH Request………$41,054
(**$** 10,263 State Funds $ 30,791 Federal Funds)

Dauphin County MH/A/DP Crisis Intervention Program
FY 2019-20 PATH IUP Budget

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Personnel Position				
Crisis Caseworker	44,723	50%	22,362	22,362
Salary sub-total			22,362	**22,362**
Fringe Benefits (55.12%)				
Crisis (55.12%)				
FICA, Health, Ret, Life			12,326	12,326
Fringe sub-total			12,326	**12,326**
Travel				
Mileage			0	0
Travel sub-total			0	**0**
Equipment				
(list individually)			0	0
sub-total			0	**0**
Supplies				
Consumer-related items			1,500	1,500
Supplies sub-total			1,500	**1,500**
Other				
Staff training			0	0
One-time rental assistance			1,612	1,612
Security deposits			1,612	1,612
Other sub-total			3,224	**3,224**
Indirect Administration @ 4%				**$ 1,642**
Total PATH Budget ($10,263 State Funds $ 30,791 Federal Funds)				**$ 41,054**

NOT FINAL

NOT FINAL

Delaware County
20 South 69th Street
Upper Darby, PA 19082
Contact: Chris Seibert

Provider Type: Social service agency
PDX ID: PA-008
State Provider ID: 4208
Contact Phone #: 6107132306

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 131,919**	**$ 43,973**	**$ 175,892**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 131,919	$ 43,973	$ 175,892	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 131,919	$ 43,973	$ 175,892	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 131,919	$ 43,973	$ 175,892	

Source(s) of Match Dollars for State Funds:

Delaware County will receive a total of $175,892 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

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

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Delaware County Office of Behavioral Health
2019-2020 PATH IUP

Local Provider Description

- Delaware County Office of Behavioral Health
- Type of Organization – Unit of Local Government
- Geographic Area – County of Delaware, PA
- Amount of PATH Funds

Provider	State	Federal	Total
Delaware County	$ 43,973	$ 131,919	$ 175,892
Horizon House	$ 32,342	$ 97,027	$ 129,369
Mental Health Partnership	$ 11,631	$ 34,892	$ 46,523

- PDX Provider: PA 008

Delaware: Delaware County Office of Behavioral Health
20 South 69th Street
Upper Darby, PA 19082

NOT FINAL

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).

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).

AFS is the managing authority for PATH funding and oversees contracting, monitoring and reporting of homeless service delivery for Delaware County. AFS convenes the Homeless Services Coalition and oversees the Continuum of Care (COC) planning process and annual submission of the HEARTH Act COC application and the CoC HMIS. OBH is also responsible for contracting homeless services utilizing various funding streams including: HSBG, HOPWA, County MH Base, and Reinvestment, in addition to federal and state PATH funds.
PATH funds are allocated and contracted by OBH to two provider agencies, Horizon House and the Mental Health Partnerships. Each agency receives an annual PATH allocation and is

responsible for preparation of an annual PATH Intended Use Plan (IUP) and Budget with Budget Narrative that describes how each agency will deliver PATH services to homeless persons with mental illness and Co-Occurring Disorders.

Collaboration with HUD Continuum of Care (CoC) Program
OBH-AFS functions as the lead entity and for the Delaware County COC (PA-502). The local Homeless Services Coalition (HSC) has been operating for 24 years and has the governing body for the Homeless Continuum of Care. The HSC established a Governance Charter and Governing Board in 2013 to comply with new HUD HEARTH Act legislation. Successful compliance with federal COC requirements results in over $5 million annually in homeless assistance funding, much of which supports the MH and COD homeless population.

The 25-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.

The 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 seven components: Outreach, Coordinated Entry, Prevention, Emergency Shelter, Transitional Housing, Permanent Supportive Housing and Supportive Social Services. Each component has many services available to meet the varying needs of the homeless population.

Both PATH providers, Horizon House and the Mental Health Partnership are longstanding members of the HSC and both have seats on the governing board, standing committees and HSC committees.

Collaboration with Local Community Organizations
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 24-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.

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The Outreach Committee is the longest standing and most active committee of the HSC structure. This committee forum is where outreach activities and teams coordinate. This team is led by the PATH liaison from OBH-AFS. Outreach training, joint street outreach events, monthly meetings, development and management of a name-by-name list and conducting an unsheltered point-in-time counts twice a year is how outreach coordination is achieved.

Delaware County has collaborated and coordinated with both housing authorities for a number of years: Delaware County Housing Authority and Chester City Housing Authority regarding permanent housing for homeless individuals.

Service Provision

PATH eligibility determination

For all individuals, initial contact is through the Coordinated Entry System, whether a direct referral or via outreach. CE/PATH staff conduct an initial assessment including determination of eligibility for various programs/subpopulations. If someone may be PATH eligible, further eligibility is determined by confirming homeless and mental health status per self-report and then with follow up documentation verification. If the individual meets eligibility criteria and chooses to receive PATH services, enrollment occurs. Eligibility is documented through CoC verification of disability, documented psychiatric evaluation, and homeless verification which are scanned into HMIS and are reviewed by CoC/OBH. If determined to not be PATH eligible, individuals are referred to other CoC or community services.

Alignment with PATH goals

The PATH Program in Delaware County provides services to adults 18 years or older who are literally and chronically homeless or at an imminent risk for homelessness, who have a mental illness, including those with co-occurring substance use disorder. The PATH Services provided in Delaware County include street outreach, case management, screening and diagnostic services, referrals for medical, mental health, substance abuse treatment, primary health, job training, educational, referrals to housing, crisis Intervention, habilitation/Rehabilitation supports and residential supportive and supervisory Services. PATH services are provided via two organizations; Horizon House, Inc. and the Mental Health Partnership. Please refer to each provider agencies IUP for their detailed description of PATH service provision.

Maximizing use of PATH funds

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)

Gaps in current service system

The gaps identified by providers in the current service system include:

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- Although general public assistance was reinstated to single individuals in 2018 and only those who apply for Social Security benefits are eligible for it,
- 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.
- The shortage in psychiatrists in Community Mental Health centers resulting in longer wait times for assessments and access for behavioral health services continues to be an issue. PATH staff works with clients to facilitate access through community mental health center open intakes.
- There is an emerging gap related to transportation resulting from the public transportation system (SEPTA) eliminating tokens and transitioning to pre-paid transportation cards

Co-occurring services available
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
- SOAR4U – Newly funded SOAR model with two full-time SOAR specialists.

42 CFR Part 2 regulations
Refer to each provider agency for their specific answers.

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Justice-involved

OBH 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 several 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 Board (CJAB), 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.

Inter-System Administrative Forums	The CJAB, Cross-System Strategic Planning Committee (CSSPC), and DelCo Cares are the primary administrative forums for inter-system forensic planning and service development.
Cross-System Mapping	In 2010, OBH and criminal justice partners participated in a MH Justice COE led Cross-System Mapping to identify strengths and gaps and create a prioritized strategic action plan to develop and enhance forensic services in the county.
Crisis Intervention Team (CIT)	The CIT program has trained and certified over 330 officers from the various municipal police departments, county park police, university police departments, state police officers, county correctional facilities, and SEPTA transit systems. CIT certification classes are held annually and faculty is comprised of consumers, families, providers, and county personnel.
Transitional Housing Program (THP)	The forensic THP, operated by GEO the provider of the county's prison and Community Corrections Center facilities, opened in March 2014. The re-entry program established at the forensic THP continues to serve both males and females in re-connecting to needed treatment and other supportive services.
Forensic ACT (FACT) Team	The FACT team continues to be an integral component of the successful discharge and transition of individuals returning to the community from NSH or county and/or state correctional facility. The team will to work with our criminal justice partners and community resources.
MH Court	The MH Court continues to address the needs of the SMI/justice-involved population. There is a strong working relationship between the criminal justice and behavioral health systems in this new venture.
Forensic Peer Support	Peerstar continues to implement this evidence-based model both in the jails and community-based providing peer mentoring services.
OBH Forensic Specialist	The Forensic Specialist helps oversee the myriad of forensic initiatives targeted to the justice-involved population.
Behavioral Health Liaisons	OBH and Adult Probation/Parole jointly fund four behavioral health liaisons at the GW Hill prison to coordinate treatment in the prison and in the community at release.
DOC Max-out Tracking	OBH staff, in conjunction with the Regional Forensic Liaison, track and develop release plans for the C and D roster priority max-out cases returning to DelCo.

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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. There is an HMIS team that meets weekly to oversee all aspects of the HMIS system operations which includes data quality oversight, monitoring performance standards, system updates and upgrades to meet federal reporting requirements, ongoing HMIS system training for upgrades and new staff, HMIS usage per program and provider. Coelho Consulting recently trained all providers on the new Coordinated Entry system. The training was completed in February 2017. Delaware County is fully utilizing HMIS to collect PATH data.

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.

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.

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Programmatic and Financial Oversight
Fiscal oversight of PATH-supported providers is managed through the Department of Human Services fiscal department accountants. Monthly invoices are reviewed and approved by both fiscal and AFS staff. DHS Audit department views all fiscal audits. AFS staff conduct on-site monitoring of providers annually. In addition, as the PATH quarterly reporting is completed, program performance is evaluated. In 2018-19, the OBH Quality Improvement monitored the performance of the two providers, this included onsite visits, file reviews and compliance with regulations.

SSI/SSDI Outreach, Access, Recovery (SOAR)
OBH AFS is currently implementing a new SOAR program in Delaware County that is newly funded through Home4Good funding. The program is currently under development, staff are hired and are completing the SOAR on-line training. There are 2 SOAR specialists, one each at Family and Community Services and Mental Health Partnership. The HELP MLP will provide legal consult. The County SOAR liaison recently attended the SOAR Leader Summit. Marketing materials and outreach will be conducted to implement the program and begin to accept referrals.

Housing
Delaware County made its priority to house homeless individuals and CoC has allocated 56% of Housing and Urban Development's funding to Permanent Supportive Housing. Delaware County, through its Continuum of Care, has over 240 beds of permanent housing for single adults and over 70 of those are targeted for chronic homeless persons and PATH clients. The OBH Mental Health Division manages placement of persons with severe mental illness in approximately 400 beds that offer varying levels of services and treatment. Most PATH participants will utilize the homeless funded beds, however, if they have high needs and barriers, beds in staff supported units and programs are available. Housing program type includes CoC funded permanent supportive housing and rapid re-housing programs.

Coordinated Entry
The PA-502 Continuum of Care for Delaware Country consists of 10 key homeless service providers and over 50 partner organizations. The Office of Behavioral Health is the Collaborative applicant for the CoC and is the lead agency for the HMIS. The OBH is also the grantee for PATH. The CoC has fully implemented the Coordinated Entry (CE) system and completed the operations manual. 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; Prioritize the households and Refer/link to stable housing

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. The CoC is using the VI SPDAT and

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SPDAT. Using these 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. The CoC will be conducting a consumer level and provider-based evaluation of the CE system in 19-20.

Justice Involved

Delaware County has a strong CIT training process and has just completed its 12th class. To date, 360 officers have been successfully trained, which represents 39 out of 45 police departments in Delaware County. Horizon House is actively involved in the planning and presentation of the CIT training, including staff and formerly homeless participants. The CIT has been effective in positively influencing the relationships and interactions of law enforcement with the behavioral health and homeless service systems and individuals within these systems. Law enforcement and county officials have also noted a positive change in culture within law enforcement department**.**

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 75%
- Black/African American
- Asian 25%

Gender:

- Male 0%
- Female 100%

Adult and Family Services staff take various training to understand the needs of Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI). Magellan, Office of Behavioral

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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

	Horizon House	Mental Health Association
Black/ African Americans	65%	72%
White	35%	27%
Hispanic/ Latino /mixed/native	3%	1%
Indian/Native American	1%	0
Male	54%	70 %
Female	46%	30 %
62+	19%	3 %
51-61	32%	38 %
31-50	34%	45 %
18-30	15%	14%
% Literally Homeless	97%	100%
Projected number to be enrolled	175	50

Consumer Involvement
Delaware County's Continuum of Care (CoC) has many opportunities for consumers/ Clients to serve in different capacities:

- Homeless Service Coalition (HSC) Annual Client Recognition Award.
- Consumer Focus Group
- CoC Program Ranking and Evaluation Committee
- Consumer Satisfaction Team
- Program Disposition Committee
- HSC Governing Board
- Housing First Advisory Committee
- Point in Time Count

Horizon House (HH) and Mental Health Partnership (MHP) are involved with the Peer Specialist Program. Both agencies have employed consumers as mentors, and at times clients' volunteers in life skills/ literacy classes. Clients are also part of program planning, program evaluation process. At MHA, to keep the consumers involved there is an idea/suggestion box and clients are encouraged to put suggestion/ ideas in the box. By having an idea box the clients feel that their voices are heard, and their input is valued.

Health Disparities Impact Statement

NOT FINAL

The OBH is coordinating the development of a TAY Provider Coalition that will meet several times per year with the goal of partnering with the CoC to address TAY homelessness and service needs.

Unduplicated TAY individuals expected to be served: 35 Total (30 HH and 5 MHP)

Total Amount of PATH funds expected to be expended on TAY population: $30,700

Types of Services funded: All services provided within the PATH project will be available to TAY individuals, including: outreach, screening and diagnostic treatment, case management, referrals for primary health, job training, educational services, relevant housing services, habilitation/rehabilitation supports, and residential supportive and supervisory services.

A plan that implements strategies to decrease the disparities in access, services use, and outcomes both within the TAY population and in comparison to the general population. The PATH project intends to increase access, service use, and outcomes for the TAY population through the following activities and strategies:

Access – We intend to expand outreach to the TAY population, increase street outreach to locations frequented by TAY individuals, triage calls/contacts of TAY individuals to PATH workers, identify TAY individuals in shelters and homeless day programs and reach out to other agencies/systems that serve TAY individuals.

Service Use- We will increase staff training on TAY issues, increase Peer Support and have an increased focus on areas of need/preference for TAY population (i.e., employment, education income/benefit, socialization, and housing).

Outcomes – Increases in TAY individuals who are employed, receiving benefits, completing and furthering education, increase their socialization opportunities and increase those who are permanently housed.

Limited English Proficiency
Please describe your organization's ability to comply with Executive Order 13166, which requires that recipients of federal financial assistance provide meaningful access to limited English proficient (LEP) persons in their programs and activities. Please assess the extent to which language assistance services are necessary in your grant program by utilizing the *HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons,* available at: https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/guidance-federal-financial-assistance-recipients-titleVI/index.html?language=es

Delaware County employees have access to a language line: Language Line Solutions has the ability to interpret 200 + languages through an interpreter service. The system is easy to use and paper instructions were given to all employees as part of their training. Also, Delaware County has diverse group of ethnicities employed which could be an asset if need be.

NOT FINAL

Delaware County Comprehensive
Horizon House Inc. & Mental Health Partnerships
PATH Program
FY 2019-2020 Budget

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**PATH TOTAL**
Position				
Director	$114,000	0.01	1,140	
Program Director	$72,814	0.05	3,750	
Administrative Manager	65,803	0.01	658	
Administrative Assistant	35,027	0.01	403	
QI Manager	51,716	0.01	455	
QI Specialist	40,290	0.01	403	
Team Leader	56,148	.24	13,878	
Behavioral Health Spec.	29,911	0.40	13,074	
Nurse	54,413	0.12	6,530	
Housing 1st BHS	34,114	1.08	37,617	
Clinical Specialist	52,010	.04	2,080	
MHP Outreach Worker	30,615	1.00	30,615	
sub-total				$ 110,020
Benefits				
				30,585
Travel				
Local Travel for Outreach/Supportive Services			13709	
Travel to training and workshops			2,736	
sub-total				**16,445**
Occupancy				
Rent			4459	
Utilities			845	
Maintenance			1,619	
sub-total				**6923**
Supplies				
Office Supplies			954	
Consumer-related items			953	
sub-total				**1,907**
Communication				
Telephone/Postage			1,513	
sub-total				**1,534**

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Other				
Other: Staff Training			1080	
Other				
sub-total				**1,080**
Administrative Expense			6,837	6,837
sub-total				
Total PATH Budget				**$175,892**

NOT FINAL

FY 2018-2019 Budget Narrative

Personnel/Positions: (Also see Roster listed on Budget) - PATH Team including Housing First provides outreach, screening and diagnostic treatment, case management, referrals, habilitation/rehabilitation, and residential supportive and supervisory service.
Fringe Benefits: @ 23.5% including FICA Tax, Health Insurance, Retirement, Life Insurance**,** for HH and 36 % including FICA Tax, Health Insurance, Retirement, Life Insurance for MHP.
Travel: Vehicle lease, insurance, and maintenance and gas/travel expense for client outreach and services **and** Travel to training/networking meeting and staff training.
Occupancy: Office expenses, rent, utilities, and maintenance for staff/service activities.
Supplies: General office supplies for staff/services **and** Client welfare emergency needs (food, clothing, medications).
Communication: Telephone and postage.
Administrative Expense: @ 4% HH and MHP.

Delaware County - Horizon House
1601 Parklane Road
Swathmore, PA 19018
Contact: Theresa Murphy

Provider Type: Social service agency
PDX ID: PA-013
State Provider ID: 4213
Contact Phone #: 610-328-2165

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Horizon House will receive a total of $129,369 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 175

Estimated Number of Persons to be Enrolled: 85

Estimated Number of Persons to be Contacted who are Literally Homeless: 170

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Horizon House Inc. PATH Program – PATH Intended Use Plan.
Delaware County, Pennsylvania
2019-2020

Local Provider Description

Full name and mailing address of provider organization(s) in the IUP

Horizon House Inc.
1601 Parklane Rd.
Swarthmore, PA 19081

Type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization)

Horizon House, Inc. is a private, non-profit organization providing community-based services to individuals with psychiatric and substance use 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.

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.

Indicate geographic area(s) to be served by provider(s)

The service area targeted for the purpose of these funds is Delaware County, Pennsylvania**.**

Amount of PATH funds the organization will receive with federal and state amounts spelled out for each provider

The total amount of PATH funds, Federal and State, to be allocated to Horizon House is indicated at $129,369 ($97,027 Federal and $32,342 State). Horizon House receives PATH funding from the State of Pennsylvania through the Delaware County Office of Behavioral Health.

List the provider number and name as it appears in PDX

PA 103
PDX: Horizon House, Inc.

Collaboration with HUD Continuum of Care (CoC) Program
The PA 502 Continuum of Care for Delaware County consists of 10 key homeless service providers and over 50 partner organizations. The Delaware County Office of Behavioral Health (OBH) is the Collaborative applicant for the CoC and is the lead agency for the HMIS. OBH is also the grantee for PATH. Horizon House and the PATH staff play a key role in the planning,

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development, and coordination of overall behavioral health and homeless services in Delaware County, including the HUD Continuum of Care program and recipients.. The PATH services and staff are an essential component within a comprehensive array of homeless services, providers, and various funding sources currently available or planned within the local Continuum of Care. The PATH Program 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 membership on the CoC Governing Board, which meets quarterly, although the Horizon House staff that served as the Chair of the board retired from the agency February 1, 2019.

Horizon House's current involvement in Continuum of Care Committee's include:

- Governing Board
- HSC Outreach/Crisis Response
- Family Services & Children
- Coordinated Entry
- Housing Accessibility
- Chronic Homeless Committee
- Homeless Youth Sub Committee
- Permanent House Clearinghouse Committee
- Emergency Shelter Committee

Horizon House has been actively involved in program coordination initiatives as described above and including coordinated entry. Horizon House is the recipient of a HUD CoC Coordinated Entry grant and the PATH services are integrated within the CoC coordinated entry process directly providing coordinated entry activities.

Collaboration with Local Community

Horizon House continues to provide a number of services, in addition to PATH funded services that are available to PATH-eligible clients. These services include: Specialized Residence for the Homeless (transitional housing), HUD Permanent Supported Housing, Community Residential Rehabilitation (transitional housing), Clubhouse (site-based psychiatric rehabilitation) Mobile Psychiatric Rehabilitation Services, Peer Support Services and ACT (Assertive Community Treatment).

Horizon House provides ACT services specifically targeted for transition age youth (YYA)/young adults, which are available to PATH eligible individuals.

The PATH Program identifies and works collaboratively with an array of external supports offered by other community organizations 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, food banks, financial and medical benefits, housing subsidies, and other housing services. The PATH program includes collaboration with supports and services for families and children.

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The PATH Program is designed to target homeless individuals with behavioral health needs who tend to be underserved and experience difficulties or barriers in accessing and maintaining services. Behavioral health services, housing, and finances are seen as most critical. The PATH staff works with the available behavioral health service providers to improve client's access to and coordination of treatment. PATH staff and others engaged in coordinated entry activities use a standardized process for assessment and referral to housing and other supports.

Horizon House maintains coordination agreements with the County's primary behavioral health services.

Horizon House is actively involved in the planning and coordination of activities and services through the Homeless Services Coalition/CoC as well as through the Delaware County Office of Behavioral Health and provider network. The CoC has developed policies and practices which are followed by all member agencies including Horizon House.

Horizon House coordinates directly with other outreach teams/staff through the CoC meeting and committees and through joint outreach efforts. During this past year, the CoC and OBH has fully implemented the coordinated entry process.

Service Provision

PATH eligibility determination
For all individuals initial contact is through the Coordinated Entry/PATH staff for initial assessment including determination of eligibility. PATH eligibility is determined by confirming homeless and mental health status per self report and then with follow up confirmation. If individual meets eligibility criteria and chooses to receive PATH services, enrollment occurs. Eligibility is documented through CoC verification of disability, documented psychiatric evaluation, and homeless verification which are scanned into HMIS and are reviewed by CoC/OBH. If determined to not be PATH eligible, individuals are referred to other CoC or community services.

Alignment with PATH goals
PATH Services are provided through two program components: the PATH/Coordinated Entry team (including outreach) and the PATH Housing First team. The CoC has implemented Coordinated Entry and the PATH outreach services are integrated within the coordinated entry process.

The PATH/Coordinated Entry team focuses its efforts on outreach, engagement, assessment, screening and referrals for homeless services, housing and other community services. Staff engage homeless individuals through coordinated entry access points and/or outreach; assess the individual needs, barriers, resources, and preferences; and assist the individual in accessing CoC services and other community supports. In addition to initial outreach, engagement and coordinated entry services, PATH eligible individuals may receive additional case management and referral services for behavioral health and other community supports to assist in accessing and utilizing those services, primarily targeting those individuals who are literally and chronically homeless.

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Referrals and coordination of services may include areas such as health, mental health and substance abuse, job training, education, income/benefits and housing referral services. A client record is maintained for all individuals 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 HUD 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 wellbeing, and a satisfying level of independence. Staff completes 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
- 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 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 with managing issues that occur with landlords, other tenants, and neighbors.
- Identify a representative payee for individuals who cannot independently manage their own funds.
- Help 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 Horizon House PATH services have maintained its focus on outreach and case management as priority services, and the target populations are the most vulnerable adults who are literally and chronically homeless.

PATH/Coordinated Entry staff are regularly scheduled at the coordinated entry access point, which is co-located with the Connect homeless drop in center. Street Outreach and other outreach are conducted periodically on an as needed basis.

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.

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Horizon House currently has office space at the service location Connect and who enable Horizon House to work alongside of their street outreach and drop in center staff promoting collaboration of services to better reach homeless persons. Case management, the linking and coordination of services to support individual's transition to housing and self-sufficiency, continues to be a priority service for this program. PATH/Coordinated Entry staff is located in a centralized location, which gives staff access to individuals with the most severe service needs and levels of vulnerability who are prioritized for housing and homeless assistance. Staff will also visit locations where literally and chronically homeless are located and conduct street outreach as needed.

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/Coordinated Entry program also utilizes individuals 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/Coordinated Entry 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 continues to work with the CoC, Delaware County Office of Behavioral Health, and Connect to assess the current street outreach activities and facilitate improvements. The CoC and PATH also coordinate with Philadelphia County's outreach teams to implement joint outreach in an attempt to connect more homeless persons to services, recognizing that there are many homeless persons traveling between counties.

Overall Services provided through the PATH/Coordinated Entry 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

Maximizing use of PATH funds
Horizon House utilizes PATH funds in a manner that leverages other significant funds and resources for PATH client services. PATH funds are used to partially support multiple positions that are members of a Coordinated Entry team and a Housing First team. Additional resources are leveraged to fully support the PATH teams and services as well as to leverage additional services and supports for PATH eligible clients. Specific additional resources leveraged include:

- Human Services Block Grant dollars received to support the PATH services and other homeless services
- HUD funds for Coordinated Entry Services
- Several HUD grants received for housing subsidies and services
- Access to the full CoC resources/services

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- Access to other Human Service Block grant funded services
- Access to MA funded behavioral health and health services
- Access to other mainstream funds/services (i.e. income benefits, nutrition assistance, health benefits)

Gaps in current service system

Although general public assistance was reinstated to single individuals in 2018 and only those who apply for Social Security benefits are eligible for it, a lack of income continues to present barriers to homeless individuals to access and maintain housing. It presents challenges for individuals to meet even basic needs such as personal hygiene. This also limits a person's access to transportation, medications, and other supports that may assist in their recovery process. Delaware County Office of Behavioral Health has made funds available to address some of the basic needs but longer term solutions are needed. The PATH service actively woks to assist individuals to obtain income benefits. Additional financial resources are typically needed for the individual during the benefit application and the appeals process.

Also related to lack of income, the lack of employment opportunities and limited employability for participants continues to present challenges, particularly for those who have a criminal background. The CoC has maintained this as a priority area to address.

There is an emerging gap related to transportation resulting from the public transportation system (SEPTA) eliminating tokens and transitioning to pre paid transportation cards. Clients are currently able to receive tokens; however, a viable alternative has not yet been developed. Therefore, termination of tokens or a viable option could create a hardship for individuals making it challenging for them to access transportation particularly those with little or no income.

Shorter life expectancy and co morbidity significantly impact chronically homeless individuals with serious mental illness and requires additional focus and services. We are seeing an increased need for nursing home services for many consumers; however, lack of income and early age are barriers to accessing appropriate housing and services for individuals. The PATH service provides case management and linkages to assist with health care issues.

The program and CoC has been successful in expanding housing opportunities particularly for individuals who meet the chronic homeless definition. For literally homeless individuals with serious mental illness and other significant needs who do not meet the chronic homeless definition, access to housing can be challenging. There have been efforts through the county, OBH and CoC to improve coordination of housing and there has been some improvement in housing access.

The shortage in psychiatrists in Community Mental Health centers resulting in longer wait times for assessments and access for behavioral health services continues to be an issue. PATH staff works with clients to facilitate access through community mental health center open intakes.

The PATH Team continues to participate in the county wide Homeless Services Coalition/Continuum of Care to actively address the services, needs, and gaps within the service system.

Co-occurring services available

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The PATH service includes identifying, engaging, assessing, and serving homeless clients with co-occurring serious mental illness and substance use disorders. The PATH services engage clients wherever they are in their recovery. An individual is not required to be abstinent in their substance use or active in D&A/MH treatment to receive PATH services. Horizon House and the PATH service have an effective working relationship with the County Office of Behavioral Health and Magellan Behavioral Health of PA which coordinate and fund MH, D&A, and MISA services. The PATH program staff has access to a range of MH, D&A, and MISA service providers throughout the County including outpatient, inpatient, detox, crisis, rehabilitation, and residential services.

Specialized training on dual diagnosis is available to staff through Delaware County Office of Behavioral Health, Drexel University College of Medicine, Behavioral Healthcare Education, Magellan, Behavioral Health Training and Education Network (BHTEN), Holcomb Behavioral Health and the Pennsylvania Certification Board through Eagleville Hospital. PATH staff has also had the opportunity to receive training via on line trainings offered through SAMSHA and Relias Learning.

Horizon House provides supported housing, mobile psychiatric rehabilitation, ICCD Certified Clubhouse, Peer Support Services, and ACT services in Delaware County. PATH clients with co-occurring disorders have opportunities to access all agency services as well as other homeless and mainstream behavioral healthcare services. To specifically address issues of opioid overdose, Horizon House ensures that staff, including PATH staff, have access to Narcan kits and have received related training.

The PATH-Housing First component facilitates housing supports and access to housing subsidies for PATH eligible clients including 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, Compeer, Vocational Rehabilitation, Crisis Intervention, Inpatient, Residential and MISA Residential, Crisis Residential, ACT, FACT, Peer Warm Line, Delaware County Crisis Connections Team (Mobile Crisis Team)
- Substance Abuse: Prevention, Outpatient, MISA Intensive Outpatient, Intensive Outpatient, Detoxification, Inpatient Rehabilitation, Case Management, Recovery Support Specialists.

Specific integrated services utilized include:

Inpatient/Rehabilitation (Eagleville Hospital, Mirmont, Fairmount Behavioral Health, Keystone, Kirkbride, Brooke Glen Behavioral Health), Outpatient Treatment (Holcomb, Merakey, American Day, OMNI, Crozer Chester Medical Center).

42 CFR Part 2 regulations

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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. Staff is trained upon hire and annually on all confidentiality requirements. QI staff monitor to ensure compliance

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 justice histories.

This includes coordination with law enforcement, probation and parole, and Mental Health Court. Horizon House, PATH staff and consumers have also been actively involved in providing CIT (Crisis Intervention Team) Training for police officers throughout Delaware County.

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Inter-System Administrative Forums	The CJAB, Cross-System Strategic Planning Committee (CSSPC), and DelCo Cares are the primary administrative forums for inter-system forensic planning and service development.
Cross-System Mapping	In 2010, OBH and criminal justice partners participated in a MH Justice COE led Cross-System Mapping to identify strengths and gaps and create a prioritized strategic action plan to develop and enhance forensic services in the county.
Crisis Intervention Team (CIT)	The CIT program has trained and certified over 330 officers from the various municipal police departments, county park police, university police departments, state police officers, county correctional facilities, and SEPTA transit systems. CIT certification classes are held annually and faculty is comprised of consumers, families, providers, and county personnel.
Transitional Housing Program (THP)	The forensic THP, operated by GEO the provider of the county's prison and Community Corrections Center facilities, opened in March 2014. The re-entry program established at the forensic THP continues to serve both males and females in re-connecting to needed treatment and other supportive services.
Forensic ACT (FACT) Team	The FACT team continues to be an integral component of the successful discharge and transition of individuals returning to the community from NSH or county and/or state correctional facility. The team will to work with our criminal justice partners and community resources.
MH Court	The MH Court continues to address the needs of the SMI/justice-involved population. There is a strong working relationship between the criminal justice and behavioral health systems in this new venture.
Forensic Peer Support	Peerstar continues to implement this evidence-based model both in the jails and community-based providing peer mentoring services.
OBH Forensic Specialist	The Forensic Specialist helps oversee the myriad of forensic initiatives targeted to the justice-involved population.

Behavioral Health Liaisons	OBH and Adult Probation/Parole jointly fund four behavioral health liaisons at the GW Hill prison to coordinate treatment in the prison and in the community at release.
DOC Max-out Tracking	OBH staff, in conjunction with the Regional Forensic Liaison, track and develop release plans for the C and D roster priority max-out cases returning to DelCo.

Horizon House provides housing subsidies which are available to individuals with a criminal history. Horizon House has been successful in working with landlords who will lease to individuals with criminal histories. Where individuals are not able to obtain a lease, Master Leased apartments available through Horizon House and other County funded providers are utilized. The program also works to identify employers who will consider individuals with a criminal history. PATH staff may also assist individuals with addressing issues with their criminal record and Legal Aid provides information and assistance with expungement or other actions.

The PATH program also utilizes forensic resources available through the County system including Forensic ACT and Forensic Peer Support. The PATH service has a high percentage of PATH clients with a criminal history.

OBH 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 several 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 Board (CJAB), 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.

Data

PATH data is currently entered into the HMIS system and all staff receives HMIS training upon hire and retraining as needed. The HMIS system is utilized for collecting and recording information as well as a case management tool to coordinate within the Continuum of Care. The County provides ongoing training on the HMIS system.

Horizon House PATH utilizes CARES-HMIS product/software. 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.

There is a written HMIS user manual on the home page of the HMIS website. It is available for all HMIS users. It is available to reference by view and/or download.

Alignment with PATH goals

"The goal of the PATH program is to reduce or eliminate homelessness for individuals with

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serious mental illness or co-occurring serious mental illness and substance use disorders who experience homelessness or are at imminent risk of becoming homeless."
Horizon House PATH provides outreach and assessment to homeless individuals, refers individuals to appropriate CoC/homeless services and provides case management and referral services to assist individuals with serious mental illness or co-occurring disorders to access and utilize mainstream behavioral health services and housing supports. Once housing has been obtained the PATH service provides case management and other supports to ensure that the person has the skills and supports to maintain housing and successfully utilize mainstream supports. The majority of individuals supported in housing meet the HUD definition of chronic homelessness.

The Horizon House PATH outreach includes street outreach in addition to other locations where homeless individuals may be located. While street outreach is provided, the majority of initial contact/engagement with homeless individuals occurs at the homeless drop in center and shelters. Increasing street outreach remains a goal of the service and overall CoC and during this year, PATH staff participated in outreach to the County's major transportation terminal as a collaborative effort with Delaware County services, Philadelphia outreach services, and SEPTA police.

Alignment with State Comprehensive 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 facilitate individuals' access to mainstream services that promote recovery, successful community living and independence. The PATH services provide outreach and case management services for the most vulnerable adults who are literally and chronically homeless.

The recent State report "Homelessness in Pennsylvania" (April 2016) identifies several recommendations which are addressed by the PATH program in its direct delivery of services as well as in the activities and services facilitated or leveraged through the PATH program. Some of these (from the state report) include:

- Expand cross-training of staff in the behavioral health, housing, and criminal justice systems
- Promote housing stability as it is a key to long-term recovery
- Expand permanent supportive housing
- Provide housing with access to treatment and recovery support services
- Facilitate access to the disability income benefit programs administered by the Social Security Administration
- Utilize certified peer specialists and other peer supports
- Increase collaboration and coordination between providers of mental health/substance abuse services, housing authorities
- At the county level, increase collaboration between county behavioral health personnel and CoCs in various areas, including the use of funds

Through its outreach and case management, the PATH services have been integral in connecting individuals with mainstream behavioral health services and benefits, providing and facilitating access to permanent supportive housing and facilitating increased collaboration across systems.

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Other Designated Funds
Delaware County Human Services Block Grant funds are designated specifically for people who experience homelessness and have serious mental illness within several services in Horizon House as well as other agencies. This includes funds specifically allocated for PATH services.

Programmatic and Financial Oversight – Describe how/when programmatic and financial oversight of PATH-supported providers is achieved on your local level (such as site visits, evaluation of performance goals, audits, etc.) *and* who conducts this monitoring of the use of PATH funds.

Delaware County OBH provides PATH funds to Horizon House through a contract which stipulates reporting and monitoring requirements. The County conducts site visits/audits and meets with Horizon House staff on a regular basis for contract monitoring.

SSI/SSDI Outreach, Access, Recovery (SOAR)
One staff who is no longer with the PATH service, completed the SOAR Online Course to date the project has not directly completed SOAR applications but rather have utilized trained SOAR staff from other agencies. The plan is for at least one PATH staff to complete the SOAR on line training course who will assist individuals with completing SSI/SSDI applications, and will use the on-line tracking.

The number of staff trained in SOAR
All staff have completed the SOAR webinar but have not completed the full SOAR training. One staff is currently signed up for the on line training SOAR training.

The number of staff who provided assistance with SI/SSDI applications using the SOAR model
No PATH project staff provided assistance directly using the SOAR model.

The number of consumers assisted through SOAR
No consumers were assisted through SOAR directly by this PATH project. There was one PATH consumer who was assisted through SOAR by a COC provider.

Application eligibility results (i.e., approval rate on initial application, average time to approve the application)
N/A

The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]

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Although there was a staff trained in SOAR, the PATH service has not been utilizing SOAR directly. There is currently no staff dedicated to implementing SOAR. However, the staff does use a process to assist individuals in getting connected to mainstream benefits. Currently, we have not tracked approval rates or average time to approve applications, however, currently, 81% of participants have income with SSI/SSDI and earned income. Currently staff gathers information from individuals regarding previous submission of applications for SSI/SSDI using a questionnaire. Staff then assists them with collecting whatever documents are needed for the application process and housing, including birth certificates, identification cards, social security cards, proof of income, proof of disability, medical documentation, psychiatric evaluations, etc. For any individuals that meet the criteria for SSI/SSDI, staff asks if they are willing to apply and if they are, staff assist them with completing the application and sending the necessary documentation to the SSA office. If individuals appeal a case, staff assists them with the paperwork affiliated with the appeals process. Due to individuals applying for SSI/SSDI prior to connecting with CE/PATH, some individuals are referred to an attorney for the appeal process. The intent is to have staff trained and certified to be able to complete the SOAR process as needed for participants.

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 one Shelter Plus Care grants managed by OBH and Horizon House and four 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 YYA population.

Horizon House continues to provide and utilize a range of housing services and supports available to PATH-eligible individuals ranging from transitional (Specialized Residence, Community Residential Rehabilitation) to permanent levels of housing (PSH, S+C funded by HUD). The PATH service refers clients to housing services and supports provided through Horizon House and other County agencies, including Delaware County Housing Authority, Community Action Agency of Delaware County (CAADC) and Local Housing Option Team (LHOT). The CoC has also initiated a housing clearinghouse which functions in tandem with the coordinated entry process to facilitate coordinated access to CoC housing.

Once an individual is referred for housing, the PATH Housing First staff assist individuals to locate subsidized apartments using a variety of sources of TBRA funding.. The staff provides ongoing case management, habilitation and rehabilitation, and residential supports for individuals until they are assimilated into mainstream treatment, case management, and rehabilitative mental health and substance abuse services. The key sources of TBRA subsidies come from:

- Shelter Plus Care Programs
- Permanent Supported Housing Programs
- Section 8 Housing Choice Voucher Program

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- MH Community Residential Services

Coordinated Entry
Horizon House is a provider of Coordinated Entry services and PATH services/staff are integrated within the coordinated entry process directly providing coordinated entry services and follow up PATH services for PATH eligible individuals. Additionally, all Horizon House homeless services are connected with the coordinated entry process.
The Coordinated Entry is governed/monitored through the CoC/Board with support through the Delaware county Division of Adult and Family Services.

The Coordinated Entry system in Delaware County is a decentralized-coordinated system with four entry points located in areas of high need. Horizon House Coordinated Entry/PATH team is the provider at one of the entry points.

The CoC CE system ensures that everyone who has a housing crisis is comprehensively assessed to determine their housing status and intervention needs in hopes of diverting households from homelessness by developing stability plans based on their ability to divert from homelessness, the housing barriers, income potential, vulnerability and level of need, housing assistance program eligibility, mainstream resources needs and other service needs. All PATH eligible clients have the opportunity to participate in the CE assessment process through initial contact/engagement with the CE/PATH team.

Some PATH eligible consumers who do not meet the HUD chronic definition may experience some barriers to housing based on the prioritization process, as would any homeless individual not meeting the HUD chronically homeless definition. However, the local CoC does provide a level of prioritization for those individuals with disabilities which would include PATH eligible consumers. The CoC and PATH also work collaboratively with the mental health system to facilitate housing supports for those individuals not prioritized for HUD homeless housing.

Justice Involved
Delaware County has a strong CIT training process and has just completed its 13th class. To date, 364 officers have been successfully trained, which represents 37 out of 45 police departments in Delaware County. Horizon House is actively involved in the planning and presentation of the CIT training, including staff and formerly homeless participants. The CIT has been effective in positively influencing the relationships and interactions of law enforcement with the behavioral health and homeless service systems and individuals within these systems. Law enforcement and county officials have also noted a positive change in culture within law enforcement department.

Staff Information

Describe the demographics of staff serving your clients

Race/Ethnicity

Black	40%
White	40%
Hispanic	20%

NOT FINAL

Gender Male 0% Female 100%

Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients

The staff receives Cultural Competency Training through Horizon House during orientation and annually thereafter. This training helps to sensitize staff to age, gender, disability, lesbian, gay, bisexual, transgender, and racial/ethnic differences of clients. 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 LGBTQI population.

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

NOT FINAL

Discuss the extent to which staff are receptive to differences of clients

Horizon House, Inc. has successfully worked with individuals with mental illness throughout the local region since 1952, helping individuals to live as independently as possible within the local community. Since the 1980's, Horizon House has helped thousands of homeless individuals with behavioral health needs in Philadelphia and Delaware Counties to regain control over their lives and become contributing members of their community. Through the experience and training provided through Horizon House, this has enabled us to develop a workforce culture and team that is extremely receptive to the differences of the clients.

Identify the extent to which staff receive periodic training in cultural competence and health disparities

All new hires participates in an orientation which includes various training including Cultural Competency, Ethics, Overview of Mental Health, Suicide Prevention and HIPPA. These trainings are required annually as well. Within their first year of hire, they are required to additional trainings ie: Language of Recovery, Recovery Principles To Practices, LGBTQI, Accessibilities and Trauma Informed Principles and Practices. Additional trainings are offered throughout the CoC and other providers. Supervisors are expected to assess the needs of staff trainings on an as needed basis

How many of your PATH staff are Certified Peer Specialists or Certified Recovery Specialists?

There are currently no PATH staff that are CPS or CRS, however, CPS and CRS are eligible to be hired as PATH staff and the team has employed CPS. The County and Horizon House have expanded availability of CPS/CRS services which are available to PATH eligible clients.

Client Information

Describe the demographics of the client population

Race/Ethnicity

Black	65%
White	35%
Hispanic/Latino	3%
Indian/Native American	1%

Gender

Male	54%
Female	46%

Age

62+	19%
51-61	32%
31-50	34%
18-30	15%

Project the number of adult clients to be contacted
The number of adult clients to be contacted is 175

Identify expected number of adult clients to be enrolled
The number of adult clients expected to be enrolled is 85

Give estimated percentage of adult clients to be served using PATH funds who are literally homeless
We anticipate that 97% of consumers served with PATH funds are projected to be literally homeless.

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:

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"Horizon House, in partnership with individuals with disabilities and their families, advocates and provides comprehensive, community-based rehabilitation services to create opportunities for those served to manage their lives through environments emphasizing individual strength and choice."

Employment opportunities are available to consumers throughout Horizon House services and many of the services currently employ consumers. Horizon House Human Resource policies includes consumers in the employee recruitment process when staff vacancies occur, including PATH project positions. In Delaware County, Horizon House employs Certified Peer Specialists that are utilized across all services and are available to provide supports to PATH eligible individuals. All staff receives training both internally and outside of the agency on recovery and overall consumer and family related issues. Horizon House has developed a training on family inclusion, which assists staff in developing skills to improve working with families.

Outreach and assessment with individuals are completely voluntary and those seeking services are informed of the benefits and any possible risks of services as part of their intake. There is also a "Consent" that is signed if individuals are willing to receive services. Consumers receive information on their rights and responsibilities, which is informed by information from the President's Advisory Commission.

Horizon House ensures opportunities for family and consumer involvement in program planning, administration, governance, policy determination, and evaluation of services through committees, focus groups, and satisfaction surveys. The Horizon House Board of Directors actively recruits and includes mental health consumer and family representation and the Board currently includes a formerly homeless individual. 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.
- Delaware County Member and Family 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 Delaware County CoC Homeless Services Coalition, which 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.
- 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.

Also as outlined in the state information:

"The MH/MR Act of 1966, which governs the provision of MH services in the

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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

Based on our HMIS data, HMIS is able to identify sub populations of age, racial, ethnic, sexual, and gender minority groups. Identified sub populations in Delaware County include mental health and substance use disorder co-occurring, criminal just involved, and YYA.

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

The expected YYA individuals to be served using PATH funds is 35

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

The total amount of PATH funds expected to be expended on services for the YYA population is $53,000.00

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

All services provided within the PATH project will be available to YYA individuals, including: outreach, screening, case management, referrals for primary health, job training, educational services, habilitation/rehabilitation supports, and residential supportive and supervisory services.

A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the YYA population and in comparison to the general population

The PATH project intends to increase access, service use, and outcomes for the YYA population through the following activities and strategies which will be data driven and tracked within the HMIS system:

- Access
  - Expand outreach to reach YYA individuals
  - Increase street outreach to locations frequented by YYA individuals

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- Triage calls/contacts of YYA individuals to PATH workers
  - Identify YYA individuals in shelters and homeless day programs
  - Outreach/coordination with agencies serving YYA individuals (i.e., Delaware County CYS, Office of Behavioral Health, Child Guidance, Family and Community Services

- **Service Use**
  - Increase staff training on YYA issues
  - Increase Peer Support
  - Increase focus on areas of need/preference for YYA population (i.e., employment, education income/benefit, socialization, housing)

- **Outcomes**
  - Increased employment
  - Increased education
  - Increased benefits/income
  - Increased socialization
  - Increased housing

Limited English Proficiency
Horizon House is committed to ensuring that all persons including limited English proficient (LEP) person have meaningful and equal access to services. In order to ensure effective communication staff will make every effort to ensure communication and understanding for those individuals who are identified as having limited English proficiency. Once an individual has been identified as needing translative or interpretive services staff will contact the corresponding appropriate agency to obtain services and where appropriate and beneficial also refer for equivalent bilingual services as needed or available. The program has access to the County's language line service for persons with limited English proficiency.
The program to date has rarely experienced person with limited English proficiency seeking PATH services. Given the expanded focus of coordinated entry services County wide, and the importance of f homeless/housing services, the program will work with the County and CoC to continue to assess the need for language assistance services informed by the four factor analysis provide in the HHS Guidance.

The program to date has not experienced limited English proficient (LEP) persons. Horizon House is committed to providing culturally and linguistically appropriate services consistent with Executive Order 13166.

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Budget Narrative

Horizon House Inc.
PATH Program
FY 2019-2020 Budget

	Annual Salary	PATH-funded FTE	PATH-funded salary	PATH TOTAL
PERSONNEL Position				
Director	$114,000	0.01	$1,140	
Program Director	$75,005	0.05	$3,750	
Administrative Manager	$65,803	0.01	$658	
Administrative Assistant	$40,290	0.01	$403	
QI Manager	$45,500	0.01	$455	
QI Specialist	$40,290	0.01	$403	
Team Leader	$57,824	0.24	$13,878	
Behavioral Health Spec.	$32,684	0.40	$13,074	
Nurse	$54,413	0.12	$6,530	
Housing 1st BHS	$34,830	1.08	$37,617	
Clinical Specialist	$52,010	0.04	$2,080	
sub-total				**$79,988**
Fringe Benefits Position				
Director			$268	
Program Director			$881	
Administrative Manager			$155	
Administrative Assistant			$95	
QI Manager			$107	
QI Specialist			$95	
Team Leader			$3,261	
Behavioral Health Spec.			$3,072	
Nurse			$1,535	
Housing 1st BHS			$8,840	
Clinical Specialist			$489	
sub-total				**$18,798**
TRAVEL				
Local Travel for Outreach/Supportive Services			$12,769	
Travel to training and workshops			$2,736	
sub-total				**$15,504**
Occupancy				
Rent			$4,459	
Utilities			$845	
Maintenance			$1,619	

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sub-total				**$6,923**
SUPPLIES/EQUIPMENT				
Office Supplies			$954	
Consumer-related items			$713	
sub-total				**$1,667**
Communication				
Telephone/Postage			$1,513	
sub-total				**$1,513**
Administrative Expense @ 4%			$4,976	
sub-total				**$4,976**
Total PATH Budget				**$129,369**

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Delaware County
Horizon House Inc.
PATH Program
FY 2019-2020 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 ($6,119), Health Insurance ($9,759), Retirement ($2,000), Life Insurance ($920)
Travel:
Vehicle lease, insurance, and maintenance and gas/travel expense for client outreach and services
Travel to training/networking meeting and staff training
Occupancy:
Office expenses, rent, utilities, and maintenance for staff/service activities
Supplies:
General office supplies for staff/services
Client welfare emergency needs (food, clothing, medications)
Communication:
Telephone and postage
Administrative Expense:
@ 4%
Funds Allocated for PATH Client Services:
Federal Allocation: $97,027
State Match: $32,342
County Allocation: $205,984

NOT FINAL

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.

Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

* Indicates a required field

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

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

Source(s) of Match Dollars for State Funds:

Mental Health Partnerships will receive a total of $46,523 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 120

Estimated Number of Persons to be Enrolled: 50

Estimated Number of Persons to be Contacted who are Literally Homeless: 120

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

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2019-2020 PATH IUP
Mental Health Partnerships PATH Program
7200 Chestnut Street, Upper Darby, PA 19082
PATH Intended Use Plan
Delaware County, Pennsylvania

Local Provider Description

Full name and mailing address of provider organization(s) in the IUP

Name:	Mental Health Partnerships
Mailing Address:	1211 Chestnut Street Philadelphia, Pa 19107
Program Location:	7200 Chestnut Street Upper Darby, Pa 19082

Type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization)

Community Mental Health Center

Private non-profit organization – Pennsylvania tax exempt under section 501(c)(3)

Indicate geographic area(s) to be served by provider(s)

Delaware County - Upper Darby and other Delaware County communities, which includes the SEPTA Transit facility located at 69th and Market St., Upper Darby, Pa. 19082.

Amount of PATH funds the organization will receive with federal and state amounts spelled out for each provider

$46,523 ($34,892 federal and $11,631 state)

List the provider number and name as it appears in PDX

Provider name appears as Mental Health Partnerships – PA 062

Brief Description

The Mental Health Partnerships (MHP), previously known as the Mental Health Association of Southeastern Pennsylvania, is a nonprofit corporation that creates opportunities for individuals and family members to effectively respond to the challenges of mental health conditions through work in five domains: advocacy, direct support to individuals, training and education, information and referral, and statewide as well as national technical assistance technical

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assistance on developing peer-run services. MHP is active in all five counties of the Southeastern Pennsylvania region: Philadelphia, Chester, Montgomery, Bucks and Delaware Counties.

MHP was initially founded in 1951 as the Mental Health Association of Southeastern Pennsylvania. For almost six decades, MHP has been organizing, educating, and advocating for the rights of people with mental health and co-occurring substance use challenges. During that time, MHP has grown to become one of the largest of Mental Health America's more than 300 affiliates. The agency manages an annual budget in excess of $17 million and operates over 40 programs supported by 270 employees. Consumers of services and family members are extensively involved in MHP operations as board members, employees, and volunteers. The involvement of consumers and family members in all operational roles gives MHP a unique perspective and authority. Since the 1980s, MHP has been a catalyst in creating behavioral health policy that supports recovery, self-determination, community inclusion and integration. MHP has the proven expertise in the field of recovery services and education to conduct the proposed project in a successful manner.

In Delaware County MHP operates the Connect and SHARE Recovery Learning Center, which provides a safe place for homeless persons to access services and supports for recovery from mental illness and substance abuse disorders, while looking for appropriate housing resources. Connect and SHARE operate a twenty-four hour haven from the streets with the assistance of our night shelter program, Connect by Night. This emergency mobile shelter program, partners with Delaware County faith communities to offer shelter from the streets, to 50 or more people every night of the year.

The primary geographic focus of the MHP PATH project is Upper Darby, Delaware County. Upper Darby is a border community of West Philadelphia that is in transition from suburban demographics to demographics that reflect the more diverse economic, social, and racial population common to an urban profile. The location of a major Southeast Pennsylvania Transportation Authority (SEPTA) transportation facility in Upper Darby has been a magnet for people who are homeless and living on the street for over 20 years. The SEPTA facility provides a modicum of shelter and safety that attracts homeless people from Upper Darby, from other low-income communities in Eastern Delaware County, and from the bordering city of Philadelphia.

The Connect PATH Program funds a full time street outreach worker who is required to have a certified peer specialist credential. This outreach worker collaborates with our other staff to engage hard to reach homeless people in Upper Darby and other Delaware County communities, which includes the SEPTA Transit facility.

For fiscal 2018, the county has offered additional funds to conduct an extended outreach at the 69th Street terminal. As of November 2017, SEPTA transit police close the station from 2am-4am each night. The extended outreach team works at the terminal from 9pm-12am, in an effort to encourage the homeless individuals to come in off the streets and accept a shelter placement for the night.

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Collaboration with HUD Continuum of Care (CoC) 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. Staff also participates in the Delaware County Systems of Care training, which provides a comprehensive overview of available county resources.

The PA-502 Delaware County CoC has implemented a Coordinated Entry system in January of 2017 and MHP has been partnering with the county and Horizon House Inc. to ensure coordinated entry assessments are completed on all homeless individuals entering the Connect site or engaged through street outreach.

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 also have an affiliation with ChesPenn's primary care practice. Connect staff works closely with case management services from Northwestern Human Services, Mercy Fitzgerald Hospital and Community Hospital, to connect eligible individuals for targeted case management services. We cooperate with Horizon House's EASR-PATH team to better serve the hard to reach, as well as other Horizon House programs for housing opportunities. Our staff refer people to Holcomb Behavioral Health and other providers for substance abuse treatment. Additionally, MHP has recently implemented a Certified Recovery Specialist Program at the site, which now allow us to offer additional peer services in the area of substance use disorder. We also refer to participants to Careerlink for

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vocational training, resume writing and job placement. Case Managers work closely with the Domestic Abuse Project to provide services to those fleeing from domestic abuse and assist in securing safe housing. When we encounter people in crisis, we ask for assistance from Project Reach/Holcomb Behavioral Health System, a mobile crisis team that provides 24-hour response, and assists with assessment and crisis management. Veterans are immediately referred to the VA outreach for eligibility assessment and placement. This year the Connect program has also partnered with the University of Pennsylvania and the University of San Diego to provide smoking cessation education and services to both the participants and staff.

Service Provision

PATH eligibility determination
Alignment with PATH goals
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 at a minimum three days per week – this has doubled the amount of hours that Connect devotes to outreach and engagement. The Connect/PATH team visits sites in the area where hard-to-reach individuals who are homeless are known to congregate. Examples of these sites include the SEPTA transportation facility, local coffee shops, pool halls, the local libraries and shopping centers, area parking lots, the nightly dinner program at the Life Center (permanent shelter facility), the Connect day-time service facility, and homeless camps located in wooded areas and other secluded sites in and around Upper Darby.

The role of the CPS/Outreach Specialist is to establish a consistent presence among the hard-to-reach homeless community and to build trust through nurturing a peer-to-peer relationship with each homeless individual in the target population. The role of the Recovery Worker is to support the CPS/Outreach Specialist in the outreach and engagement process and to develop their own ongoing relationships with the individuals who are homeless in the target population. The CPS/Outreach Specialist is the primary contact with the hard-to-reach individuals who are homeless during the engagement process. The ultimate goal is to connect individuals who are homeless to the ongoing services provided by the Recovery Worker. The collaborative staff relationship between the CPS/Outreach Specialist and the Recovery Worker is a key factor in achieving the final outcome.

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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.

PATH Project entry is established at first contact and is followed by the engagements. The interactive client relationship results in the client assessment to determine eligibility. If the participant meets the criteria for both homelessness and serious mental illness, then the client can be enrolled if they are in agreement to engage in services.

Maximizing use of PATH funds
MHP maximizes the use of PATH funds by integrating PATH outreach work with the following services offered at our facility, 7200 Chestnut Street:

- Outreach
- Case Management
- Referrals for medical, mental health and substance abuse treatment
- Referrals to appropriate housing
- Crisis intervention
- Providing training for local law enforcement around the issues of homelessness, mental illness and substance abuse

PATH funding acts as a gateway to allow individuals experiencing homelessness to access services offered by MHP and Delaware County.

Gaps in current service system
The gaps in the current service system include:

- Insufficient numbers of housing opportunities and the long time on waiting lists with which people contend
- Insufficient supports and lack of discharge planning for people post discharge from drug and alcohol inpatient treatment. Many who have had some inpatient treatment must return to Connect, which is not well equipped to support the sobriety of people new to recovery from drugs and alcohol. (Connect does support the individual in attending local 12 step meetings for abstinence and encourages rehabilitation in the case of relapse)

Co-occurring services available
PATH eligible participants in Connect's services are able to access a variety of services for co-occurring disorders in the county and the region. Through effective working relationships with the County's Office of Behavioral Health and Magellan, our staff assist participants with accessing appropriate services and supports. Staff are familiar with an array of services providing inpatient and outpatient treatment, detox, crisis, and rehabilitation services. We have a useful referral relationship with Northwestern Human Services and Holcomb Behavioral Health for dual diagnosis treatment and a relationship with Omni Services and can now offer in-house CRS

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peer services for substance use disorder.

42 CFR Part 2 regulations
MHP is required to follow 42 CFR Part 2 regulations. The agency ensures that these regulations are followed through the oversight of the Compliance Director to ensure all information both written and electronic records are safeguarded and meets all HIPAA requirements. The agency also completes annual releases of information for all participants receiving services. Each release of information contains the following information to ensure that the person signing understands that his/her information is protected.

I understand that my records are protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 C.F.R. Parts 160 and 164 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

I have been informed of my rights to:

1. *Revoke permission at any time. This authorization is subject to revocation at any time, except to the extent that action has been taken to reliance on the authorization;*
2. *Inspect and receive a copy of the material to be released;*
3. *Request restrictions on how my health information is used and disclosed; and*
4. *Receive a copy of this authorization and the Notice of Privacy Practices*

MHP employees receive HIPAA training annually and the Director of Compliance monitors and addresses any violations in these areas.

Justice-involved
The CPS/Outreach Specialist works to support the challenges faced by PATH clients with criminal histories in the following ways:

Clients often arrive from prison without any documentation, which is a critical part for reintegration back into the community. The CPS/Outreach Specialist connects the individual to the appropriate agencies so that they can secure documents such as a birth certificate, Driver's license, state ID and social security card. Without these documents, it becomes extremely difficult for individuals to reestablish their identity in the world.

The CPS/Outreach Specialist also links the client to resources for employment and housing, which includes the following agencies:

- Employment: Work/Labor Ready, The Minds of Men, and Career Link
- Housing: MHP Rapid Rehousing Program, Permanent Supportive Housing, Community Action Agency and the Office of Behavioral Health

OBH 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

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several 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 Board (CJAB), 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.

Inter-System Administrative Forums	The CJAB, Cross-System Strategic Planning Committee (CSSPC), and Delco Cares are the primary administrative forums for inter-system forensic planning and service development.
Cross-System Mapping	In 2010, OBH and criminal justice partners participated in a MH Justice COE led Cross-System Mapping to identify strengths and gaps and create a prioritized strategic action plan to develop and enhance forensic services in the county.
Crisis Intervention Team (CIT)	The CIT program has trained and certified over 330 officers from the various municipal police departments, county park police, university police departments, state police officers, county correctional facilities, and SEPTA transit systems. CIT certification classes are held annually and faculty is comprised of consumers, families, providers, and county personnel.
Transitional Housing Program (THP)	The forensic THP, operated by GEO the provider of the county's prison and Community Corrections Center facilities, opened in March 2014. The re-entry program established at the forensic THP continues to serve both males and females in re-connecting to needed treatment and other supportive services.
Forensic ACT (FACT) Team	The FACT team continues to be an integral component of the successful discharge and transition of individuals returning to the community from NSH or county and/or state correctional facility. The team will to work with our criminal justice partners and community resources.
MH Court	The MH Court continues to address the needs of the SMI/justice-involved population. There is a strong working relationship between the criminal justice and behavioral health systems in this new venture.
Forensic Peer Support	Peerstar continues to implement this evidence-based model in both the jails and community-based providing peer mentoring services.
OBH Forensic Specialist	The Forensic Specialist helps oversee the myriad of forensic initiatives targeted to the justice-involved population.
Behavioral Health Liaisons	OBH and Adult Probation/Parole jointly fund four behavioral health liaisons at the GW Hill prison to coordinate treatment in the prison and in the community at release.
DOC Max-out Tracking	OBH staff, in conjunction with the Regional Forensic Liaison, track and develop release plans for the C and D roster priority max-out cases returning to Delco.

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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. Pre-enrollment contacts are entered into HMIS.

All PATH and Connect staff have been trained in January 2019 in the recently upgraded version of HMIS operations to learn how the HMIS network will be integrated to provide a more comprehensive system of reporting and increase the resources available to PATH participants. On–going training is provided to all staff. Greg Coelho is the HMIS Director who is responsible for changing the computer code.

The HMIS product title is CARES and is provided by Coelho Consulting, Inc.

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 encourage the hardest to reach participants to access services with more consistency.

The Connect PATH CPS/Outreach Specialist and our other outreach staff will develop an outreach target list to identify men and women who are most resistant to services in order to facilitate consistent responses and keep track of any progress made in responding to their needs. This year the PATH Outreach Specialist was successful in engaging and successfully bringing in several participants who were living in a parking lot that was set for demolition.

During the upcoming program year, the Connect PATH CPS/Outreach Specialist will make referrals from among her assigned participants to a Peer Support program affiliated with the MHP to offer additional supports available from this evidence based practice.

Alignment with State Comprehensive Mental Health Services Plan

PATH services provided are consistent with the PA Mental Health State Plan to end homelessness and reduce/eliminate chronic homelessness by providing services with outreach, case management, crisis intervention and by collaborating with other providers to provide a holistic system of care. By partnering with other providers, the PATH CPS/Outreach Specialist is able to address the needs of each individual whether they have been a victim of domestic abuse, have been diagnosed with a co-occurring disorder, were formerly incarcerated or a homeless veteran. The PATH CPS/Outreach Specialist works with the client to complete all necessary application processes, while providing trauma informed care to combat the effects of trauma, which is necessary to combat recidivism. With the addition of the CoC's Coordinated Entry system, staff are able to work quickly to identify the needs of a homeless individual, and develop solutions to any barriers in place so that stable housing and any needed services can be quickly

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obtained. MHP also provides on-going training in many areas such as Mental Health First Aid, Suicide Prevention, and Trauma Informed Care, to both educate staff and reduce the stigma of mental illness, which often prevents a person from reaching out for help.

Other Designated Funds
All PATH funding received is designated solely to providing services for PATH eligible participants who are experiencing both homelessness and serious mental illness. Delaware County has budgeted an additional $30,171 of Mental Health base block grant funding for MHP's PATH program in FY 2018-19.

Programmatic and Financial Oversight
MHP submits detailed monthly and quarterly reporting with appropriate backup for expenditures. Annually, MHP submits its annual financial audit to the county. The audit is performed by BBD, an independent accounting firm. The County has a fiscal and a program-monitoring plan for 2018-19 and it supports MHP throughout the year.

SSI/SSDI Outreach, Access, Recovery (SOAR)
In 2019, MHP secured a contract to implement the SOAR Program for participants applying for SSI and SSDI. The goal of the SOAR program is to fast track the SSI and SSDI application process. In addition, the use of the Coordinated Entry system has ensured timely determination for eligibility and completion of housing applications. The Delaware County CoC has established a clearinghouse for all housing applications, which will identify and prioritize the housing needs of this vulnerable population.

Housing
Our staff persons work with participants to access the entire range of housing options maintained by Delaware County. Agencies within this group include the Delaware County Housing Authority, Delaware County Office of Services for the Aging (COSA), the VA in Coatesville, PA, Horizon House Inc., and local landlords within the community.

Our staff are also familiar with other housing options available with Delaware County's CoC, which include; shelters (including specialized domestic abuse and family programs), transitional housing (including specialized housing for MH, D&A, Dual diagnosis, domestic violence and HIV), CRRs, and personal care homes.

Coordinated Entry
The PA-502 Delaware County CoC s has implemented a CE system and the Mental Health Association is a partner in that program. The CE Program is monitored and governed by the Delaware County CoC. The process begins with a coordinated entry assessment that gathers all relevant participant information, scores the application based on criteria, then makes

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recommendations to the housing placement best suited to the individual. There are five main components to this process, which include the following:

1. Establish locations where the individual can access help
2. Conduct an assessment to assess the situation, gather general information, assess current situation, vulnerabilities and housing barriers
3. Assign a solution by developing an "Immediate Needs Plan" to identify and address what is needed for housing stability and what are the housing barriers
4. Implement a solution by connecting the individual to resources to address the barriers, complete all service plan immediate needs previously identified, gather the documentation of eligibility and connect to the appropriate housing program
5. Ensure stable housing by providing a safety net plan, proper discharge planning, assistance with budgeting and money management, follow up and provide adequate resources the individual may need once they are reintegrated back into the community

Key partners include the CoC, and Horizon House Inc. who was appointed by the county to conduct all CE assessments for MHP. Horizon House staff works to quickly identify the needs of a homeless individual, and develop solutions to any barriers in place so that stable housing can be obtained. Information is then communicated to Connect, who works with the client on his/her housing stability plan. Both Horizon House and MHP meet monthly with the CoC to discuss the disposition of all clients being served.

Based on the Delaware County Coordinated entry system, CoC prioritization policies are consistent with CoC and ESG written standards. The CoC adopted the HUD Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons. Prioritization will be based on length of time homeless and severity of service needs. SPDAT is utilized as a comprehensive score of barriers and need.

Justice Involved

CIT training is provided annually in Delaware County and the PATH worker participates in the curriculum to educate law enforcement about the challenges and barriers homeless individuals face and ways to assist and support these individuals. This year in Delaware County approximately 80 law enforcement officers participated in the training. The PATH and Connect Programs have found this training to be highly effective as program staff now work collaboratively with local law enforcement to assist homeless individuals to come in off the streets into shelter and begin the process of applying for the services necessary to rebuild their lives.

Staff Information

Demographics of all Connect Staff:

Race/Ethnicity:	Black/African American:	90%
	White:	10%

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Gender:	Male:	33%
	Female:	67%
Age:	62+:	10%
	51-61:	20%
	31-50:	65%
	18-30:	5%

All our services are available to homeless men and women who are residents of Delaware County regardless of race, ethnicity, gender, LGBTQ and age. The PATH-funded fulltime CPS/Outreach Specialist is an African American female in her 40's with a Certified Peer Specialist credential.

The staff of MHP's Delaware County homeless services is sensitive to the racial/ethnic diversity of the program participants and receives cultural sensitivity training at the time of hire and annually thereafter. Although we do not have bilingual persons on our program staff, we are able to call upon other MHP staff for assistance with translation and interpreting when necessary. All staff receives training in Cultural Diversity, LGBTQ, Equal Access to Housing and Trauma Informed Care annually.

All direct service PATH staff are Certified Peer Specialists.

Client Information

- Describe the demographics of the client population
- Project the number of adult clients to be contacted = 120
- Identify expected number of adult clients to be enrolled = 50
- Give estimated percentage of adult clients to be served using PATH funds who are literally homeless

Race/Ethnicity:	Black/African American:	72%
	White:	27%
	Hispanic/Latino	1%
	Asian:	0%
Gender:	Male:	70%
	Female:	30%
Age:	62+:	3%
	51-61:	38%
	31-50:	45%
	18-30:	14%

One hundred percent of the adult clients served using PATH funds are literally homeless. MHP estimates that 100+ people will be engaged and 50 enrolled in PATH services in the coming program year. Over the program year, MHP will undertake efforts to increase number of enrolled clients as a percentage of clients contacted.

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Consumer Involvement
Consumer and family member involvement are central to the recovery transformation that MHP is currently undergoing. MHP has developed a new vision statement and a new mission statement

- MHP's Vision Statement: Individuals challenged by mental health conditions are empowered to direct their recovery journeys, and family members are prepared to play supportive roles, all as members of informed and inclusive communities

- MHP's Mission Statement: To promote groundbreaking ideas and create opportunities for resilience and recovery by applying the knowledge learned from the people we support, employ, and engage in transformative partnerships

At Connect, we are putting these values into operation in our day-to-day services. Connect holds weekly community meetings, which are open to all participants and staff. The community check in meeting is the forum for discussing and processing all proposed changes in program policy or procedure. The community meeting is also the forum for problem solving for community issues that arise from many people living together under crowded circumstances. Representatives for a Participant Advisory Committee are chosen from the community meeting to meet regularly to develop programming ideas, propose revisions to policy and procedure and help to set the direction for program decisions. Consumer Satisfaction Teams also visits on a quarterly basis to ensure the quality of services and Connect has a suggestion box on site for those who may not be comfortable participating in a large group.

MHP is at the forefront of including individuals who have lived experience as consumers of mental health services as employees, board members and volunteers. Of our 270 staff people, 60% have lived experience as a consumer of mental health services or a family member.

Health Disparities Impact Statement

The unduplicated number of YYA individuals who are expected to be served using PATH funds = 30

The total amount of PATH funds expected to be expended on services for the YYA population = 25% or approximately $11,500

The types of services funded by PATH that are available for YYA individuals – All PATH services provided by MHA will be offered to YYA individuals, including, outreach, case management, coordinated entry etc.

A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the YYA population and in comparison, to the general population:

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- Expand outreach to YYA individuals, including street outreach
- Increase known outreach locations
- PIT Count YYA access site
- Coordinate outreach with other agencies serving YYA
- Strive for service outcomes such as: increase employment, education, mainstream benefits, permanent housing placement

In the first nine months of the fiscal year (7/1/17 to 3/31/18), the CPS/Outreach Specialist engaged thirty (30) transitional aged youth that presented at the shelter for services. With Coordinated Entry now being on site at our location, every individual regardless of age are assessed for housing. Connect staff and case managers work with each individual to collect all documentation necessary to complete a housing application and obtain eligible entitlement benefits.

Limited English Proficiency

It is our responsibility to ensure that all eligible persons with disabilities have meaningful and equal access to services. This responsibility encompasses the most basic of human needs, the need for communication and understanding.

To ensure effective communication, staff will make every effort to ensure communication and understanding for those participants or their immediate families who are identified as having Limited English Proficiency (LEP).

In addition, the public offices have been equipped with universal symbols for bathrooms, exits and water fountains.

Once participants or his /her families have been identified as needing translation of interpretive services, staff will contact the corresponding appropriate agency.

This policy is applicable to all programs of MHP, including but not limited to Philadelphia, Bucks, Montgomery, Chester and Delaware Counties, as well as services provided in the state of Delaware, and other jurisdictions.

Budget Narrative

Budget Narrative- Mental Health Partnerships FY2020

Personnel:

Federal funding of $30,615 is being requested to provide for the full-time salary, 100% time, of an Outreach Liaison (Certified Peer Specialist). This position will be located at Mental Health Partnerships, whose work concentration is to provide mental health and housing resources for homeless or at imminent risk of homelessness persons with serious mental illness.

Sub-Total request for salaries is $30,615.00

Fringe Benefits:

NOT FINAL

Funding of $11,787.00 is being requested to provide for the full-time fringe benefits of an Outreach Liaison (Certified Peer Specialist). Fringe benefits include the following: FICA, unemployment insurance, retirement, life insurance, disability and health insurance. The benefits rate is 38.5% of total full-time wage.
Sub-Total request for fringe benefits is $11,787.00.

Travel:
Funding of $940.00 is being requested to provide local travel for outreach. This travel will be for the Outreach Liaison to engage with individuals experiencing homelessness.
Sub-Total travel request: $940.00

Supplies/Equipment:
Consumer related items:
Funding of $20.00 is being requested to provide for participant related outreach items that are an immediate need.
Sub-Total supplies/equipment request: $20.00.

Other:
Staff Training:
Funding of $1,080.00 is being requested to provide for staff training. Staff training costs are the annual PATH conference, other live training and a seat in Relias, an online training tool.
Administrative:
Funding of $1,861 is being requested at the allowable rate of 4.00%.
Sub-Total request for other expenses: $2,941.00.

Total PATH Request: $46,523.00

Federal Allocation: $34,892
State Match: $11,631

The Connect PATH program is also funded with additional $30,171 Mental Health base block grant funding for the following items:

- MHP Support Staff $4,831
- Fringe Benefits for Support Staff $1,835
- Other Expenses $15,361
- (Rent, utilities, insurance, phone)
- Administrative Expenses @15% of total direct costs $8,143
- Total Expenditures of PATH and Mental Health Base Block Grant: $76,694

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MHP BUDGET
PA-062: Delaware County
PATH Program
FY 2019-2020 Budget

	Annual Salary	PATH-funded FTE	PATH-funded Total
PERSONNEL Position			
Outreach Liaison (Certified Peer Specialists)	$30,615	1.0 FTE	$30,615
sub-total			$30,615
Fringe Benefits – 38.5% of salary			
Outreach Liaison (Certified Peer Specialists)			$11,787
sub-total			$11,787
Travel			
Local Travel for Outreach			$940
Travel to training and workshops			$0
sub-total			$940
Supplies/Equipment			
Consumer-related items			$240
sub-total			$240
Other			
Staff training			$1,080
Administrative Costs 4%			$1,861
sub-total			$2,941
Total PATH Budget			**$46,523**

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Erie County - Erie County Care Management
1601 Sassafras Street
Erie, PA 16502
Contact: Sheila Silman

Provider Type: Social service agency
PDX ID: PA-066
State Provider ID: 4266
Contact Phone #: 8145280727

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◯ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 90,821**	**$ 30,274**	**$ 121,095**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 90,821	$ 30,274	$ 121,095	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 90,821	$ 30,274	$ 121,095	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 90,821	$ 30,274	$ 121,095	

Source(s) of Match Dollars for State Funds:

Erie Co will receive a total of $121,095 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 100 Estimated Number of Persons to be Enrolled: 80

Estimated Number of Persons to be Contacted who are Literally Homeless: 65

Number staff trained in SOAR in grant year ending in 2018: 3 Number of PATH-funded consumers assisted through SOAR: 0

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Erie County Mental Health/Intellectual Disabilities
Erie County Care Management, Inc.
PATH IUP
FY 2018-2019

Local Provider Description

Provider name as it appears in PDX:

Erie County Care Management, Inc.
Non-profit 501 (c) 3 Corporations
1601 Sassafras Street
Erie, PA 16501
PDX Provider Number: PA-066

Erie County Care Management, Inc., (ECCM) 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 children or adults 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 (COC).

Mission Statement
ECCM provides administrative case management and other support services to Erie County's behavioral health, intellectual disabilities, and other human service consumers. By offering local support that assures access, ECCM ensures that care decisions are consumer-based and individualized, offering comprehensive, holistic care that fosters independence.

ECCM's Coordinated Entry team, which began on January 23, 2018, is part of the Administrative Case Management Division (the Mental Health Base Service Unit) that provides screening and intake for persons with serious mental illness into the County mental health system and works to insure availability and timely, prioritized access to resources for housing and/or mental health services.

While basic services are provided to all persons who have a mental health diagnosis, Administrative Case Management's most intensive activities are often conducted with persons who meet the criterion for the State Priority Groups which are defined as adults who meet the threshold for Serious Mental Illness (SMI) and children who meet the threshold for Serious Emotional Disturbance (SED). This definition is referenced directly in the Commonwealth of Pennsylvania, Department of Public Welfare's Mental Health Bulletin of March 4, 1994, Serious Mental Illness: Adult Priority Group.

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Specialized focus is directed toward individuals who are self-reported, or otherwise identified, as homeless, fleeing domestic violence, veteran, dually-diagnosed, forensic, and/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, emergency shelters, consumer centers, nursing homes, schools, etc.) with professionals in order to identify persons in need of service and encourage their participation, as well as mental health holistic assessment and service planning, referral and 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 2018-2019 Total = $121,095
- Federal Funds = $90,821
- State Funds = $30,274 *Block Grant County

Collaboration with HUD Continuum of Care Program

ECCM is a long-standing member of the Home Team which is part of the Erie County COC (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 a number of subcommittees which include: Coordinated Entry; Children and Youth; Gaps and 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 in the Coordinated Entry and Housing subcommittees, 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. ECCM participates annually in the Single Point in Time (SPIT) survey, which documents the housing and support needs of the homeless. including the chronic homeless. ECCM also participates in the Local Housing Option Team (LHOT) whose mission is to facilitate the development of permanent housing for persons with disabilities.

ECCM works collaboratively with other mental health care providers such as Lakeshore Community Services, Safe Harbor Behavioral Health, St. Vincent Hospital, Millcreek Community Hospital, Erie Veterans Affairs 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. ECCM will assist an individual experiencing homelessness in accessing Drug & Alcohol 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. ECCM has established and maintained very strong

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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 Coordinated Entry 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, ECCM's staff are 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.

Collaboration with Local Community Organizations:
PATH grant eligibility determination and inclusion, as well as requests for support and service access, come through to ECCM 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, Erie County's Managed Care 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 & Alcohol service providers, Certified Peer Supports, Intellectual Disabilities, Early Intervention, Greater Erie Community Action Committee (GECAC), PA Probation & 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.

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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 services, without discrimination. All referrals and requests for assistance for homeless individuals are addressed by the ECCM Coordinated Entry team.

Service Provision

PATH eligibility determination

ECCM determines PATH eligibility for clients via Coordinated Entry referrals, emergency shelter referrals, MH and/or D&A provider referrals, Erie County DHS referrals, and internal ECCM agency referrals upon notification of a client's serious mental illness (SMI) verification and homeless verification. PATH-eligible clients are, in nearly all cases, enrolled in PATH during the first interface with a PATH case manager. The PATH eligibility of identified individuals is documented in HMIS and in Base MH funding databases.

Alignment with PATH goals

ECCM prioritizes PATH funds to align with PATH goals to target street outreach and case management services via coordination between Coordinated Entry and PATH case managers, both of which are interconnected internally at ECCM and in tandem provide PATH-eligible individuals celeritous connection to homeless prevention, mental health, and drug & alcohol levels of care to support individuals' recovery. Coordinated Entry identifies PATH-eligible individuals, especially those living on the streets or living in a place not meant for human habitation, as acutely needful of outreach, and resultantly Coordinated Entry refers individuals to PATH case management upon the individuals' consent to do so during the Coordinated Entry screening process.

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 Coordinated Entry 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. ECCM 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, then 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 Affairs Medical Center.)

Maximizing use of PATH funds

ECCM maximizes PATH funds by leveraging the use of Erie County MH/ID Support Funds, which are intended to address the non-mental health service needs of Erie County individuals

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with serious mental illness, with particular emphasis on the reduction of their risk of out-of-home displacement via hospitalization or homelessness.

Gaps in current service system
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), 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.

Co-occurring services available
ECCM 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.

42 CFR Part 2 regulations
ECCM is not a provider of Drug & Alcohol Services, and consequently, is not required to follow 42 CFR Part 2 regulations.

However, ECCM'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 an individual's treatment.

Justice-involved
ECCM is a team member of the CROMISA (Community Re-integration of Offenders with Mental Illness and Substance Abuse) Program to support the ostensible community reintegration

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of incarcerated Erie County individuals who struggle with co-occurring mental illness and substance abuse and who have at least one year remaining in their criminal sentences. ECCM coordinates directly with Stairways Behavioral Health, Erie County Office of Drug & Alcohol Abuse, Erie County Office of Mental Health/Intellectual Disabilities, the Probation & Parole Board of Pennsylvania, Gaudenzia Crossroads, and the Greater Erie Community Action Committee (GECAC) to support the CROMISA mission. ECCM also performs holistic Forensic Mental Health Assessments in respective Erie County Correctional Facilities to ascertain the holistic needs of and provide level-of-care referral to Erie County individuals who are referred by Erie County Corrections. ECCM additionally provides Erie County individuals with co-occurring mental illness and substance abuse problems who are exiting Erie County Correctional Facilities with Coordinated Entry support via the specialized support of a Homeless Transportation Specialist, who provides free transportation to and from mental health appointments, physical health appointments, housing/homeless shelter stays, and social service appointments to support mental health recovery and to support housing/homeless shelter stabilization.

ECCM is proud to be a team member of the Erie County Treatment Court, which is specifically designed to serve adults 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.

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Data

Currently, ECCM's Coordinated Entry staff input information into Erie County's designated HMIS Service Point system, produced by Bowman Systems, LLC. Erie County's HMIS Administrator 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.

ECCM has access to a written HMIS user manual for reference to support accurate PATH data entry into HMIS electronically at the following web address: https://www.hudexchange.info/resources/documents/PATH-Program-HMIS-Manual.pdf.

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 trainings offered by the HMIS Administrator. Erie County's HMIS System is fully compliant at this point.

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 Coordinated Entry 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.

In the spring and autumn seasons, the Erie County area continues to have an increase of individuals 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 Coordinated Entry staff conduct the initial need screening, 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.

Alignment with Comprehensive State Mental Health Services Plan

ECCM's PATH project continues to prioritize the identification and support to individuals who are experiencing homelessness, who also have been diagnosed with serious mental illness and/or co-existing substance abuse disorders. Referrals come directly to the Coordinated Entry staff 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.

ECCM 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

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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 health 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 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.

Erie County Emergency Preparedness Plan (www.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.

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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 (HAP), are used to purchase services at ECCM in the Administrative Case Management Division for homeless 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.

Programmatic and Financial Oversight
Erie County Department of Human Services (DHS) is the direct recipient of PATH funds for the Erie community. Erie County DHS provides the PATH funds to Erie County Care Management (ECCM), who provides direct services using the funding. Erie County DHS is responsible for the oversight of ensuring that the PATH funds are being utilized appropriately through the subrecipient, ECCM. The fiscal monitoring of PATH funds includes ensuring that the federal portion of the funds is correctly listed in the agency contract; Erie County DHS participation in provider budget/monitoring meetings as applicable; reviewing a Compliance Review Tool annually which ensures document, financial, and administrative compliance; ensuring that payments to ECCM for ACM services do not exceed the contract maximum; ECCM audit confirmation and identification of Federal PATH funds and the CFDA number; ensuring that PATH funds are recorded properly on the HSBG Annual Expenditure Report, and confirming that PATH funds are correctly reported on the Single Audit Schedule. Erie County DHS has biweekly meetings with ECCM to discuss and review any pertinent issues regarding any contracted services with Erie County DHS.

SSI/SSDI Outreach, Access, Recovery (SOAR)
Three (3) ECCM staff are trained in SOAR, provide assistance with SI/SSDI applications using the SOAR model, and are dedicated to implementing SOAR, part- and full-time.

Currently, for clients who require support to apply for SSI/SSDI, ECCM staff provides contact information for the Erie County Assistance Office and offers transportation to and from the Erie County Assistance Office via a Homeless Transportation Specialist upon appointment. ECCM also provides support funds for transportation for PATH-eligible clients funded either by Support Funds (if the client is eligible for Base-funding) or by PATH funds (if the client is eligible for PATH). ECCM staff ensures a warm handoff to SSI/SSDI agents to support the SSI/SSDI application.

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In FY 2017-2018, PATH case management successfully assisted two PATH-eligible clients through SOAR. The application eligibility results of the two PATH-eligible clients that were successfully assisted via SOAR have been deemed as closed, as they both chose to pursue Rapid Rehousing and Section 8 housing and resolved their SSI and SSDI concerns independently in the meantime (while staying in emergency shelter), all of which was and has been closely monitored and supported by PATH case management.

Erie County offers training to the entire homeless delivery system via Coordinated Entry. It is the intention that no matter where a person presents for homeless services that they may be connected with appropriate services, in an individualized treatment/goal plan to foster greater health, economic, and housing self-sufficiency.

SOAR case management was available for clients throughout the 2018-2019 reporting period; however, clients resolved their SSI/SSDI needs with support instead of PATH case management and PATH homeless transportation assistance to travel to necessary SSI/SSDI offices in Erie County to complete SSI/SSDI documentation.

All PATH-eligible clients were expediently and efficiently serviced with PATH transportation and PATH case management services to directly visit agencies in the Erie County, PA, area that provide all eligibility requirements for PATH-eligible clients seeking SSI and SSDI benefits. Resultantly, no updates existed for this category.

Housing
ECCM is identified by the Erie County Department of Human Services as the Local Lead Agency (LLA) that acts as a consultant to secure affordable housing for people with serious mental illness in federally-funded tax credit projects, 811s and 202s.

Strategies utilized to seek and secure available housing depend on the individual’s circumstances. For those individuals who receive welfare benefits, locating affordable housing is a tremendous challenge. ECCM staff assists these consumers in applying for all subsidized housing programs for which they are eligible, such as through the Housing Authority of the City of Erie (HACE), Housing and Neighborhood Development Services (HANDS), 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 her/his income so that s/he can afford the other necessities of living.

For consumers who are able to afford non-subsidized housing, ECCM maintains productive relationships with community landlords to advantageously utilize apartment availability as openings occur. ECCM has been successful in assisting many individuals in establishing permanent housing with neighborhood landlords who have demonstrated understanding, and in some cases making allowances for, individuals with serious mental illness who are too often rejected by landlords due to stigmatization. Advocacy is key in these cases, and ECCM staff have been instrumental in assisting consumers to assert their rights when it comes to securing housing and other community services.

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In addition to utilizing community housing resources, ECCM continuously applies for grants that fund permanent housing opportunities, such as permanent supportive housing initiatives.

ECCM is a sponsor of three (3) Permanent Supportive Housing (PSH) grants, supporting over one hundred (100) individuals with serious mental illness and/or substance abuse disorders. Emergency 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 supporting families to remain intact by providing stable housing and individualized case management, reducing the cycle of homelessness.

PATH Case Managers have the opportunity to refer their consumers who are experiencing homelessness and are also considered disabled by virtue of their serious mental health or substance abuse issues, as a priority for the PSH programs. The positive peer relationships between the ECCM PATH case managers and the ECCM PSH staff engenders advocacy on behalf of the individual.

Coordinated Entry

Erie County is currently in the activation phase of its Coordinated Entry system for the Erie County community. The Coordinated Entry system in Erie County began on January 23, 2018, and ECCM is the Administering Agency that performs all facets of Coordinated Entry for Erie County.

Coordinated Entry collaborates directly with PATH case managers to support individuals who are identified as PATH-eligible to additionally obtain necessary mental health supports and services and to obtain referral for emergency shelter, Rapid Re-Housing (RRH), and Permanent Supportive Housing (PSH) for housing stabilization. Under Erie County's Continuum of Care (CoC), Coordinated Entry's assessment/prioritization enhances linkage and referral of PATH-eligible clients to housing and/or mental health and/or drug and alcohol treatment services that are essential for the holistic recovery of PATH-eligible individuals.

Justice Involved

ECCM employs a Forensic Specialist who has direct access to individuals incarcerated in Erie County Prison. The Forensic Specialist works with the correction facility counselors and its mental health staff to identify individuals who are soon to be released from the Erie County Prison and 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. Corrections facility staff, parole officers, Forensic Outpatient Clinic staff, and other providers will contact the PATH Case Managers, Forensic Specialist, and/or the Director of

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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 to which the individual wants to apply. 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, and PATH Case Managers assist the person in making referrals to the program. PATH Case Managers are able to provide firsthand information on the individual's ability to live independently and help provide valued information for the selection process. ECCM estimates that 60% of the individuals of PATH individuals have had criminal history.

Erie does not currently utilize Crisis Intervention Training (CIT). Safe Harbor Behavioral Health of UPMC Hamot is our local Crisis provider. They offer a Crisis 101 overview to the Erie Police Department, the Millcreek Police Department, and the Pa. State Police Department when invited to do so. They have also provided training on the Mental Health Procedures Act, Mental Health First Aide, and Applied Suicide Intervention Skills Training. (ASIST).

Staff Information

ECCM 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 language interpretation services. Staff will always secure a language interpreter for individuals who have a primary language which does not allow them to communicate their needs for services and supports.

PATH case managers are not currently certified as Certified Peer Specialists or Certified Recovery Specialists.

The ECCM PATH case management team reflects cultural diversity and experience, as it is comprised of the following:

- PATH Program Director (Caucasian male, age 42)
- PATH Team Leader (Caucasian male, age 53)
- PATH Homeless Case Manager (Caucasian female, age 26)
- PATH Homeless Case Aide (Caucasian male, age 30)

ECCM utilizes Administrative Case Managers, who are master's-level mental health professionals, to conduct holistic 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 PATH case management team as requested by the PATH Program Director, for expertly directed response for identified individuals with special needs.

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ECCM has been providing homeless case management services since its inception in 1994. ECCM personnel receive 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 will send a representative to the next annual PATH training or other appropriately aligned training targeted for PATH.

Client Information

Adults Consumers Contacted	175
Adults Consumers Enrolled	125

*(*Number based on full homeless case management complement of 2 FTE Case Managers and 1 FTE Case Aide)*

Percent of Consumers Contacted Literally Homeless	95%
Percent of Consumers Enrolled Literally Homeless	90%

Demographics for the PATH-funded client population are as follows, including projections of expected numbers of clients contacted and enrolled:

Age Range	Contacted	Enrolled
18-23	20	15
24-30	30	25
31-40	40	35
41-50	35	30
51-61	40	35
62 and over	10	5

Race	Contacted	Enrolled
American Indian or Alaskan Native	1	1
Asian	0	0
Black or African American	80	50
Native Hawaiian or Other Pacific	3	3
White	90	70
Two or more races	1	1

Gender	
Male	63%

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Female	36%
Transgender	2%

Ethnicity

Non-Hispanic/Non-Latino	95%
Hispanic/Latino	4%
Neither (per client report)	1%

Consumer Involvement
A director on the ECCM Board of Directors has a family member who is a consumer of services. ECCM employs a consumer advocate on a full-time basis who is a mental health consumer. ECCM is partnered with the Erie County Mental Health Association which employs at least two persons who have been homeless in the past and are currently consumers of services. The Erie County Office of MH/ID hosts monthly meetings of the Mental Health Consultative Committee, which is led by current and former consumers and family members of mental health and homeless services. Further, the behavioral health managed care organization for Erie County, Community Care Behavioral Health (CCBH), convenes quarterly Family Advisory Committee (FAC) and Member Advisory Committee (MAC) meetings to promote consumer and family participation in service development and improvement efforts.

Health Disparities Impact Statement
The PATH consumers are identified and Erie County MH/ID will use their names and social security numbers to track their services utilizing HMIS (Service Point administered directly by Erie County Department of Human Services), Medical Assistance (PsychConsult through CCBH HealthChoices), and MH Base-funding databases (HCSIS, PROMISe, Susquehanna, and Credible). All of the aforementioned databases work concurrently to accurately verify Erie County residency; salient demographic and identifiying information; behavioral health insurance status in Erie County; SMI/D&A/disability diagnoses pertaining to PATH eligibility; and existing mental health authorizations that may assist PATH case managers with the continuity of care for PATH-eligible individuals. Only ECCM personnel (including PATH case managers) internally share the confidential information within the aforementioned databases to support the recovery of PATH-eligible individuals.

ECCM will analyze the PATH data to ascertain if there are any differences to accessing services and positive outcomes for people by race, ethnicity, gender, sexual orientation, and/or age. If differences are noted, then ECCM will seek training for PATH case managers to deliver a more client-centered quality of service.

Through CCBH, Erie County's managed care partner for behavioral health services, and Erie County's Department of Human Services, ECCM continues to contract with four agencies to provide interpretation services for people who have limited English proficiency.

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ECCM 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.

The Erie County Department of Human Services will measure, track, and respond to disparities in HMIS data inputted by PATH personnel. 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 funding 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, then 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 LGBTQA population.

YYA Disparity Population Projection Plan
Unduplicated number of YYA individuals to be served with PATH funds in the 2018-2019 fiscal year is anticipated to be 40. These individuals will be in the age range of 18 to 30 years old.

The total amount of PATH funds expected to be expended on services in the YYA population: $47,777.00 for the fiscal year 2018-2019.

The types of services funded by PATH that are available for YYA individuals consist of outreach, engagement and case management services, which align with the primary PATH goals of serving Erie County's youth and young adults who are literally or chronically homeless. The PATH case management team will prioritize their outreach activities to all individuals, including the YYA group within the local homeless shelters, overflow shelters, churches, drop-in centers, city parks, and other designated and informal areas where homeless YYA individuals are reported to gather.

Case management supports to individuals who are PATH-eligible and within the YYA population will be holistic and individualized, as for all other special populations served. Examples of past support for the YYA 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; SNAP benefits application; disability application; and traditional stabilization housing activities (including referral to Erie County Coordinated Entry to determine eligible housing supports at each individual's request).

A plan that implements strategies to decrease the disparities in access, service-use, and outcomes both within the YYA population and comparatively to the general population.

In the event that PATH staff identify a disparity for the YYA 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 Erie County's Housing Program Specialist, to create a corrective action plan with the specific agency. The corrective action plan

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will be monitored for a change in outcome for YYA individuals through Erie County's contract monitoring process, as it would be for any other vulnerable population.

Limited English Proficiency

ECCM supports the provision of effective, equitable, understandable, and respectful quality services that are responsive to diverse cultural health beliefs and preferred languages. Subsequently, because the primary goal of Administrative Case Management is to link individuals with or who are at risk for serious mental illness with identified supports and services, it is essential that Administrative Case Management staff ensure access to interpreter services, as needed, to create a supportive environment for the client interview.

Administrative Case Management personnel (ACMs) will make every effort to identify issues in regard to language and culture which must be addressed in the process of assisting a client.

For services to be rendered by ECCM to a client, ECCM will pay the cost of interpreter services required to complete this activity. For services to be delivered by another provider agency to an ECCM client, that agency is responsible for any interpreter costs (per the MH/ID Office). ECCM personnel may help to arrange an interpreter for meetings at other provider agencies, and they must take care to ensure that all parties understand which agency is responsible for the cost.

If a client has difficulty conversing in spoken English, then they will be offered an opportunity to have an interpreter obtained for additional services at ECCM. ACMs will not rely on written notes (in the case of a deaf or hard of hearing individual), on an individual's limited use of spoken English, or on a friend/family member as interpreter, unless it is the individual client's expressed wish to do so.

Additionally, ECCM will use only certified interpreters for individuals who are deaf or hard of hearing, unless a client signs a waiver to use a non-certified interpreter. TTY/TDD capability for those members who are hearing-impaired or speech-impaired is also available.

ACMs will consult with supervisory and administrative personnel for assistance in making accommodations which are outside the realm of routine interpreter services. Where appropriate, consultants will be employed to assist the agency in meeting the language and cultural needs of all clients.

ECCM will contract with interpreters in the community who are generally held as qualified and in good standing in the community. The list of interpreters and their rates and contact information will be provided upon request. ACMs wanting to use an interpreter who does not have a contract with ECCM must review the need with the Administrative Officer.

There is never a cost charged to a client or family member for an interpreter service for services to be rendered by ECCM. The agency will always cover this essential cost to assure that the client's needs are met in a way that is responsive to culture and language reference.

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Budget Narrative

Director of Supportive Housing and Forensic Services: $9,501 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: $30,052 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: $25,626 or 60%
A full-time position, this Case Manager provides direct care to shelters and their clients through daily visits to multiple shelters. This position focuses on engagement with the individual to identify needs, refer, when appropriate, for psychosocial assessment to the Housing Specialist, and help connect the individual with various resources and/or benefits the individual needs help in obtaining; e.g. facilitating housing program applications, assisting in locating stable housing options, assisting with MA benefit application, obtaining personal identification documentation, etc.

Homeless Case Management Team Case Aid: $21,771 or 60%
A full-time position, the Case Aid provides direct care by supporting individuals with transportation from the shelter to their medical or mental health clinic appointments. If the individual is in need of support and agrees, the Case Aid will escort the person to their mental health appointment to facilitate discussion with the mental health professional, go to the Department of Public Welfare and/or Social Security Office to assist the individual with filling out benefit applications and meet with their caseworker. In addition, the Case Aid can offer support in obtaining personal identification documentation, clothing or household items access from donation centers, access to county support funds, etc.

Fringe Benefits: $ 31,055, social security, retirement, and insurances for assigned personnel.

Travel: $1,000, $0.545 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: $200, to provide training, and to develop strategies, methods and competence for the assigned staff to assist PATH clients to re-enter the community.

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Client Funds: $1,890, Funds to support and assist PATH clients as they re-enter the community and transition to stable housing.

Erie County MH/ID
Erie County Care Management, Inc.
PATH Budget 2019-2020

Partial salary for PATH-assigned staff	$86,950
Benefits	31,055
Staff Travel	1,000
Staff Development	200
Client Funds	1,890
TOTAL	**$121,095**

Personnel			
Annual Salary	PATH Funded FTE	PATH Funded Salary	
Director Supp. Housing	63,337	15%	$9,501
Team Leader	50,086	60%	30,052
Case Manager	42,711	60%	25,626
Case Aide	36,285	60%	21,771
			$ 86,950
Fringe Benefits			
Social Security/Medicare			6,652
Retirement			6,956
Insurance			17,447
			$ 31,055
Travel			**$ 1,000**
Other			
Staff Development			200
Client Funds			1,890
			$ 2,090
Total			**$121,095**

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Fayette County - City Mission - Living Stones, Inc.
155 N. Gallatin Ave
Uniontown, PA 15401
Contact: Dexter Smart

Provider Type: Other housing agency
PDX ID: PA-034
State Provider ID: 4234
Contact Phone #: 7244390201

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 58,392**	**$ 19,464**	**$ 77,856**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 58,392	$ 19,464	$ 77,856	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 58,392	$ 19,464	$ 77,856	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 58,392	$ 19,464	$ 77,856	

Source(s) of Match Dollars for State Funds:

Fayette Co will receive a total of $77,856 in federal and state PATH funding.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 450

Estimated Number of Persons to be Enrolled: 55

Estimated Number of Persons to be Contacted who are Literally Homeless: 383

Number staff trained in SOAR in grant year ending in 2018: 4

Number of PATH-funded consumers assisted through SOAR: 3

NOT FINAL

Fayette County Behavioral Health Administration
PATH Intended Use Plan
2019-2020

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:

<u>City Mission-Living Stones, Inc., 155 North Gallatin Avenue, Uniontown Pa 15401</u>
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. City Mission continues to seek creative and innovative ways of addressing the problems of rural homelessness. City Mission's comprehensive housing and service programs and professional, compassionate staff help clients by supporting them step-by-step through the arduous process of moving from homelessness to self-sufficiency.

City Mission has two emergency shelters to meet the immediate needs of homeless families and individuals. Homeless individuals receive food, clothing, case management, and transportation support at these shelters. The men's shelter have beds for 21; the agency's shelter for women and children has a 12-bed capacity.

Home Again was a 14-bed therapeutic facility that is specifically designed to meet the residential, mental health and social service needs of youth ages 9-17. Home Again closed at the end of April 2019. Open since 2002, Home Again targeted youth who may have been victims of abuse and neglect, youth placed by Juvenile Probation, and some who simply need respite services as an alternative to a more restrictive hospital placement.

In addition to these facilities, City Mission operates the Gallatin School Living Centre, a 30-unit housing and service complex. Gallatin School Living Center has 11 transitional housing units; one emergency unit shelter for families, and 18 permanent housing Single Room Occupancy (SRO) units. All units are fully furnished. City Mission serves clients from birth to adulthood.

The continued need for permanent housing linked to supported services, has been a priority for City Mission. Liberty Park and Sycamore Hills Apartments, both comprised of 4-units, are occupied by families/individuals who were formerly homeless. Additionally, City Mission operates Stone Ridge Apartments, a 6-unit apartment complex opened in September 2015. These permanent supportive housing units prioritize serving individuals with mental health disability.

City Mission received funding for the first phase of building a four-unit, permanent supportive housing complex. Additional funding is being researched to support the second phase of this project to add four additional units.

In November of 2016, City Mission opened PROMISE House, an independent living program/facility supporting young adults ages 18-21. PROMISE House consists of three 2-

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bedroom cottages – one for young men, one for young women, and a third cottage functions as both housing for either a young man or women plus space for staff living and administrative functions. The Office of Children, Youth, and Families licensed PROMISE House according to the Pennsylvania Chapter 3800 regulations concerning Child Residential and Day Treatment Facilities. PROMISE House serves youth with little to no parental involvement who may age out of the foster care system. Having no options for housing other than adult shelter, PROMISE House provides eligible youth with life skills programming while accessing safe, permanent, and affordable housing.

City Mission employs 25 staff members with various post-secondary education levels who offer extensive work experience that uniquely qualifies them to work with the homeless population.

City Mission-Living Stones, Inc. $ **77,856**
State funds of $19,464 is allocated for Fayette County's PATH program. Federal funds of $58,392 are included to equal the total allocation of $77,856. Funds contracted with City Mission-Living Stones, Inc. will be used for salary and benefits for one (1) FTE Case Manager. Additional expenses include program supplies, consumer transportation, staff training and client rental assistance. Please see the attached budget for more details.

PDX – PA-034 Fayette: City Mission-Living Stones, Inc

Collaboration with HUD Continuum of Care (CoC) Program
City Mission continues to be an active participant in the HUD Western PA Continuum of Care PA-601 division since its inception. City Mission's executive director played a vital role in developing key components of the Southwest PA Region Continuum of Care, prior to the State of Pennsylvania hiring a developer to complete that task; her efforts resulted in the first successful funding of the Balance of State's application. In addition, City Mission's Executive Director chaired the SW Region Homeless Advisory Board for several of its early years while policies and procedures were being developed. Employees of City Mission have continued to participate as active members of the Southwest Regional Homeless Advisory Board (SWRHAB) and attending all scheduled meetings of the Western Regional Homeless Advisory Board (WRHAB). City Mission's shelter supervisor represents City Mission at both the SWRHAB and WRHAB. Membership at the RHAB provides City Mission's representative with opportunities to participate in the scoring of applications for the region, formulating policy, and as a committee member help to target the special housing needs of youth and young adults. City Mission participates with the coordinated entry and assessment activities of the RHAB.

Over the years, City Mission has obtained numerous HUD grants through the Western Continuum of Care process to help address the needs of Fayette County's homeless population. This process includes assessing gaps in service, coordinating services with other providers, and spearheading capital campaigns.

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 continues to focus

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on implementing housing and support services for homeless individuals and families in Fayette County. Both Fayette County Behavioral Health Administration and City Mission representatives are active on the Fayette County Partnership for Housing and Homelessness and its Local Housing Options Team (LHOT). This organization is made up of representatives from all county agencies that deal with various aspects of housing throughout the Fayette County area. This team has been active in affordable housing studies that help to understand 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 whose mission is to provide care for 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. Centrally located in Uniontown is 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 review individualized needs to 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. Highlands Hospital in Connellsville continues to provide inpatient Mental Health services.

Fayette County has also established a Forensic Diversion and Reentry Program for persons with mental illness who have been incarcerated or are at risk of incarceration. The Fayette County Mental Health Treatment Court, The Veterans Court, and Fayette County Drug and Alcohol Court each refer their participants to treatment and rehabilitation programs. Since 2012, five classes of municipal and state police officers have completed the Memphis Model CIT Training. These officers are trained to effectively intervene in situations regarding individuals who may be experiencing symptoms of mental illness. 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 support consumers through advocacy and supports PATH clients by attending appointments and helping to maintain their overall treatment plan. This coordination helps to provide a more holistic approach to PATH client services. The PATH Case Manager accesses additional guidance and funding through the Fayette County Behavioral Health Administration in order to better support client needs. Through stabilization funds provided through Fayette County Behavioral Health

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Administration, PATH clients are able to access funding support for rental assistance and household items such as furniture, beds etc… This funding allows clients the ability to move into their own apartments, increasing their independents in the community. Individuals with severe mental illness have the option of accessing skill-building supports through three providers of Psychiatric Rehabilitation services, Chestnut Ridge Counseling Services, Crosskeys, and Goodwill- Clubhouse model. These programs can assist clients within the living, working, learning, and socialization environments through skill building to increase independents.

Substance Abuse: Outpatient drug and alcohol services; residential drug and alcohol services; ambulatory detox clinic; methadone treatment services; Suboxone Treatment; and 12-Step programs are located throughout the county. PATH eligible clients have 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. The PATH Case Manager is familiar with both private and county run programs that offer D&A support meetings.

Housing: City Mission's permanent, transitional, and emergency shelter services are described throughout this plan. Fayette County Community Action Agency and Fayette County Behavioral Health Administration have collaborated on a permanent housing initiative Fairweather Lodge in Connellsville, Pa. can support eight individuals with mental illness. This, along with the development of Fayette Apartments, a 10-unit permanent supportive housing complex in Uniontown for chronically homeless single adults with Mental Health diagnoses. Fayette County Community Action in collaboration with Fayette County Behavioral Health Administration is continuing its Housing Opportunities Program (HOP) into 2021. This program provides Case management services, tenant-based and master leasing opportunities for homeless and near homeless residents with a mental health diagnosis. Fayette County Behavioral Health Administration contracts for Community Residential Rehabilitation Services (CRR); Supported Housing programs; and a Long-Term Structured Residential (LTSR) treatment-based 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 collaborates with local community providers and Fayette County Behavioral Health Administration to help support the housing needs of individuals with mental illness, through increasing the availability of supportive housing and scattered housing 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, which includes medical appointments and behavioral health appointments. There is limited transportation outside of Fayette County to the Pittsburgh and Morgantown WV areas for medical appointments.

Employment Services:Workshops, Transitional Employment, Mental Health supportive employment programs, Intensive Vocational Rehabilitation Program for individuals with substance abuse disorders, and Psychiatric Rehabilitation Programs are available through several local employment-support providers. Literacy programs are offered by a variety of organizations.

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Career Link provides assistance in arranging for job training, securing employment, and GED preparation. Office of Vocational Rehabilitation (OVR) maintains a local office, providing vocational assessment and assistance in arranging job training and supports.

Education Services: Penn State Fayette – Eberly Campus and Westmoreland Community College- Fayette Campus offer assistance in admission and financing for higher education programing. Laurel Business Institute, centrally located in Uniontown offers continuing education opportunities, along with Pennsylvania Institute of Health and Technology and Fayette County Career and Technical Institute.

Community Support Services: A number of local organizations provide tangible goods, including food, clothing and household items. Among them are local churches, Society of St. Vincent DePaul, Salvation Army, Connellsville Area Community Ministries, Goodwill Industries, Fayette County Community Action Agency, and City Mission.

The PATH Case Manager understands eligibility, referral and access procedures for all of these programs and supports. The PATH Case Manager also participates in several established councils to insure coordination of care for individuals with mental illness. These include the Continuity of Care Committee (representatives from local inpatient units, outpatient, case management providers and Fayette County Behavioral Health Administration), Fayette County Human Service Council, the Fayette County Partnership for Housing and Homelessness and its Local Housing Options Team (LHOT). City Mission is one of the community's primary provider of services to Fayette County's homeless population. The agency receives referrals from area hospitals, local police departments, and other related service organizations that encounter individuals who fall within the targeted PATH eligibility. 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 online training certification program, which provided intensive step-by-step instruction on completing SSI/SSDI applications.

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Service Provision

PATH eligibility determination

In alignment with the PATH HUD guidelines, City Mission assess individual eligibility for PATH services utilizing the following criteria:

o An individual is determined to be experiencing "serious mental illness or serious mental illness and substance abuse" and the individual is experiencing homelessness or is at imminent risk of homelessness.

o All staff working in the emergency shelters are trained to do outreach, assess needs, helpful communication and dealing with the most basic needs first.

o City Mission's primary source of referral is through the shelter programs. A specific intake form was developed to immediately identify PATH eligible clients that move through the shelter.

o City Mission's shelter director then sends the referral to the PATH Case Manager, at that time immediate follow-up takes place to insure the individual has access to help before hastily leaving the shelter program.
o During the intake process, potential PATH clients are required to sign an authorization for release of information concerning mental health diagnosis and treatment. This step is to insure documentation of diagnoses and primarily, for the PATH Case Worker to have the information need to help assess needs and maintain continued access to community-based supports.

Alignment with PATH goals
Fayette County, Pennsylvania is a rural community with few documented street homeless. City Mission continues to be active within the county's Point in Time (PIT) count. Based on data obtained from the 2019 PIT count, Fayette County located zero homeless individuals. This number decreased from 2018 when three street homeless individuals were identified and supported. The PATH Case Worker provides ongoing outreach through shelter visits and partnerships with other social services agencies. There is outreach, collaboration with Fayette County's service systems, including the local prison, Probation Office, and Children and Youth Services. The PATH Case Manager continues to participate in community provider meeting. As a rural community, Fayette County providers have develop resourceful relationships, helping the PATH Case Manager to better access services and address client needs.

Maximizing use of PATH funds
Financial assistance is available and utilized through several organizations and county resources on a case-by-case basis. Fayette County Community Action Agency, St. Vincent de Paul, Salvation Army and the County Assistance Office as well as several local churches, are willing to provide direct financial assistance to PATH clients. These agencies are always the first consideration. The PATH Case Manager also accesses financial support for PATH clients through Fayette County Behavioral Health Administration's Consumer Stabilization funds. These funds assist with rental assistance and household items that help support independence.

Gaps in current service system
An ongoing gap that exists within Fayette County is providing holistic support to clients with co-occurring disorders. PATH clients with co-occurring disorders often move between mental health and addiction service providers with limited collaboration between systems and accessible information. Consumers who find themselves without safe, permanent, and affordable housing tend to focus on these areas rather than accessing treatment. Housing needs of PATH eligible clients continue to be addressed by City Mission through the Gallatin School program, Liberty Park Apartments, Sycamore Hills and Stone Ridge Apartments. These units are dedicated to families and individuals who present with a need for supportive housing. Residents who experience mental health or addiction concerns are able to live independently in the community, in large part, due to the support services integrated with their housing. All of these projects have help fill this housing gap by providing PATH clients with access to 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 maintaining City Mission's vans and collaborating with the

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County Office of Human Services' Fayette Area Coordinated Transportation (FACT) Program. PATH clients who live on fixed routes, have access to MATP, or require support for transportation needs beyond the county line receive support in accessing FACT services. The PATH case manager is able to register and document client eligibility for FACT transportation. The FACT office continues to be an important asset to the community and is working hard to meet the needs of all Fayette County residences.

The PATH case manager faces many obstacles when supporting PATH eligible clients in the community. Rurality creates some ongoing barriers to supporting independence. These barriers seem to focus on the availability and accessibility of employment and housing for forensic involved PATH clients. As stated, Fayette County Behavioral Health Administration works to provide access to choice within mental health services that promote recovery, along with providing funding for ongoing housing case management services for all residents regardless of forensic history. Employment and housing barriers continue to exist among PATH clients with criminal record history, addiction, and secondary education services for low income. In spite of the ongoing community supports, full-time employment, in general is difficult to access. The majority of jobs are part-time preventing individuals from earning enough money to support themselves. The PATH Case Manager works on addressing these obstacles through supporting PATH clients with additional training and building ongoing relationships with community business owners, property owners, and employment programs.

Co-occurring services available
PATH clients who experience both a serious mental illness and substance use disorder have access to the following services through City Mission: case management, transportation, housing, emergency shelter, and permanent housing onsite at the Gallatin School Living Centre, Liberty Park Apartments, Sycamore Hills and Stone Ridge Apartments.

A Master's level social worker employed by City Mission facilitates support group sessions at the Gallatin School Living Centre. These sessions function on need for clients with co-occurring disorders, and help to address the unique needs of dually diagnosed individuals. The PATH Case Manager works with county agencies Chestnut Ridge Counseling Services and Family Behavioral Resources to set up intake appointments quickly to ensure access to mental health and drug and alcohol services.

Outreach: Fayette County Behavioral Health Administration conducts ongoing outreach activities with the Fayette County Prison in partnership with Southwestern Pennsylvania Human Services. The Forensic Diversion and Reentry Program is setup to complete assessments, design treatment plans, and create release strategies for individuals in the county jail. The PATH Case Manager has access to the Public Defender's office, Adult Probation and Legal Aid to help provide linkages for forensically involved PATH clients. The PATH Case Manager is able to go into the jail to provide case management services for incarcerated PATH clients. City Mission is working with the county's Children and Youth Services, along with Juvenile Probation Office to identify youth who are aging out of their systems and need ongoing supportive housing services. PROMISE House will continue to be a key resource for those youth needing housing and support services beyond the age of 18. Fayette County Behavioral Health Administration collaborates with City Mission to identify and assess referral needs of individuals who are homeless. City

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Mission staff stays in contact with the Veterans Affairs and other local veterans support organizations, helping veterans to access benefits and create linkages to other community supports.

Transportation: The PATH program continues to offer transportation support, with the PATH Case Manager helping to schedule appointments as needed. 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. Some PATH clients have special needs, which makes them more dependent on the transportation support through City Mission. City Mission's two passenger vans are used throughout the agency to help meet the transportation needs of all City Mission's clients. This transportation resource help clients access basic community amenities, such as, medical facilities, shopping malls, grocery stores, and treatment services, including recovery-focused services. This support is provided through City Mission until clients are able to successfully utilize the community's public transportation services.

Rental assistance and/or security deposit assistance: A percentage of PATH funds will be utilized as emergency monies to assist PATH eligible individuals with one-time rental-assistance/security deposits. During fiscal year 17-18, the significate decrease in funding from the Department of Community and Economic Development-Emergency Shelter Grant, impacted services at the temporary emergency shelter programs for PATH eligible consumers. City Mission received tremendous support from local agencies and private donors to help maintain Emergency shelters. However, state and federal officials should reexamine the availably of ESG funding for emergency shelters.

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 scattered community-based housing. The PATH case management coordinates and advocates on behalf of the PATH clients, working with local property owners to find and access safe, affordable, and permanent housing. Typically, by the time a PATH eligible client is homeless, he/she has burned many bridges, with family, the Fayette County Housing Authority, or other supportive housing programs. Often, clients have poor credit and do not qualify for loans, or other types of housing assistance. The proposed use of PATH funds 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. Fayette County Behavioral Health Administration requires the PATH provider to inform participants of the benefits and risks of services in order to support informed decision making by PATH eligible clients. PATH clients and their family members are 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. The PATH Case Manager is responsible for ensuring all PATH client's needs are identified, including attainment of client eligible mainstream benefits. The PATH caseworker has completed Mental Health targeted case management (ICM/RC) training increasing the understanding of psychiatric disorders, treatment strategies and recovery principles. This approach has ensured appropriate mental health

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screening and follow-up assistance for individuals presenting at City Mission facilities. This approach has helped to enhance the awareness of mental health disorders and effective approaches to recovery throughout the agency. The PATH Case Manager continues trainings focused on promising approaches, cultural competence, recovery principles, and SOAR trainings.

In the summer of 2017, the PATH Case Manager participated in a 2-day Aggression Replacement Training (ART). While designed primarily as an intervention to target aggression in youth, this training provided trainees with the tools to implement a 10-week ART course with clients in the program who would also benefit. ART covers social skills training, anger control and moral reasoning.

PATH clients have access to a variety of treatment and care options available through the mental health, drug and alcohol, and healthcare systems within the region. The PATH Case Manager completes a comprehensive assessment of client's needs, and uses that information to create an individualized goal plan. PATH clients are offered assistance in completing a Wellness Recovery Action Plan (WRAP) if they so choose. Fayette County's PATH program is designed to be individualized for each client. Each goal plan focuses on specific components and needs related to each client. Services within goal plans may include, life skills training, budgeting, resume assistance, health care screenings, and literacy classes.

42 CFR Part 2 regulations
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) 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 is built when a client knows that his/her concerns are kept confidential. Staff at City Mission understand the importance of client confidentially. 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 are supported through the agency.

While an individual is receiving services through City Mission, they may become familiar with other clients and their life situations. In consideration of this, City Mission asks that each client take every precaution not to give out information on the identity or life circumstances of any other individual. Each client is also required to sign a Statement of Confidentiality upon entering the shelter programs.

Justice-involved

NOT FINAL

The PATH Case Manager maintains a positive working relationship with many of the county's forensic service providers. These providers include, Southwester PA Human Services (SPHS), County Assistance Office, Adult Probation, Legal Aid, Local magistrates and several private medical service providers. The PATH Case Manager also helps to play the role as advocate and supporter in attending court hearings, medical appointments, and mental health treatment. Continued coordination helps to provide a more holistic approach to client services.

Crisis Intervention Team (CIT) training for local and private Police Officers have continued within the county. These officers are trained to effectively intervene in identifying and assessing situations where individuals may be experiencing overwhelming mental health symptoms. Fayette County Behavioral Health Administration conducts ongoing outreach activities with the Fayette County Prison to complete assessments and design treatment and release strategies for individuals in the county jail. PATH Case Manager also has access to incarcerated PATH clients to provide direct case management service. Approximately 70% of PATH clients have been involved with the Criminal Justice System.

Jail Diversion: Fayette County has established a Forensic Diversion and Reentry Program through SPHS for persons with mental illness who have been incarcerated or are at risk of incarceration. The Fayette County Mental Health Treatment Court, The Veterans Court, and Fayette County Drug and Alcohol Court each refer participants to treatment and rehabilitation programs. The PATH Case manager has access to each of these programs and is able to refer individuals.

Primary health: Physical health care is available through individual practitioners and several clinics that have as their mission to provide care to low-income individuals. Two Federally-Qualified Health Centers are Centerville Clinic and Cornerstone Care and Wesley United Methodist Church Medical Clinic in Connellsville, PA. Adagio Health located in Uniontown address preventative and primary care for women. Criminal histories do not restrict access to medical services.

Housing Programs: Housing stability is essential for successfully reintegrating formerly incarcerated persons back into the community. As discussed previously, an ongoing gap in housing services for ex-inmates continue to be affected by tenant-selection criteria in most public housing throughout the state. This barrier to housing has prevented individuals with criminal histories the ability to access affordable housing, or even return to their family homes in public housing. Lacking other housing options, many of these people still live with their families in public housing but off the lease and "in the shadows," which put their entire family at risk of eviction. Through Fayette County Behavioral Health Administration's Stabilization Funds Program and housing assistances thru Fayette County Community Action, PATH clients are able to access funds for rental assistance and necessary household items. These supports have allowed clients to increase independents and help access or maintain current mental health and drug and alcohol treatment.

Job Opportunities: Community workshops, Transitional Employment Consultants (TEC), Intensive Vocational Rehabilitation Program for individuals with substance abuse disorders, and Psychiatric Rehabilitation Services are available through several local employment-support

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providers. Literacy programs are provided through many different 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 for higher education. Fayette County Community Action Agency offers training, education, and employment services through its Community Training Institute and the Work Ready program. The Office of Vocational Rehabilitation maintains a local office, providing vocational assessment and assistance in arranging job training and supports.

Data

City Mission has been utilizing the Housing Management Information System (HMIS) since its inception in 2006 and inputs both universal and program specific data for all City Mission clients. Staff working directly with HMIS have 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 on HMIS updates and changes are implemented. City Mission has already taken the necessary steps required to transition PATH data into the HMIS system. At present, all clients that are PATH eligible are entered into the ClientTrack 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. City Mission's HMIS trained staff will continue to utilize HMIS online trainings and manuals from the Pennsylvania Continuums of Care website.

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Alignment with PATH Goals

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

Fayette County's PATH Case Manager will continue to provide outreach by facilitating shelter visits, collaborating with other social services agencies, helping with the annual point-in-time count, and partnerships with local church organizations. Outreach takes place daily with the PATH Case Workers continued association with Fayette County's service systems, including the local jail, Probation Office, Children and Youth Services, and the local hospitals human services departments.

The PATH caseworker has completed Mental Health targeted case management (ICM/RC) training increasing the understanding of psychiatric disorders, treatment strategies and recovery principles. This approach has ensured appropriate mental health screening and follow-up assistance for individuals presenting at City Mission facilities. This approach has helped to enhance the awareness of mental health disorders and effective approaches to recovery throughout the agency. The PATH Case Manager continues trainings focused on promising approaches, cultural competence, recovery principles, and SOAR trainings.
All PATH clients work directly with the PATH Case Manager. The continued responsibilities of the PATH Case Manager is to support clients by helping identify needs, acquire mainstream benefits, and develop an individualized goal plan to access permanent and safe housing. Each client's program is designed to contain the components specific to his/her needs and includes, as

necessary, life skills training, budgeting, resume assistance, health care screenings, and literacy classes. The PATH Case Manager is trained in promising approaches, cultural competence, recovery principles, and SOAR.

Alignment with State Comprehensive Mental Health Services Plan

City Mission's overall program development has been consistent, over the years, with the State's plan to end homelessness and help to deinstitutionalize individuals in state hospitals. City Mission's programs have helped individuals successfully live within supportive housing units and in scattered housing of their choosing with community-based services. The PATH Case Manager works with clients on skill building focused on budging and accessing community resources through referrals. Partnerships with local property owners have helped to prevent eviction through communication, accessing assistance through other community agencies, and connecting clients to other program supports that focus on strength building. In following the Housing First model, Fayette County Community Action Agency and Fayette County Behavioral Health Administration have collaborated on permanent housing initiatives. The Fairweather Lodge in Connellsville, Pa. model is for individuals with mental illness at a capacity of serving eight individuals at any one time. Fayette Apartments is 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 understanding the importance of collaboration among community providers, the PATH Case Manager participates in local and state housing meetings. The PATH Case Manager continues to maintain community-based collaboration community leaders, program managers, Landlords, and church organizations. The PATH Case Manager is SOAR trained and has an extensive understanding of the Medicaid and Social Security Disability processes.

City Mission and Fayette County Community Action are Fayette County's primary HUD funded housing support providers. These agencies have created a partnership in establishing a process for implementing the coordinated entry system. Fayette County Community Action helped to pilot the coordinated entry system within the western region of Pennsylvania. Both agencies have been successfully utilizing this system since its state established start in January 2018. This process has helped to identify and immediately support individuals and families that are chronically homeless. In continual alinement with the state's housing plan, City Mission continues to operate PROMISE House, an independent living program that service young adults ages 18-21. PROMISE House helps Youth and Young Adults transition from the child serving system to the adult serving system, along with assisting the development of independent skills and accessing continued education and job training. The goal of PROMISE House is to transition these Youth and Young Adults into community-based housing of their choosing.

Other designated Funds

NOT FINAL

No specific funding is earmarked for PATH services in the county under the Mental Health or Substance Abuse sections of the Human Service Plan 18-19. The County Human Service Plan continues to focus on needs surrounding increase access to safe, affordable, and permanent housing along with access to community-based mental health and drug and alcohol services. PATH works in partnership with Fayette County Community Action Agency to access funding through the Homeless Assistance Program, a component of the County Human Service Plan. This funding helps to support all homeless individuals and families in the county.

Programmatic and Financial Oversight

Fayette County Behavioral Health Administration designates a Master's level Mental Health Program Specialist to oversee PATH spending and to assist the PATH case manager in completing all required State and Federal PATH trainings and reports. The Mental Health Program Specialist actively participates in PATH trainings to secure a better understanding of PATH goals and data collection. PATH monitoring takes place at the county level, through visits, billing review, and plan updates. The county PATH monitor and the PATH Case Manager have a positive working relationship and are open in discussing client needs, community needs, and required PATH data collection.

SSI/SSDI Outreach, Access, Recovery (SOAR)

The number of staff trained in SOAR

In addition to the PATH case manager, City Mission has three other full time staff person who have completed the SOAR on-line certification training.

The number of staff who provided assistance with SI/SSDI applications using the SOAR model:

In addition to the PATH case manager, City Mission has three other full time staff person trained in SOAR who provided assistance with SI/SSDI applications.

The number of consumers assisted through SOAR

For fiscal year 2018-2019, three PATH consumers have successfully received benefits (SSI/SSDI) from directly working with the SOAR trained staff at City Mission.

Application eligibility results (i.e., approval rate on initial application, average time to approve the application)

Average time for client approval using the SOAR process is approximately 60 - 90 days from day of application. Each client situation is different. Those that have been denied benefits in the past, and are reapplying, determination can take up to a year or more.

The number of staff dedicated to implementing SOAR, part and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative

NOT FINAL

system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]
In addition to the PATH case manager, City Mission has three other full time staff who completed the SOAR on-line certification training. City Mission does not show a need to have a staff person dedicated strictly to completing SOAR applications within the program. Steps have been taken to assure appropriate staff are trained in SOAR and SSI/SSDI benefits so that clients have access to the process and information. The staff trained in the SOAR process work with homeless, chronically homeless, youth, and adults within City Mission Programs.

Housing
Fayette County has a continuum of housing services in place to meet the needs of its homeless population. The PATH Case Manager works with the consumer to present options of safe, appropriate, and affordable housing to meet the needs of each individual client. Since the PATH program became operational in Fayette County, City Mission has worked to develop relationships with private property owners 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.)
    - Promise House (Independent living facility serving youth ages 18-21)
- Fayette County Community Action Agency
    - Bridge Housing
    - Housing Supports Program
    - Master Leasing
    - Tenant-based rental subsidy
    - Lenox Street Apartments
    - Fairweather Lodge
    - Fayette Apartments
    - Hosting continued Landlord summits, helping to provide support and resources to local property owners.
- 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)

NOT FINAL

- Housing Supports Program
- Southwestern Pennsylvania Human Services
  - Community Residential Rehabilitation (CRR)
  - Housing case management
- Goodwill Industries
  - Jefferson Apartments
- Fayette County also has numerous small (less than 16 resident) personal care homes that provide housing for individuals with mental illness.

Coordinated Entry

City Mission is participating directly with the Coordinated Entry process, working with Fayette County Community Action Agency (FCCAA), to implement the process and meet requirements. Several individuals and families have utilized housing case management services through Coordinated Entry. Clients using emergency shelter services are assisted in setting up an appointment with FCCAA to complete the coordinated intake process. A point person at FCCAA contacts City Mission's property manager to streamline the entrance process into permanent housing.

Justice Involved

The Memphis Model Crisis Intervention Team training is employed in Fayette County. There are many small municipal police departments with only a couple of officers. In those communities, 50-100% of the officers are CIT-trained. In larger communities, 10-20% are of officers are trained. Within the local State Police Barracks, less than 10% are trained. The chiefs from the departments that actively use CIT officers as their specialists when responding to persons with mental illnesses are very pleased with officer safety, consumer safety, and reduced arrests.

Staff Information

Describe the demographics of staff serving your clients

City Mission as the PATH program provider is comprised of a diverse array of staff, which includes:

- Male and female staff.
- White, African-American and other ethnic minorities.
- Master's level, Bachelor's level, and High-School trained staff
- City Mission employs and uses volunteers who were formerly homeless clients

Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients.

City Mission has more than 30 years of experience serving the diverse 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

NOT FINAL

customs unique to the area. The PATH Case Manager will continue to look for opportunities to develop a better understanding of the LGBTQI2-S community. City Mission does not discriminate based on sex, gender, race, age, sexual preference, or disability.

Discuss the extent to which staff are receptive to differences of clients
City Mission has employee orientation programs that address human diversity within its individual service delivery system. Additional, training programs are setup to reinforce the importance of cultural sensitivity and provide opportunities for employees to examine their personal beliefs, attitudes towards different cultures, and develop plans for personal growth in this area.

Identify the extent to which staff receive periodic training in cultural competence and health disparities
City Mission has addressed these service barriers through program design and the utilization of a specialized Case Manager, working within City Mission with all specialized sub-populations who utilize PATH services. It is the practice of the Fayette County Behavioral Health Administration to engage local consumers and family members in all aspects of program development and evaluation.

Fayette County Behavioral Health Administration has identified cultural sensitivity as a priority for training and staff development. FCBHA has continued to work closely with the Fayette County Human Service Council and Penn State Fayette – Eberly Campus to make trainings available. Other trainings are offered through local universities including California University, West Virginia University and the University of Pittsburgh. Fayette County and PATH providers seek out opportunities for cultural sensitivity training for all staff.

Finally, in order to assure that services are being delivered in a culturally sensitive manner, consumers are advised of procedures for filing complaints with the Fayette County Behavioral Health Administration about any problems they perceive in the delivery of services, including disrespectful behavior on the part of staff. The County reviews all such complaints with providers and works with them to develop corrective action plans.

Listed below are trainings completed by the PATH Case Manager since the PATH program was implemented in Fayette County.

- Improving Practice in our African American Appalachian Community
- PA Office of Mental Health & Substance Abuse in collaboration with Drexel University—16th Pennsylvania Case Management Conference
- Suicide / Risk Assessment – Penn State Fayette
- Co-Dependency – Penn State Fayette
- Forensics and Addiction – Penn State Fayette
- Evidence-Based Practices – Employment Transformation Project
- Strategic Planning session – Employment Transformation Project
- Basic Case Management/Resource Coordination Web-Based training
- Motivational Interviewing for Mandated Treatment
- PATH National Teleconference on Recovery

NOT FINAL

- Substance Abuse & Axis II Personality Disorders Assessment & Treatment
- Wellness Planning – First Annual Recovery Conference in Fayette County
- Choices in Recovery seminar
- Motivational Interviewing Skills for Mental Health Care Workers
- Outreach to People Experiencing Homelessness & PATH National & State Perspectives
- Learning About Adult Services in Fayette County
- Working with Family Systems – Fayette County Drug & Alcohol Commission, Inc.
- Peer Employment Training
- SOAR – Stepping Stones to Recovery
- HIV & Pregnancy – Fayette Healthy Start
- Cross Systems Mapping & Taking Action for Change
- Promoting a Healthy Work Environment in Homeless Services: What Works (web training / SAMHSA)
- Supportive Housing; Speaking Landlord (OMHSAS web training)
- PREP - Prepared Renters Program I & II (coach training)
- PATH Data Reporting 2010 (SAMHSA)
- Fair Housing: Rights & Responsibilities
- Evidence Based Practices KITs: Shaping Mental Health Services Toward Recovery (SAMHSA)
- “The Mystery of the Mind and the Demystification of Psychiatric Drugs” – (CRCSI)
- SAMHSA Street Outreach Video
- Healthy Start/University of Pittsburgh School of Social Work… HIV & Pregnancy, Impact & Issues
- FCBHA/Fayette Court of Common Pleas …Cross Systems Mapping & Taking Action for Change
- SAMHSA…Promoting a Healthy Work Environment for Homeless Service Agencies
- Veterans: Return, Reintegration and Reconnecting
- SAMHSA…Homelessness Prevention
- Recovery & Resiliency-based Individualized Service Treatment Planning
- Stalking: Know it/Name It
- HMIS Training – (HMIS Intake/Caseworker and HMIS Intake/Caseworker Supp.- 11/2012; HMIS Intake/Caseworker - 10/2013; HMIS Core Training & HMIS/PATH Training - 11/2014; HMIS/PATH Programs – 2/2015)
- CPR First Aid
- SOAR Certification on-line training
- 2-day Aggression Replacement Training (ART)- 2017

How many of your PATH staff are Certified Peer Specialists or Certified Recovery Specialists?

City Mission’s PATH program does not currently employ a Certified Peer Specialist or Certified Recovery Specialist. However, two local agencies, Chestnut Ridge Counseling Services and Southwestern PA Human Services (SPHS), provide these important supports.

Client Information

NOT FINAL

Describe the demographics of the client population
Based on data provided by City Mission on homeless clients served from 2000-present, as well as information from Fayette County Behavioral Health Administration, a description of the demographics for clients in the PATH program is as follows:

- The majority of the clients are single white males, between the ages of 25 and 40.
- Five (5) clients identified as Veterans.
- 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 2018- June 2019

o Clients that received services as of June 5, 2017
Total **74**

- **38** entered July 1, 2018 thru May 31, 2019
- **36** were carried over from previous year

o	**Gender**	**Race/Ethnicity**
	Female – **28**	White **46**
	Male – **46**	Black **26**
		Hispanic **2**

Of those who entered July 1, 2018 thru May 31, 2019

21 Entered the program from the emergency shelter
2 Entered from programs (180 Degree; Bridge House)
2 Entered from domestic violence shelter
4 Being Evicted
6 Staying with family or friend
1 Was staying in hotel
1 Released from Fayette County Prison
1 Living on the street

Project the number of adult clients to be contacted
City Mission expects to provide outreach to approximately 450 homeless clients primarily at City Mission's two emergency homeless shelters.

Identify expected number of adult clients to be enrolled
City Mission anticipates enrolling approximately 50-60 adult clients using PATH funds in FY 2018-2019.

Give estimated percentage of adult clients served using PATH funds who are literally homeless.
City Mission expects that 85% of PATH eligible 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,

NOT FINAL

transportation, and case management. For those who are at risk of being homeless City Mission uses homeless prevention funds for PATH eligible individuals. Funding 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, and Fayette County Community Action.

Additionally, City Mission links non-PATH eligible individuals to housing case management services through Southwestern Pennsylvania Human Services (SPHS) or Crosskeys Human Services. Upon the start of services the PATH Case Manager works to stabilize the client in housing, assures all housing related supports are established, and once stable clients may then be referred for Mental health Case management through SPHS or Centerville Clinics for further mental health case management

Consumer Involvement
Each year City Mission's PATH consumers are given the opportunity to discuss, evaluate and provide feedback on the PATH Program. City Mission requires that their governing board include representatives who are either current service users or have used services in the past. Two PATH consumers presently sit on City Mission Board. The Board currently meets at the Gallatin School Living Centre regularly to assess satisfaction of services.

City Mission currently employs five formally homeless individuals. Fayette County Behavioral Health Administration's Advisory Board also includes consumer and family representation.

Health Disparities Impact Statement
Based on HMIS data, Fayette County PATH clients represent a limited number of diverse cultures and ethnicities. Being a rural community and set in certain cultural and traditional ways, residents may not feel comfortable disclosing anything about them that may be "different" from the norms. Fayette County Behavioral Health Administration (FCBHA) understands the importance of breaking down these barriers and helping to reduce stigma. FCBHA continues to work on providing cultural sensitivity and LGBTQS-2 acceptance trainings. FCBHA and City Mission work to address these disparities through program development and trainings. The Youth and Young Adults population has been and identified group impacted by service gaps. This continues to be addressed through the development of consumer/peer run advocacy groups and program creation focused on serving Youth and Young Adults within Fayette County. In August 2016, City Mission opened PROMISE House, an independent living program/facility that serves young adults ages 18-21. PROMISE House consists of three small two-bedroom cottages—one for young men, one for young women, and the third functions as a staff unit and young adult unit for either a man or women. Youth with no parental involvement who age out of the Home Again program have had no options for housing other than adult shelter. PROMISE House provides life skills programming, along with safe, permanent, and affordable housing for the underserved youth and young adult population. In 2018, Fayette County Behavioral Health Administration started the county's first Gay, Straight Alliance group. This group has been helpful in addressing challenges within the human services field and understanding the specialized needs of individuals that are LGBTQS-2.

NOT FINAL

As the direct provider of PATH supports, City Mission's PATH Case Manager has noted disparities inclusive to all categories in regarding access to support services, specifically individuals with criminal histories. PATH eligible clients with criminal histories have significate barriers to affordable housing and full-time employment. The PATH Case Manager is working to address these disparities through community partnerships with Landlords, Property Managers, community business leaders, and employment assistance programs.

Also, please identify efforts to support the current disparate population of Youth and Young Adult (YYA, ages 18-30) by providing the following:

The unduplicated number of YYA individuals who are expected to be served using PATH funds.
City Mission anticipates serving 6-8 transition age youth during the 19-20 fiscal year. Of these, we anticipate two (2) will be PATH eligible.

The total amount of PATH funds expected to be expended on services for the YYA population
That amount is difficult to determine at this time. Each PATH client is assisted on an individual basis and needs vary. However, based on previous year's amount it is estimated that $800 will be spend on YYA PATH eligible clients.

The types of services funded by PATH that are available for YYA individuals
Services funded by PATH available for YYA individuals include PATH Case Management, as well as rental assistance to help with transitioning in to community-based housing.

A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the YYA population and in comparison to the general population
PROMISE House helps to fill some of the current gap in services that exists supporting the needs of youth and young adults. The program works to target the specialized needs of YYA in the community. PROMISE House implements a comprehensive curriculum focused on life skills programming and other related independent skills.

Limited English Proficiency
City Mission continues to have access to faculty and student body at the University of Pennsylvania, Fayette Campus, who are willing to provide assistance when needed. A long-standing partner and friend to City Mission PSU offers instruction in well over 50 languages, and will be a definite, unlimited, benefit to clients that English is not their first language.

NOT FINAL

Budget Narrative

When reviewing the overall budget for the Fayette County PATH program, fiscal year 2019-2020, the majority of the expenditures are prioritized for professional expenses. These include PATH case manager and benefits, totaling $54,776. City Mission will continue to fund PATH outreach without changing the PATH budget. 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 to travel and staff trainings, have an estimated cost of $250. Housing related expenses, including one-time rental assistance and security deposits, total $7,000. City Mission will absorb the cost of individual and group support meetings for PATH clients and staff held as needed at the Gallatin School Living Centre location. Transportation expenses include bus tokens, fuel, and insurance coverage estimated at $6,185. Other PATH related expenses include Office Supplies, Equipment/Furnishings, internet cost, and other consumer-related items estimated at $6,650. Administration cost of monitoring the PATH program funding is 2,995. The total budgeted cost for the PATH program is $77,856.

NOT FINAL

Fayette County
City Mission - Living Stones, Inc.
PATH Program
FY 2019-2020 Budget

Position	**Annual Salary**	**PATH funded FTE**	**PATH funded salary**	**TOTAL**
Case Manager	$ 48,000.00	1	$ 48,000.00	$ 48,000.00
sub - total	$ 48,000.00		$ 48,000.00	$ 48,000.00
Fringe Benefits				
FICA	$ 3,686.00		$ 3,686.00	$ 3,686.00
Retirement	$ 1,440.00		$ 1,440.00	$ 1,440.00
Life Insurance/WC/UC	$ 1,650.00		$ 1,650.00	$ 1,650.00
sub-total	$ 6,776.00		$ 6,776.00	$ 6,776.00
Travel				
Travel to training	$ 250.00		$ 250.00	$ 250.00
and workshops				
sub-total	$ 250.00		$ 250.00	$ 250.00
Equipment/Furnishings	$ 1,000.00		$ 1,000.00	$ 1,000.00
as needed				
sub-total	$ 1,000.00		$ 1,000.00	$ 1,000.00
Supplies				
Office Supplies	$ 500.00		$ 500.00	$ 500.00
Postage	$ 50.00		$ 50.00	$ 50.00
Telephone/Internet	$ 3,500.00		$ 3,500.00	$ 3,500.00
Consumer related items	$ 1,600.00		$ 1,600.00	$ 1,600.00
sub-total	$ 5,650.00		$ 5,650.00	$ 5,650.00
Therapy Sessions				
sub-total				
Rental Assistance				
One time rental				

NOT FINAL

assistance	$ 4,000.00		$ 4,000.00	$ 4,000.00
Security Deposits	$ 3,000.00		$ 3,000.00	$ 3,000.00
sub-total	$ 7,000.00		$ 7,000.00	$ 7,000.00
Transportation				
Transportation	$ 6,185.00		$ 6,185.00	$ 6,185.00
includes bus tokens, fuel				
insurance for van				
sub-total	$ 6,185.00		$ 6,185.00	$ 6,185.00
Administration	$ 2,995.00		$ 2,995.00	$ 2,995.00
includes 4% allowable				
costs				
Sub-total	$ 2,995.00		$ 2,995.00	$ 2,995.00
TOTAL PATH BUDGET				**$ 77,856.00**

NOT FINAL

Forest-Warren - Warren Forest Economic Opportunity Council
1209 Pennsylvania Ave West
Warren, PA 16365
Contact: Chad Ressler

Provider Type: Social service agency
PDX ID: PA-038
State Provider ID: 4210
Contact Phone #: 8147262400

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 34,816**	**$ 11,605**	**$ 46,421**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 34,816	$ 11,605	$ 46,421	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 34,816	$ 11,605	$ 46,421	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 34,816	$ 11,605	$ 46,421	

Source(s) of Match Dollars for State Funds:

Forest/Warren Counties will receive a total of $46,421 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 75

Estimated Number of Persons to be Enrolled: 39

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

Number staff trained in SOAR in grant year ending in 2018: 6

Number of PATH-funded consumers assisted through SOAR: 1

NOT FINAL

Warren and Forest Counties Economic Opportunity Council

PATH Intended Use Plan for FY 2019-2020

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 publicly-funded human service system.

Forest Warren Human Services is responsible for the fiscal management of allocated federal, state, and county funds received for the specific purpose of providing identified human service programs. In conjunction with the fiscal management of these monies, Forest Warren Human Services is responsible for the management of contracts with private providers who agree to provide services in compliance with licensing, regulatory, and contractual requirements.

Forest Warren Human Services is also responsible for the planning requirements of each categorical program (MH, ODP, CYS, and ATOD). Each year a plan is developed, with consumer and community input, describing the current status and future goals for each program, utilizing the principals and advancement towards a recovery-oriented approach.

Forest Warren Human Services receives PATH funding through OMHSAS and contracts with the *Forest Warren Economic Opportunity Council* (EOC) as our PATH provider in the amount of $46,421.

The Warren-Forest Counties Economic Opportunity Council (E. O. C.), Inc. is a private, non-profit Community Action Agency and part of a 43-agency network covering the 67 counties in Pennsylvania and more than 1,000 Community Action Agencies nationwide, adhering to the philosophy of the Economic Opportunity Act of 1964. The agency utilizes available funds to operate programs designed to eliminate poverty in Warren and Forest Counties. The organization was incorporated in 1965.

The Agency Board of Directors responds to the needs of the local community through its operation of targeted programs. Since its inception, The Warren-Forest E. O. C. has ventured to move individuals to a higher economic position through services provided and by instilling a self-reliant and self-sufficient attitude in each client. It provides a systematic set of programs that attacks poverty through employment training, budget and savings assistance, and Head Start. It also addresses the conditions that low-income persons face in such areas as housing (through its homeless prevention, weatherization, housing counseling, transitional housing units and supportive housing units), and utility assistance. Some other examples of programs include: Housing Rehabilitation, Veterans Assistance, and Transitional Housing for Victims of Domestic Violence, Homelessness Prevention and Rapid Rehousing Program. The Economic Opportunity Council continues to provide exceptional services for people seeking to improve their quality of life through community, economic, personal, and family development.

The full name and address of the organization is:

Warren-Forest Counties Economic Opportunity Council
1209 Pennsylvania Avenue West
Warren, PA 16365

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This provider appears in the PDX as: PA-038 Forrest/Warren: Forrest Warren Economic Opportunity Council.
Services are provided throughout Warren and Forest Counties. The Warren and Forest Counties EOC is contracting PATH funds in the amount of $46,421.00

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

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 trainings. The Warren-Forest Co. Executive Director is a member of the CoC for our region and is a member of the Regional Homeless Advisory Board (RHAB) and Housing Alliance of PA. The E. O. C. currently operates a permanent supportive housing program and a domestic violence transitional housing program which will end 6/31/18 and become permanent supportive 7/1/18 through HUD CoC funding. E. O.C. actively participates in the coordinated entry process. The Housing Specialist continues to work with existing housing stock to house consumers and works with other community programs such as the local Housing Authority, and the multitude of services available at Warren-Forest Counties Economic Opportunity Council, local churches, and the Salvation Army to identify resources to prevent homelessness. E.O.C. Housing Specialists chair the Local Housing Options Team that encompasses staff from Mental Health, Drug and Alcohol, Housing Authority, Warren-Forest E.O.C., local C.S.P., landlords, Community Resources for Independence, Warren County Prison, Area Agency on Aging, Veterans Affairs and local tenants. The L.H.O.T. is continuing to expand their representation of service providers and Mental Health consumers. In addition, the PATH Housing Specialist organizes the "Point in Time Survey" conducted yearly housing staff attend quarterly meetings for the Western Regional Housing Options Coalition. The Warren Forest E.O.C. is a designated Homeless Assistance Program (HAP) coordinating Agency for Warren County, the E.O. C. is also the local lead agency for the 811 project.

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

The E. O. C. Housing Specialist works closely with each PATH eligible client to assist them in accessing needed services within the community. The community organizations that we work closely with are the Forest Warren Human Services, Warren State Hospital, Beacon Light Behavioral Health, Warren County Assistance Office, Forest County Assistance Office, Safe Place, Career Link, Salvation Army, Warren General Hospital, Deerfield Behavioral Health, Veterans Affairs, 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

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services are accessible to PATH eligible clients. As Warren-Forest E. O. C. is the only PATH provider in Warren and Forest Counties, no coordination between outreach teams is required. The 2-1-1 system is operational in the Warren-Forest Area and is another tool in coordinating outreach. Warren Forest E. O. C., local churches, service providers such as Salvation Army, Mental Health/D&A caseworkers, and local law enforcement will be incorporated into this system. Word of mouth as well Warren Forest EOC's website provide opportunity for outreach and the local community organizations to contact and send referrals.

Service Provision

PATH eligibility determination

Approval for Warren Forest E.O.C. PATH transitional housing can be obtained in one of two ways. Generally, applications are taken and reviewed by housing specialist to ensure that all necessary items have been included. A report is then put together listing all new applicants as well as vacancies in our MH Transitional Housing Program; this is the Advisory Board Report. On the second Monday of each month, the Advisory Board meets to discuss current participants and new applicants. The Advisory Board consists of the Housing Specialist, Warren County Prison Social Worker, Warren General Hospital/Deerfield Behavioral Health Unit representatives, Beacon Light Behavioral Health representatives, Forest Warren Mental Wellness Association representatives, Forest-Warren Human Services representatives, and Warren-Forest Counties Economic Opportunity Council representatives where they review all referrals. Referrals will be evaluated and accepted for admission based on meeting the PATH eligibility criteria and passing Housing Advisory Approval. A past history of criminal or serious behavioral problems will also be evaluated. Each member will vote on the applicant after discussing the application, and, if approved, applicant will be assigned to one of the vacancies in the transitional housing program that is the most appropriate to the individual. Once approved, Housing specialist will follow up with applicant and case manager (if applicable) to arrange a time for completion of the move-in process.

At times it is necessary to do an "emergency move in". This will generally take place when an individual is literally homeless (i.e. living "on the street"). The applicant may or may not have services completely in place, however, as much of the required documentation should be sought prior to seeking approval. Once the Housing Specialist has determined that the individual may qualify for PATH transitional housing, the applicant may be put up for an email vote to all Advisory Board members and the housing specialist outlines the applicant and status seeking a "yes-no" vote from all members. If approved, applicant is scheduled to be brought in to complete the move-in and enrollment.

All other PATH eligible clients that are not moved into the PATH transitional housing are screened using the PATH Screening and Eligibility form and connected to other EOC homeless housing programs, housing options, and services. All PATH eligible clients are entered into HMIS.

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Alignment with PATH goals
As a PATH provider we prioritize services by working closely with the various service providers that are available in our community. We connect clients to local case management services provided through Beacon Light Behavioral Health, Forest Warren Human Services, and Deerfield Behavioral Health as well as housing and mainstream benefit services provided by the E. O. C. Housing Specialist. Referrals for services, applications for employment/benefits, budget counseling/meal planning, and life skills are various topics that are covered through housing service plans. The PATH housing specialist works with each client on an individualized housing plan. Clients are connected to programs and services that will assist them with any mental health and/or substance abuse issues. Clients are also assisted with applications to various housing subsidies, Housing Authority, and private landlords. Clients are also referred to programs offered through E. O. C. such as budget counseling and employment and training.
Street Outreach is provided through the collaboration of the service agencies, county government, and general word of mouth. Warren-Forest E.O.C. is located in a rural community where many individuals move between family and friends rather than on the street. There are also several campgrounds where homeless individuals can go. Staff works closely with other local agencies to identify and assist those who are homeless.

Maximizing use of PATH funds
Warren-Forest Counties E. O. C. provides many programs and services throughout Warren and Forest counties in addition to PATH funds that can be utilized to assist PATH clients. Warren-Forest Counties E. O. C. works in conjunction with the Salvation Army to provide H. A. P. funds for individuals who are moving from transitional housing to permanent supportive housing. Contingency funds are also applied for and utilized to assist with moving clients to permanent housing. Warren Forest E.O.C. Housing program also provides a permanent housing program for individuals with mental illness or co-occurring mental health and substance abuse. Section 8 vouchers are housing subsidies which are also applied for in our goal to achieve stable permanent housing.

Gaps in current service system
Gaps that are occurring for many consumers are low incomes and lack of ideal employment services (i.e. job coaching services). Sufficiently covering fair market rent is a barrier in Forest and Warren Counties. Connecting consumers to the correct programs, along with consumers not knowing what resources are available to them. Lack of advocacy for M. H. consumers, and social supports within the counties. Housing for young adults, state hospital discharges, previously incarcerated, dual diagnosed and low-income families also seem to be target populations that have difficulty finding and maintaining housing. Another gap is the time management aspect between service providers most likely due to the lack of understanding and clarification of HIPPA rules and regulations. Lack of Adult Foster Care system and sufficient family-based transitional housing options are hindrances facing community reintegration efforts. Limited personnel and large caseloads in Mental Health Blended Case Management Services and lack of Supported Living Services inhibit the depth of which these services can be provided.

Co-occurring services available
The EOC Housing Specialist works with the dual diagnosis clientele and coordinates with the various staff of these programs available to assure PATH eligible clients receive services while they remain in their home. Consumers, ranging from teenagers to the elderly, with co-occurring disorders are a challenge and frequently use the costliest services. This combination of problems

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increases the severity of the mental health and substance abuse problems increasing the risk of homelessness. Services include community agencies as follows; Deerfield Behavioral Health, Family Services, Forest Warren Human Services, Beacon Light, Dickinson Center, and Warren General Hospital.

Physical health care in Forest /Warren Counties is provided by primary care physicians at Warren General Hospital, clinics, and doctor's offices.
Mental Health services are provided by Family Services, Beacon Light Behavioral Health, and Deerfield Behavioral Health, and Corry Counseling. In-patient care is provided by Warren General Hospital, Clarion Psychiatric, Millcreek Community Hospital, Elk County Regional Hospital-Generations Geriatric Unit, Bradford Regional Hospital, St Vincent Health Center, Dubois Regional Medical Center, UPMC Northwest, Sharon Regional Hospital, Meadville 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. Dickinson Inc provides Certified Peer Specialist services in Warren County.

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, including Medicated Assisted Treatment is also provided by Deerfield Behavioral Health. Deerfield Behavioral Health offers a Certified Recovery Specialist.

In-Patient Detox is provided by Deerfield Behavioral Health through Warren General Hospital.

ODP service coordination is provided by the county. Residential services are provided by Lakeshore and Lifestyles.

Sheltered employment is provided by Bollinger Enterprises in Warren, Barber National Institute in Corry PA, and Venango Training Development Center in Seneca, Pa.

42 CFR Part 2 regulations
Warren-Forest E. O. C. is not required to follow 42 CFR Part 2 regulations.

Justice-involved
Clients with criminal justice histories may have a hard time in any setting dependent upon the charges that are in each individual's history. Some clients are easier to link to supports that are in place for each aspect mentioned such as job opportunities. Clients are referred to PA Career Link as well as they are given opportunity to utilize the Employment education and training program provided by Warren-Forest E. O. C. These programs help with resume building, career counseling, employment applications, and work readiness. Reintegration into community comes through referrals and communication with the Warren County Prison, Probation and Parole officers. The PATH Housing Specialist helps provide the structure and routine through establishing house rules and by conducting weekly housing preventative maintenance inspections and monthly cleanliness and environment of care inspections. Communication on community services hours owed and with the PATH Housing Specialist helping to coordinate with other local non-profits such as PAWS Along the River, the local Y.M.C.A. and various local churches allows the clients to complete their hours owed in a timely manner so as to lessen that hindrance. Clients meet with Public Assistance Office Caseworkers as part of PATH intake and access to

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mainstream benefits and are referred to any provided/needed services through the case management process. Beacon Light provides Mobile Medication services to meet transportation/various medical needs to PATH clients.

The Housing Specialist is a certified Offender Workforce Development Specialist (OWDS) through the National Institute of Corrections (NIC)- Offender Workforce Development Specialist Partnership Training Program. As there is a staggering amount of evidence that shows unemployment leads to recidivism. This evidence also shows that individuals leaving correctional facilities, the search for employment is often much more difficult with a multitude of obstacles that must be overcome to progress. These obstacles include limited work history, limited education credentials, lack of life planning skills, and the common stigma that often follows individuals coming out of facilities of not hiring an ex-offender. With the amount of complex struggles that a person exiting a correctional facility, the person assisting with the progress of this must also poses a complex set of skills. There is no single agency that can meet all the needs of offenders who are returning to their communities. To promote these partnerships and the development of a professional workforce that is prepared to assist and help offenders find and maintain stable employment, the NIC established the OWDS partnership training. This training carefully selected and created multidisciplinary teams that currently have professional competencies that address challenges faced by the offenders in the search for employment.

Forest Warren Human Services now offers Forensic Case Management for those individuals with a Mental Health Diagnosis and criminal history within 2 years of criminal justice involvement. The Forensic Case Manager can provide services to those individuals coming out of the local prison or a state correctional institute.

Data

Warren-Forest Counties E.O.C. has fully utilized PA HMIS for several years. E. O. C. will continue to provide funds for trainings and conferences offered so staff may be trained. All webinar trainings dealing with HMIS are attended as well. New housing staff will attend live, on site trainings, and will attend offered webinars as well. Previously trained staff will function as mentors for new staff as they become familiarized with HMIS. E. O. C. enters data into HMIS for our PATH, ESG Shelter/Rapid Re-housing programs, and Permanent Supportive Housing programs.

Alignment with PATH goals

As a PATH provider we target street outreach and case management as priority services by working closely with the various service providers that are available in our community. Our PATH clients have or are referred to case management services in the community provided through Beacon Light Behavioral Health, Forest Warren Human Services, Deerfield Behavioral Health as well as those provided by the E. O. C. PATH Housing Specialist. Referrals for services, applications for employment/benefits, budget counseling/meal planning, life skills are various topics that are covered through housing service plans. Independent living skills, mental health services, drug & alcohol services, and other needs are sought through local service providers. Clients residing in E.O.C.'s PATH housing are provided quality case management services. The PATH housing specialist works with each client on an individualized housing plan. Clients are connected to programs and services that will assist them with any mental health and/or substance abuse issues. Clients are also assisted with applications to various housing subsidies, Housing Authority, and private landlords. Clients are also screened to determine their need for any of E.O.C.'s other programs such as budget counseling and employment and training, and, when applicable, referrals are made to such programs by the housing specialist.

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Street Outreach is provided through the collaboration of the service agencies, county government, and general word of mouth.

Alignment with State Comprehensive Mental Health Services Plan
Warren-Forest E. O. C. will use PATH funds to increase collaboration between E. O. C. and service providers in Warren and Forest counties in an effort to educate and assist service providers in referring homeless individuals to the PATH program for services. PATH funds will be used to prioritize housing those who are suffering from mental health and/or dual diagnosis to prevent them from becoming chronically homeless. As stated in the Agenda for Ending Homelessness in Pennsylvania (2005), nationally, roughly 80% of the homeless population is situationally or transitionally homeless. E. O. C. PATH funds will be used to provide quality case management services to those who are situationally or transitionally homeless in an effort to obtain permanent housing and prevent chronic homelessness. PATH funds will also be used to provide case management services to those in transitional supportive housing. The housing specialist will work with clients on individualized housing plans. These case management services will be focused on providing clients with proper referrals to supportive services, housing education, assistance with applications, and connection to all mainstream benefits/services in preparation for transitioning to permanent housing (e.g. Utility programs, budget counseling, home ownership education, and prepared renters training).

Other Designated Funds
Forest Warren Human Services has Special Grant funding designated specifically for homeless/housing.

Forest Warren Human Services designates Mental Health and County funds for 4 rental properties that provide 15 beds for PATH consumers. The housing is located on the Warren State Hospital grounds and is maintained by Warren - Forest E. O. C.

Programmatic and Financial Oversight
Forest Warren Human Services provides oversight of EOC through monthly housing meetings to discuss referrals and current individuals living in PATH housing. Quarterly reports are sent to Forest Warren Human Services to monitor the budget spending. EOC as well as Forest Warren Human Services participates in the Local Housing Options Team (LHOT) meetings held bi-monthly to discuss housing options for homeless. Invoices are reviewed and approved by Forest Warren Human Services prior to payment.

SSI/SSDI Outreach, Access, Recovery (SOAR) –
Currently, Warren-Forest E. O. C. is in the process of the web-based SOAR training. 3 staff team members are currently certified and 3 more staff team members will be trained on SOAR. One other E.O.C. staff member became certified over the course of the last FY, but that staff member left for a position with SCI-Forest. The former PATH Housing specialist was also a certified staff but no longer works for the agency. So in all 5 total staff team members overall have been certified but only the previously mentioned 3 are still employed by E.O.C. Currently one PATH consumer SOAR application resulted in obtaining of benefits for the PATH client. One other resident obtained Social Security benefits while in PATH housing project but was not through the SOAR method. 2 cases were approved overall for the agency including the 1 PATH referral with a 5-month turnaround for approval, the other approval was for a minor and went through instantaneously. 4 other cases were denied from initial application through SOAR

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process. Update: Warren-Forest E.O.C. recently took over as Local Lead with the PATH Housing Specialist after obtaining certification and attending a SOAR Leadership Academy and taking on this role. E.O.C. has 2 others currently certified in the SOAR process and 3 more currently taking the online adult course. The PATH Housing Specialist recently held a cohort helping to add to the number of adult-course certified with 2 Blended Case Managers from Beacon Light obtaining certification, 6 persons of various positions within the Forest Warren Human Services system obtaining certification with 1 more still working on the adult course. The PATH Housing Specialist also recently became certified in the child course and is looking to expand with Forest Warren Human Services - CYS asking about possible involvement. PATH Housing Specialist also attended Pennsylvania SOAR Leaders' Summit with intent to expand more into Forest County and bring said child/adult course there as well. E.O.C. has 2 cases in the appeal process and 2 in the initial application phase awaiting outcome.

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 specialists also provides referrals for clients to various attorneys that handle appeals.

Housing

Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Warren Forest Counties Economic Opportunity Council provides transitional housing (4 sites where individuals have their own bedroom, with a shared living space, specifically for PATH eligible clients), Faith Inn - 9-unit Re-Entry Shelter 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 E. O. C. transitional housing is a suitable, safe, and affordable while clients are working on goals to obtain permanent housing.

The Warren-Forest Counties Economic Opportunity Council owns several permanent housing properties throughout Warren and Forest Counties. In total, the E. O. C. currently manages 3 apartment units in Tionesta, and 21 throughout the City of Warren. E. O.C. owns 2 Fairweather Lodge properties that are currently managed by Forest Warren Mental Wellness Association. There are a total of 8 units under Fairweather Lodge one 5-bedroom unit and one 3-bedroom unit. With involvement in the CoC and use of ESG Rapid Rehousing/My First Place funds through a Regional grant from Lawrence County we have used these funds to help move several PATH clients into permanent solutions. Through this same grant we also have homeless prevention that will be utilized to help persons in need as well.

E. O. C. also provides permanent supportive housing in cooperation with HANDS at the Anthems site that includes 8 private apartments (6-1 bedroom & 2-2 bedroom.).

- Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
  There are currently 15 beds available in four transitional houses through the local E.O.C. 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.

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- There are eight apartments available for permanent supported housing through the "Housing and Neighborhood Development Services" (HANDS)
- The Housing Authority provides housing for the elderly population, individuals with disabilities and individuals or families with low income.
- 4 Personal Care Boarding Homes are available.
- Faith Inn has 6 units designated for the Forensic Population, and 3 units designated for emergency shelter.
- 2 efficiency apartments; 1 in Warren County 1 in Forest County
- 5-unit Male Fair Weather Lodge - supportive housing in Warren county
- 3-unit Female Fair Weather Lodge - supportive housing in Warren County
- 811 project in Forest County - 2 Units, 1 1-bedroom and 1-2 bedroom
- 3-1 bedroom units (EOC)-permanent supportive housing in Warren County
- 4-2-bedroom unit (EOC)-permanent supportive housing in Warren County
- 2-3-bedroom unit (EOC)-permanent supportive housing in Warren County
- 1-1-bedroom unit (EOC)- permanent supportive housing in Forest County
- 1-2-bedroom unit (EOC) – permanent supportive housing in Forest County
- 1-3-bedroom unit (EOC)-permanent supportive housing in Forest County
- 6-1 bedroom units (EOC)-permanent supportive housing in Warren County
- 3-1-bedroom units (EOC) – permanent supportive housing in Warren County
- 1-2-bedroom unit (EOC)-permanent supportive housing in Warren County

Coordinated Entry
Our region is located in the Western PA Continuum of Care (PA-601) as part of the Coordinated Entry System. Warren - Forest E. O. C. housing department is the assessment center for Warren/Forest Counties. PATH eligible clients are entered into the Coordinated Entry System for housing search and placement. The Coordinated Entry System will be used for those PATH eligible clients who are on the waiting list for our mental health transitional housing program. E.O.C. is the Coordinated Entry Assessment Center for Warren/Forest County.

Justice Involved
Forest Warren Human Services and Warren Forest E. O. C. both do not have a Crisis Intervention Team.

Staff Information
E. O. C. staff serving these populations are 4 females, ages ranging from 34-47 and a male – age 39. The Warren Forest Counties E. O. C. delivers services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, traditions, believes, and values. The majority of Warren and Forest Counties primary language is English. For the deaf and hard of hearing population, a certified interpreter is available. The PATH Housing Specialist receives periodic training in cultural competency/diversity. PATH Housing Specialist also serves as local high school football coach which has a cooperative learning program with a local Juvenile Drug & Alcohol treatment facility which deals with a diverse population. All the Housing specialists have experience working with diverse populations and local upcoming trainings as well as previous training classes in cultural competency and counseling of diverse populations provide a knowledge base that assists staff team members continuing to be leaders as agents of change in an ever-expanding diverse population of our clientele and community we serve.

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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 Caucasian population. Ages range from 18-74 with most of those served in the 18-49-year-old age range. While geographically large, the estimated population of the two counties for 2017 is approximately 46,956 persons with a declining population as the 2016 estimation was 47,346. Forest County saw a 5.4% drop in population, from (April 2010) 7,416 to (July 2017) 7,297 persons. While Warren County saw a 5.2% drop from (April 2010) 41,815 to (July 2017) 40,025. Rural communities need to improve access to services, but too often, policies and practices are developed for urban areas and are erroneously assumed to apply to rural areas. Compounding the problems of availability and access is the fact that rural Americans have lower family incomes and are less likely to have private health insurance benefits for mental health care (see US Census data). It is projected for Fiscal Year 2019-2020 that over 70 adult clients will be contacted and 80% of those adults will be enrolled into the PATH program and served by the MH Housing Specialist through Warren-Forest E. O. C. It is projected that the percentage for PATH eligible clients literally homeless will be approximately 5-10%. The number of literally homeless individuals in Warren County remains generally consistent with minor fluctuations each year.

Consumer Involvement

The Warren Forest Counties E. O. C. Board of Directors includes consumers from agency services. Six seats out of eighteen are designated for low income /consumer representation. The agency has employed several PATH clients through E. O. C. and have had PATH clients as volunteers to the agency. Consumers are given opportunity to complete community service hours as volunteers. Family members are kept apprised of the various activities through multidisciplinary team meetings and are given opportunity of inclusion through service providers involved in the treatment planning for those that want to be meaningfully involved. We encourage clients and family members to participate in LHOT.

LHOT has consisted of PATH clients as members. Clients participating in LHOT may participate in all discussion and future housing needs assessments.

Health Disparities Impact Statement

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

- The Warren-Forest Counties E.O.C. expects to serve approximately 12 to 15 unduplicated Youth and Young Adults in the 2019-2020 year.

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

- Warren-Forest Counties E.O.C. expects to spend roughly $14,280-$17,280 on services for the YYA population.

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

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YYA individuals will receive similar services to those of the general population. Warren-Forest E. O. C. will provide case management services that will link YYA individuals to community resources, landlords, mental health service providers, and assisting YYA individuals to obtain benefits. Employment & Training is also offered to YYA individuals to promote job skills job training, and assistance in finding employment. Housing services will also be provided which include, but are not limited to, advocated for YYA individuals with landlords, assistance with filling out applications for the housing authority, HANDS, Section 8, etc.

- A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the YYA population and in comparison to the general population

The YYA population's principle need is to be supported in their efforts to obtain employment and maintain gainful income. For most, once on their own, they fail to finish high school or obtain a G.E.D. This is pivotal as Warren-Forest E.O.C. will implement a three-part approach to assist the YYA population. First, the Housing Specialist will work closely with the client, and other agencies to ensure that the individual has the tools necessary to complete their education. The PATH Housing Specialist is a certified OWDS trained individual. Which will help this subpopulation that is re-entering from jail/prison population. The Housing Specialist will also guide them through the maze of available services in order to demonstrate how one navigates the system. Second, E. O. C. provides the YYA population with budget counseling and a prepared renter program. E. O. C. also offers the YYA population an employment and training program that will assist in filling out applications, completing resumes, job interview skills, and maintaining employment. Third, the outcomes will be monitored through case management services and documented in case notes as well as updated in the individual's service plans. EOC utilizes an agency wide ORS system in an effort to measure and track disparities. The ORS system combined with data entry into HMIS provides a measurement and an enhanced ability to track disparities.

Limited English Proficiency

Our primary language in the area is English. We are a non-discriminatory agency. Service is not denied on the basis of language. E. O. C. has an agreement with a translation service that can provide translation over the phone 24 hours a day 7 days a week.

NOT FINAL

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.

Total Federal PATH Allocation………………………………. $ 34,816
Total State PATH Allocation…………………………………. $ 11,605
Total PATH Allocation…………………………………….... $ 46,421

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Forest/Warren Counties PATH Program FY 2019-2020 Budget

Position	Annual Salary*	PATH-funded FTE	PATH-funded Salary	Total
Supportive Housing Specialist	$32,240	0.75	$ 24,180	
Housing Director	$44,000	0.04	$ 1,760	
Subtotal Position				$ 25,940
Fringe Benefits (38.5%)			$ 9,987	
Subtotal Fringe Benefits				$ 9,987
Travel Local travel 1200 miles @ $.58/mile			$ 696	
Travel to training, workshops and Statewide meetings			$ 20	
Subtotal Travel				$ 716
Supplies Office Supplies			$ 95	
Postage $6.00/month			$ 72	
Subtotal Supplies				$ 167
Training & Technical Assistance			$ 39	
Telephone $97/month			$ 1,164	
Space Costs $97.00/month			$ 1,164	
Insurance $17.00/month			$ 204	
Subtotal Other				$ 2,571
Indirect Costs – Administrative Costs @ 27.14% of Salaries				$ 7,040
TOTAL				$ 46,421

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Franklin-Fulton County Mental Health/Intellectual Disabilities/Early Intervention
425 Franklin Farm Lane
Chambersburg, PA 17201
Contact: Jennifer Johnson

Provider Type: Social service agency
PDX ID: PA-030
State Provider ID: 4230
Contact Phone #: 7172645387

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 0	$ 0	$ 0	
No Data Available				
d. Equipment	$ 0	$ 0	$ 0	
No Data Available				
e. Supplies	$ 0	$ 0	$ 0	
No Data Available				
f. Contractual	$ 0	$ 0	$ 0	
No Data Available				

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 54,558**	**$ 18,186**	**$ 72,744**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 54,558	$ 18,186	$ 72,744	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 54,558	$ 18,186	$ 72,744	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 54,558	$ 18,186	$ 72,744	

Source(s) of Match Dollars for State Funds:

Franklin/Fulton will receive $72,744 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 90

Estimated Number of Persons to be Enrolled: 45

Estimated Number of Persons to be Contacted who are Literally Homeless: 20

Number staff trained in SOAR in grant year ending in 2018: 18

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Franklin/Fulton County Mental Health/Intellectual Disabilities/Early Intervention
PATH Intended Use Plan
FY 2018--2019

Local Provider Description

Franklin/Fulton Mental Health/Intellectual & Developmental Disabilities/Early Intervention (MH/IDD/EI) is a county agency that operates within the Franklin County Human Services Division of Franklin County government. The provider office address is: Franklin/Fulton MH/IDD/EI, 425 Franklin Farm Lane, Chambersburg, PA 17202, in the South Central Region of the State of Pennsylvania. Through a joinder agreement, Franklin/Fulton MH/IDD/EI program serves individuals in both Franklin County and Fulton County with a variety of special needs. Franklin/Fulton MH/IDD/EI programs contract with SAM, Inc. for all case management services, which include Administrative, Resource Coordination, Forensic, and Intensive Case Management. In an effort to continue moving toward an oversight role within the MH Housing program, the decision was made to subcontract with SAM, Inc. for the PATH program. SAM, Inc. was chosen due to their extensive experience in providing services to individuals with a serious mental illness. Additionally, SAM, Inc. is already a PATH provider in other counties in Pennsylvania. This experience with the PATH program provided added assurance that subcontracting with SAM, Inc. would be successful. The program is scheduled to begin on July 1, 2018. The necessary data will be tracked by SAM, Inc. staff, and is pending addition to PDX.

Franklin/Fulton MH will receive $73,232 in total PATH funds ($488 County Match, $18,186 State Match, $54,558 Federal Allocation) to continue the operation of a PATH program that will reach individuals in Franklin and Fulton Counties. The total of these funds will be subcontracted to Service Access and Management, Inc. (SAM, Inc.) to administer the PATH program for Franklin/Fulton MH. Franklin Co office of SAM, Inc is located at 1061 Lincoln Way East, Chambersburg, PA 17201.

Collaboration with HUD Continuum of Care Program

Many local housing-related agencies have been involved in the Regional Homeless Advisory Board in the Central/Harrisburg region in Pennsylvania through the HUD Continuum of Care (CoC) program. Those agencies include: Franklin County Human Services Division, South Central Community Action Program, Center for Community Action, Maranatha Ministries, CandleHeart Ministries, Franklin County Cold Weather Shelter, Fulton County Center for Community Action, Supportive Services for Veteran's Families (SSVF), and Waynesboro New Hope Shelter. Several agencies have received funds through the HUD CoC process to increase housing programs and supports in Franklin and Fulton counties. As Franklin/Fulton Mental Health continues to utilize the PATH program and funding, local housing agencies and mental health providers will be involved in the referral process, will help to create new housing opportunities, will serve on the HUD/PATH Advisory Board, and provide/coordinate supportive services.

Franklin/Fulton Counties are a member of the Eastern CoC, PA-509 and is in the South Central PA RHAB within that CoC area. The Mental Health Housing Program Staff works to establish

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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 Staff attends the local RHAB meetings monthly and the regional CoC meetings semi-annually to network and collaborate with other members of the CoC on these efforts. The Franklin County Grants Manager periodically attends CoC meetings as well and works closely with the Mental Health Housing Program Staff to seek appropriate grants related to new housing opportunities. We occasionally provide training and information to our area RHAB on new programs or grant opportunities. We regularly seek partnership with other agencies in meeting the housing and service needs for the homeless population in Franklin and Fulton Counties. This collaboration is expected to be ongoing and will benefit the homeless population of Franklin and Fulton Counties.

The 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 permanent supportive and Shelter Plus Care.

The Franklin County Human Services Division, including Mental Health and Grants Management, are at the forefront of planning efforts within the county. These agencies serve on numerous boards, taskforces and committees that provide services and supports for the homeless, including the Behavioral Health Advisory Board, the Criminal Justice Advisory Board, the Re-Entry Coalition, the Forensic Initiatives committee, the Re-Entry Case Review Committee, the CCAP Housing Task Force, the DHS Housing Stakeholder Workgroup, the Recovery House Standards Committee, the FCOAAT Stakeholder Board, the Fulton County Partnership and Housing committees, the County Block Grant Committee, the HUD/PATH Advisory Board, the Community Support Program, Jail Diversion, and the Housing Task Force/LHOT committee.

Four formal collaborative partnerships between the County and local housing entities exist through the TrueNorth Wellness Services, New Visions, Tharp Community Development, LLC, and Keystone Community Health Services. The details of these collaborations include the following:

TrueNorth Wellness Services provides a campus to accommodate 17 individuals with a diagnosed mental health illness. Support services are provided to the individuals residing there 24 hours a day. Individuals are educated on activities of daily living to work toward independent living. TrueNorth Supported Living employs a psychiatric nurse who works with the individuals. The Franklin/Fulton Mental Health program contracts 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 daytime hours as needed. Independently, New Visions also has 16 individual apartments that receive Case Management support from mental health caseworkers.

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Tharp Community Development, LLC has a memorandum of understanding with the county for a housing initiative to rehabilitate substandard downtown multi-family housing units into safe, accessible, affordable housing options for Franklin County. A certain number of units in this initiative (and any subsequent development phases) are dedicated to specialized populations served by Franklin/Fulton MH/IDD/EI, Franklin County Human Services, and Tuscarora Managed Care Alliance. This initiative includes an allotment of 811 vouchers for eligible populations. Applications are screened by Franklin/Fulton MH/IDD/EI and the developer works within HUD and county guidelines for affordable rent calculations.

Keystone Community Mental Health provides a Specialized Community Residence and it is licensed as a Personal Care Boarding Home. This is group living in the community for eight individuals with special medical needs in addition to Mental Health needs.

The Jail Diversion Program links individuals with a serious mental illness and often co-occurring (substance abuse) disorders who have come into contact with the criminal justice system with 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 Targeted Case Management 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 with housing, medications, birth certificates, etc. Some qualifying participants have received rental assistance or security deposits 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/IDD/EI Program regularly collaborates with other agencies to coordinate home plans and supportive services for those exiting the Franklin County Jail and is currently participating in the Intensive Re-Entry Grant Program and on the Re-Entry Case Review Committee to facilitate these efforts.

The Intellectual & Developmental Disabilities Program, through Franklin/Fulton MH/IDD/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.

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Through the Housing Task Force/LHOT Committee, Franklin/Fulton MH/IDD/EI has joined in the creation of a planning committee with numerous agencies and providers, including New Visions, Franklin County Homeless Shelter, New Hope Homeless Shelter, Franklin County Jail, Maranatha Ministries, the Franklin County Housing Authority, Borough of Chambersburg, Franklin County Planning Commission, SCCAP (South Central Community Action Program), Cold Weather Shelter, Women In Need, Keystone Health System, Individuals, Parents, Faith-Based Groups, Program Planning, Franklin County Adult Services, LINK, PA-211, and the Salvation Army. By working in this collaborative setting, the following priorities have been identified: Create new housing and supports for individuals with mental illness that are facing homelessness or near homelessness, or are returning to the community after incarceration; create more transitional and permanent housing in our area and continue to work with partners to enhance these services; address community housing needs using creative and innovative solutions that utilize the strengths of Franklin and Fulton counties; and improve landlord and human services communication by educating landlords on community human services and benefits of serving those with disabilities. The Housing Task Force/LHOT Committee coordination and oversight is provided by the Franklin County Mental Health Housing Program Staff.

Collaboration with Local Community Organizations

Franklin/Fulton Mental Health/Intellectual & Developmental Disabilities/ Early Intervention Department contracts with SAM, Inc. , Inc. to provide case management services to qualifying individuals. PATH eligible individuals who are not already open for Mental Health Case Management are referred to the SAM, Inc. Administrative Case Manager for an intake for case management services if they indicate interest in these services. The purpose of this linkage is to make key support services are available to individuals in the PATH program. A case management intake will be encouraged as soon as a person is identified for participation in the program. For interested and eligible individuals, case management will provide regular contact visits with the individual and can be utilized as long as the service is needed. Case management services will assist in navigating medical assistance, Social Security, the health and mental health systems, linking individuals with representative payee services, linking individuals with specialized housing and housing supports, and assisting in the management of day to day activities. The case managers will help individuals to enhance the quality of their lives by effectively and efficiently managing and/or providing needed and accessible human services. The Mental Health Housing Program Staff will work closely with SAM, Inc. , Inc. and other entities to ensure that adequate housing assistance and supports are in place for PATH individuals. SAM, Inc. also serves on several outreach boards with the Franklin/Fulton Housing Program staff, including the HUD/PATH Advisory Board.

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.

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The Mental Health Association (MHA) is available to the PATH participants. MHA has the ability to provide Peer Support Services. They also facilitate the Community Support Program meetings on a monthly basis in both Franklin and Fulton Counties. 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 operates the Individual/Family Satisfaction Team (I/FST) that creates surveys to find out how satisfied people are with the services they receive from providers within our community. MHA staff refers individuals they feel may be eligible for PATH services to SAM, Inc. . MHA staff serves on the HUD/PATH Advisory Board.

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**.** Summit Behavioral Health through the 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, 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 Clubhouse in Chambersburg offers recreation and group activities for individuals who live with mental illness. The Clubhouse is open six days a week with day and some evening hours. 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 Community & Human Services, 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

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Church, Salvation Army, The Closet at Valley Ministries, Waynesboro Community & Human Services Clothing and Diaper Bank, and the Fulton County Catholic Mission. Franklin/Fulton MH/IDD/EI regularly communicates with these entities regarding referrals for eligible individuals they serve.

Maranatha Ministries provides financial counseling, representative payee services, and personal finance/budgeting instruction. They provide rapid rehousing services throughout the county. CandleHeart, an entity of Maranatha Ministries, provides budgeting, parenting, anger management, and life recovery programs. Maranatha's Cold Weather Shelter and CandleHeart program refer individuals to the PATH program for assistance and call the PATH program when they locate an individual living on the streets who is in need of emergency or safety supplies. The PATH program refers individuals to both ministries to receive assistance, when eligible. Maranatha's Food Bank regularly provides emergency food allotments to the Franklin/Fulton MH/IDD/EI HUD program as well as PATH participants.

Family Care Services provides representative payee services for individuals with mental illness. They refer eligible individuals to the PATH program for assistance. PATH staff refers individuals in need of rep payee service to Family Care if this is indicated in their needs assessment.

Females in the PATH program who need assistance with independent living skills will be referred to the House of Grace. The House of Grace is open Monday through Friday and provides the following services to help women succeed in life: household skills, budgeting, social skills development, 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 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 Staff/and SAM, Inc. staff will outreach to these and other local agencies to advocate for housing for individuals, and grow housing resources/supports for individuals. PATH staff regularly communicates and collaborate with these programs to meet the needs of individuals experiencing homelessness. Staff from the emergency shelters serves on the HUD/PATH Advisory Board and LHOT, as well assist with the PIT Count.

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

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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 eligibility is determined by participant submission of appropriate documentation to the SAM, Inc. Housing Specialist. This documentation is reviewed by the SAM, Inc. Housing Specialist to assess eligibility requirements including:

- Adult who is at least 18 years of age
- Currently live in or will be directly discharged to Franklin or Fulton County
- Have a documented serious mental illness or dual diagnosis (SMI and substance abuse)
- Have sufficient income to maintain housing and documentation of income for each household member.
- We require individuals to have sufficient income to maintain housing because assistance can only be provided once per year. Without sufficient income, one month's rent or security deposit will not ensure continued housing stability.

Enrollment in the PATH program occurs when the SAM, Inc. Housing Specialist determines the individual is eligible, based on the criteria listed above and the individual has agreed to participate in the program.

PATH-enrolled individuals' eligibility documentation is contained in each participant's file.

Street outreach and case management are priority services. PATH funds will be used to pay the salary and benefits of the Service Access and Management PATH Housing Specialist to compensate for the time spent doing administrative duties, case management, and community outreach. Community and street outreach will include 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. Ongoing collaboration between the PATH Housing Specialist and Franklin/Fulton Housing staff will allow for more focused and effective outreach within the community. PATH funds will be used to support street outreach by providing expense reimbursement for travel to and from these agencies and events. Outreach will include providing individuals with contact information, program information, necessary survival supplies, apartment start up supplies, and community information on where their basic needs can be met. Intakes into the PATH program can also be done on-the-spot or an appointment for an intake can be made at that time.

PATH funds are used to fund travel expenses for PATH staff to attend trainings and conferences. PA HMIS trainings and HMIS TA Conferences are attended whenever possible to ensure staff is

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up-to-date on the latest information and evidence-based practices. PATH staff also participates 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. SAM, Inc. collaborates with Franklin/Fulton MH/IDD/EI, the Catholic Mission in Fulton County, and Maranatha Ministries to distribute emergency and safety items to those in need. Franklin/Fulton MH/IDD/EI has a Housing Expansion fund that may be used to supplement the outreach and case management needs for PATH applicants. In addition, Franklin/Fulton County MH/IDD/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 also available for referring veterans for additional services.

Through regular contacts with SAM, Inc.'s Housing and/or Case Management staff, PATH individuals are assisted in achieving their identified goals. Referrals to needed services (housing, mental health, behavioral health, medical, veteran's benefits, county assistance, food, clothing, furniture, utility assistance, transportation, social security, education, employment, etc.) are assessed and provided on an ongoing basis. In addition, each PATH participant is provided with a copy of the county "Where to Turn" resources guide. Follow up is done with each assisted applicant to ensure their needs continue to be met.

The number of individuals needing services continues to grow each year. With the growth in the number of individuals, the following gaps have been identified in the services we provide:

- Lack of new dollars entering the system to assist individuals
- Lack of residential forensic services available for the seriously mentally ill offender. Those without approved home plans continue to populate the Franklin County Jail. Assistance with finding those offenders home plans to transition them from the jail in to the community is needed
- Lack of landlords willing to work with programs to assist with housing for individuals with mental health or co-occurring disorders, criminal records, suffering from homelessness, having poor credit, having poor employment history, and/or who are low income
- Lack of enough residential services available for the transitioning youth (ages 18-26) population from Juvenile Probation and from Children and Youth Services
- Lack of multi-lingual staff to communicate with the increasing number of minority and non-English speaking individuals
- Lack of safe, affordable, and adequate housing and housing supports in the two-county area
- Lack of human service and disability knowledge among local landlords
- Lack of landlord knowledge of Housing First principle

Specifically, in regards to the mental health population served, the lack of safe and affordable housing units has been identified as a top priority in housing needs for the counties. In addition, residential services available for individuals with mental health illness who are ex-offenders have been identified as a significant programming gap. The Housing Task Force/LHOT team, along with the Franklin County Re-Entry Coalition, are working to address the housing needs of

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individuals in the mental health service system, those with co-occurring disorders, and those re-entering the community after incarceration who have one or more disabilities, and/or who are suffering from homelessness. The Mental Health Housing Program Staff is working with the Grants Manager in identifying grant opportunities for the creation of more safe, affordable, and supportive housing for individuals with disabilities in both Franklin and Fulton counties. Additionally staff is working to identify supplemental funding to support existing programs that regularly run out of funds before the end of the program year.

The Franklin/Fulton PATH program helps to decrease this “gap” by assisting individuals to gain access to affordable housing in both counties, and to provide continued assistance and supports to establish and maintain housing. PATH funds will be used to support PATH funded staff, supplies/materials necessary for job performance, and housing support services for individuals. Additional monies pay for community outreach and training events for homeless or at-risk individuals, outreach materials, safety and emergency supplies, emergency food, apartment start-up kits for those exiting homelessness, and training/travel for the SAM, Inc. Housing Program Staff.

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 SAM, Inc. Housing Program Staff 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 Staff serves as the county Local Lead for many housing initiatives, which facilitates coordination efforts.
- Security Deposits and one-time back rent payments to landlords to prevent eviction: Case management services will assist individuals with monetary assistance in the form of security deposits for those experiencing homelessness and one-time rental payments equal to one month’s back rent for those facing eviction and homelessness to assist them with maintaining their housing, as needed
- Providing assistance to eligible homeless individuals to obtain income support services, including housing assistance, food stamps, and supplemental social security income benefits: Case management will assist individuals with co-occurring disorders to ensure they receive necessary services, and will also be responsible for connecting the individual with Drug and Alcohol services. Integration of these agencies has been identified as a priority, as well.

Reading material and information will be made available at local homeless shelters and at the PATH office on current drug trends, treatment facilities, and Al-Non, NA and AA meetings

The PATH funded staff, in collaboration with Mental Health staff, will also work with behavioral health and substance abuse service providers to make sure that PATH program participants have access to needed treatment services. Co-occurring programs that exist within

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the County include Pennsylvania Counseling Services, Roxbury Outpatient, Pyramid, True North, and Laurel Life. Roxbury Treatment Center also provides 28 day rehabilitation and has an inpatient MH unit on the SAM, Inc. property.

While not directly falling under 42 CFR Part 2 regulations, Franklin/Fulton MH/IDD/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 MH 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 MH staff will have access to, and must abide by, Franklin County's HIPAA policies and all HIPAA laws
- Annually, MH/IDD/EI staff will review HIPAA policies and procedures

SAM, Inc., as subcontracted by Franklin/Fulton MH/IDD/EI, must follow confidentiality procedures as stated in their contract with the counties.

The PATH program supports individuals who have been involved in the forensic system and have experienced mental health and/or substance abuse issues. Franklin/Fulton MH/IDD/EI staff and SAM, Inc. staff are actively involved in re-entry initiatives in the counties. The PATH Housing Specialist is a member of the Jail Diversion Treatment Team. The Jail Diversion Treatment Team reviews each participants needs and identifies available resources within the county that can meet those needs.

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 into the PA-HMIS system. The program goal is to have individuals' information entered into HMIS immediately following the enrollment of the individual. Updating information on the individuals in PA-HMIS is completed promptly upon obtaining new information.

Data obtained from PA-HMIS has been able to provide improvements on how MH staff focuses on outreach. Since PA-HMIS provides data on the demographics of individuals in Franklin and Fulton County who are experiencing homelessness, the PATH Housing Specialist 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.

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The Mental Health Housing staff access PA-HMIS trainings as they are available. SAM, Inc. is expected to participate in all relevant PA-HMIS trainings. In addition to travel, supplies and operating costs in the budget allow for the Housing Program Staff to continuously attended PA-HMIS trainings if/when necessary, both on-line and at conferences. Ensuring that multiple staff within both agencies are trained to enter data into PA-HMIS will better support accurate PATH data in the system.

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 receiving housing rental assistance to achieve this goal, individuals 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 MH/IDD/EI and SAM, Inc. Housing Program Staff will 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 and SAM, Inc. Housing Program Staff) at the Housing Task Force/LHOT Meeting. There are then two subcommittee planning meetings held by the Mental Health and SAM, Inc. Housing Program Staff. 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 at 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 and Mental Health programs to hold these events. Previous events included “Help for the Hungry and Homeless” and “Help for Heat and Housing”. These events are advertised to target the 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.

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Street Outreach will be conducted on a regular basis in 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 and Mental Health staff. Formerly 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.

PATH case management begins during initial contacts with homeless individuals during street outreach. PATH 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 Comprehensive Mental Health Services Plan

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 agencies that have contact with these populations, to include: shelters, schools, veteran's 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 maintain stability 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 funding.

As a county government entity, Franklin/Fulton MH/IDD/EI staff is part of the county Continuity of Operations Plan. Under this plan, if a disaster or other emergency occurs, staff is 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 Team. The county regularly holds drills to practice for emergency preparedness and response.

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Other Designated Funds
As previously noted, 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/IDD/EI. The Franklin County MH/IDD/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. While there are no specific funds earmarked for PATH besides the PATH grant, County allocated funds from the State Block Grant may be utilized when available to extend the program's ability to continue offering assistance to individuals eligible for PATH.

Programmatic and Financial Oversight
For the 2018/2019 Fiscal Year, Franklin/Fulton Counties will subcontract with Service Access & Management to provide PATH services. SAM, Inc. has indicated that their ACM supervisor will act as the Housing Specialist for the PATH program. Programmatic and financial oversight of our PATH-supported provider (SAM, Inc.) is achieved through the following:

- Franklin/Fulton Housing staff will meet at the SAM, Inc. office monthly to discuss open cases, review files, discuss remaining budget utilization, program goals, and generally discuss the overall program status
- Franklin/Fulton Housing staff will conduct an onsite audit of the PATH program operations annually, at a minimum. Should issues be identified, subsequent follow-up will occur until the issues have been resolved
- Franklin/Fulton Fiscal and Housing staff will review the SAM, Inc. monthly invoice for accuracy and appropriateness. All issues will be resolved before the invoice is processed for payment
- Franklin/Fulton staff will review and discuss the financial status of the PATH program at the MH monthly administrative meetings
- Franklin/Fulton staff will review and approve the annual budget from SAM, Inc. for the PATH program

SSI/SSDI Outreach, Access, Recovery (SOAR)
Franklin/Fulton MH/IDD/EI and PATH programs sponsored an SSI/SSDI Outreach, Access, Recovery initiative in the 15/16 fiscal year. The Mental Health Housing Program Specialist II coordinated an effort to provide funding incentives from the Franklin County MH/IDD/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. The SOAR initiative was only for the 15/16 fiscal year. Franklin County is unaware of agencies utilization of SOAR or the OAT reporting system. There are two staff at SAM that are trained by the SOAR initiative. While SOAR has been infrequently utilized at SAM, the new site director will

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be looking at SAM's appropriate utilization of the SOAR process and if there is an opportunity to serve more people.

Area agencies that now have one or more SOAR trained caseworkers through this initiative include: South Central Community Action Program, Franklin County Shelter, Maranatha Ministries Shelter/Food Bank, CandleHeart Life Recovery Program, Service Access and Management, and Franklin County Adult Probation (Jail In-Reach). The face-to-face training was completed the beginning of March, 2016.

The MH Housing Program Specialist II resigned during the 17/18 fiscal year. The Housing Program Specialist II was the only county staff trained in SOAR. Therefore statistics cannot be obtained from the OAT system due to lack of access and training. SAM has reported that they completed three SOAR applications in the 16/17 fiscal year. Two of those individuals were not awarded benefits. There is one application pending currently.

Housing

The Franklin and Fulton areas need additional housing resources to serve the growing homeless and mentally ill population. There are eight CRR beds available, 17 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 additional housing to men, women and children throughout the past year. The shelters estimated that a large portion of the homeless population they served were diagnosed with a mental illness.

The shelters find housing resources and support for the homeless, often working hand in hand with the Mental Health Housing Program Specialists, SAM, Inc. PATH Housing Specialist, Mental Health case managers, the Homeless Assistance Program, outside agencies, and the Housing Authority to assist individuals in their search for housing.

The Franklin County Jail has connected with the New Hope Shelter, New Hope Ranch, Maranatha Cold Weather Shelter, Noah's House, and CandleHeart Programs to provide a home plan for individuals who are in jail and cannot be released due to the lack of a home plan. A renewed re-entry grant was received that will allow for master lease and transitional housing options for up to ten women re-entering the community. There are currently re-entry initiatives to expand the amount of re-entry housing for various populations in Franklin County.

The Mental Health Program Housing Staff in collaboration with the SAM, Inc. PATH Housing Specialist 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, and CandleHeart Life Recovery Program. In addition, the Mental Health Housing Program Staff 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,

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and the 811 Stakeholders Group. This allows for maximum 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
- Franklin County Shelter for the Homeless
- Women In Need, Victim's Services Shelter
- Maranatha Ministries Cold Weather Shelter
- Fulton County Catholic Mission

Transitional Housing:

- 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 County Mental Health Housing Expansion Program
- Franklin County Intellectual Disabilities Independent Living Program

Housing Support Services:

- Franklin/Fulton County Homeless Assistance Program
- Waynesboro Community & Human Services
- Various Area Churches (seasonally)
- Tharp Community Development, LLC
- Salvation Army
- Maranatha Ministries
- PATH
- 811 Housing Voucher Program

While individuals overwhelmingly desire to live independently, the lack of funding and resources within the county proves challenging to assist all individuals. Franklin/Fulton County Mental Health uses the above-mentioned programs to their fullest housing capacity and there are waiting lists for many of the housing entities. This demonstrates the need for the PATH program to continue to provide outreach to housing entities in the area. The mental health individuals who experience homelessness or are at imminent risk of homelessness utilize PATH funds to enable them to transition from homelessness and/or maintain housing.

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Coordinated Entry
The Franklin/Fulton Mental Health Housing Programs are fully participating in the Pennsylvania Coordinated Entry System as of January 2018. Franklin/Fulton Housing Program Staff works closely with the County's Information and Referral Specialist to ensure the program is being utilized effectively throughout the County. The coordinated entry system will be governed and monitored by the CoC.

Justice Involved
Crisis Intervention Team training is being utilized and conducted twice a year in Franklin/Fulton Counties.

- The training program is in its fifth year and continuing to gain momentum. The team is now 108 strong with over half of our members representing law enforcement and first responders to include one Pennsylvania State Police Lieutenant. The remainder of the team represents crisis, jail officers/staff, probation/parole officers, hospital staff, mental health professionals and advocates. South Central Region CIT continues to follow the fidelity of the Memphis Model of CIT
- Our CIT training has been approved by Municipal Police Officers Education & Training Commission (MPOETC) for 40 credit hours and 30 continuing education hours for EMTs, paramedics and first responders
- CIT has collaborated with Cumberland/Perry County to share in costs and resources for our CIT training
- During the 40 hours of training, we are fortunate to have a certified trainer for the Veterans module, 2 certified trainers for the de-escalation and 1 scheduled to complete in May 2018. We have 1 CIT Coordinator that is responsible for the program. We also offer evidence based training such as QPR (Question Persuade Refer) and Pat Madigan's *Hearing Voices* throughout the week
- Outcomes:
  To date we have held seven (7) CIT trainings and have 108 members with half of our team being represented by law enforcement and first responders

Staff Information
Staff members who serve the individuals in the PATH program come from a wide variety of backgrounds. The SAM, Inc. PATH Housing Specialist was hired as a Resource Coordination Case Manager in 2012 and was promoted to Administrative Case Management Supervisor in April 2016. The PATH Housing Specialist has an employment background of TSS, Behavior Coach, and Guidance Counselor for 8 years with Manito prior to County/SAM, Inc. employment. The Mental Health Housing Program Specialist I who will oversee the PATH program was hired in 2014 and has an employment background that includes Case Management Supervisor, Psychiatric Rehab Program Manager, and various positions within the Mental Health field.

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

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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. SAM, Inc. , as required by their contract, will follow all AA, EEO, and ADA requirements as specified by law.

The mission statement for MH/IDD/EI states "Franklin/Fulton Mental Health/Intellectual & Developmental Disabilities/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 and SAM, Inc. staff on a yearly basis that helps to foster diversity by:

- Providing training (Human Services Training Days) and educational programs through the HCQU on social equity issues for county employees
- Providing materials and translation services for a multi-linguistic population
- Advising departments on equitable employment practices and searches; and
- Being proactive in assisting departments to increase and retain a diverse administration and staff
- The County has a responsibility for documenting physical and other disabilities of individuals and employees and providing general oversight and coordination of services and accommodations appropriate to the specific disability and consistent with the laws and accepted standards of practice of the Commonwealth. The County also has a responsibility to ensure that materials and evaluation of programs are culturally appropriate to the populations served in County Human Service programs. In addition, through groups listed below, the County gets regular feedback and suggestions for programs and services:

    - Behavioral Health Advisory Board
    - Housing Task Force/LHOT
    - Community Support Program
    - Franklin County Re-Entry Coalition
    - Individual/Family Satisfaction Team

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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/IDD/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.

Currently PATH staff, both through the Counties and SAM, Inc., are not Certified Peer Specialists or Certified Recovery Specialists. However, individuals needing or requesting these services are linked to them as needed.

Client Information

- Franklin and Fulton County residents
- Individuals with serious mental illness or dual diagnosis (SMI and Substance Abuse)
- In and out of county homeless shelters/streets, community programs serving the homeless, or revolving in and out of jail, or transitioning from youth services
- Individuals needing support with everyday life skills, such as cooking, medication management, cleaning, etc
- Do not have adequate income supports to afford them reasonable housing
- Do not have federal assistance, and/or Medicaid or health insurance that covers mental health services
- Have a limited or fixed income and are often receiving Social Security benefits or benefits from the Department of Public Welfare

The projected number of adult clients to be contacted using PATH funds is expected to be 80-100 individuals throughout 2018-2019. 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, 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 2018-2019 year is 30-40 through the continuation of housing resources and supports. 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. The age of individuals to

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be served are any adults, 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 or at imminent risk of homelessness. The individuals on the mental health housing wait list that 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 the PATH program will benefit.

Consumer Involvement

- Individuals and family members are offered opportunities to serve on boards and steering committees (PATH/HUD Advisory Board, MH/IDD Advisory Board, Community Support Program, Franklin County Block Grant Planning Committee)
- MH/IDD 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 Staff and the SAM, Inc. Housing Program Specialist 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
SAM, Inc. Housing Specialist will collect basic demographic information as part of the PATH intake process. This information will be tracked via PA-HMIS and internal mechanisms to provide a broad overview of PATH participants' demographics.

It is estimated that Youth and Young Adults (YYA) will comprise at least 30% of participants served using PATH funds. Estimated projections for number of people served in the 2018-2019 grant year is expected to be 10-12 individuals. The total amount of PATH funds estimated to be utilized on services for the YYA population is $6,350.00. This figure includes rental assistance, outreach, informational materials, and safety and emergency supplies to be dispersed as needed.

An increased focus on outreach to YYA individuals as well as improvement of information sharing with relevant organizations/agencies will be utilized during the 2018-2019 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 YYA individuals experiencing homelessness/at imminent risk of homelessness. Outreach will also include posting information

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pertaining to services, community events, assistance, etc. for people experiencing homelessness in areas that are identified to be frequented by YYA individuals.

In general, PATH funds will be utilized to measure, track and respond to disparity-vulnerable populations. PATH funds will allow for staff to coordinate outreach activities, including occasional meals for people experiencing homelessness while they receive information and access to relevant services.

Limited English Proficiency
PATH funds will allow for provision of materials in both English and Spanish. Through a contract with Bopic, a Spanish interpreter is available, if needed. The PATH staff continues to expand services to and collect data on individuals who are served through PATH funding and identified as disparity-vulnerable subpopulation.

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Budget Narrative

Personnel:
Funding of $26,816.52 is being requested to provide for the full-time salary, 50.00% time, of a SAM ACM Supervisor. This position will be located at the SAM office, 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 or dually diagnosed. Total request for salaries is $26,816.52.

Benefits:
Funding of $8,964.48 is being requested to provide for the full-time fringe benefits for the SAM ACM Supervisor. Total request for fringe benefits is $8,964.48.

Travel:
Funding is requested to pay for travel costs for the SAM ACM Supervisor. Costs include monies for the Housing Specialist 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 the PATH program success. Costs associated with the trainings include registration fees, lodging, food, and mileage expenses. Other costs associated with the PATH program include the local travel to housing entities, shelters, LHOT meetings, evaluation meetings and regional housing/homeless meetings for SAM Housing Staff. Total travel request: $2,612.04.

Supplies:
Funding is requested for supplies necessary to ensure efficient operation of the PATH program and to supply individuals experiencing homelessness with greater access to needed emergency, safety, new apartment set-up, hygiene, and habilitation resources. The following supplies enable the SAM Housing Program Staff to efficiently and successfully implement the PATH program: general office supplies—paper, pens, stapler, etc. at $300.00, Cell Phone at $350.00 and safety/emergency/apartment set-up/hygiene/habilitation supplies at $9,977.20 for a total of $10,627.20 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 30-40 individuals experiencing homelessness or at imminent risk of homelessness at approximately $485 each, not to exceed $14,548.80, outreach at $6,000.00, staff training at $800.00; administrative costs are computed at 3.26% of the total budget. Administrative costs included here of 3.26%, $2,374.96, Total request for other expenses: $23,723.76.

In-Kind:
In-kind services provided toward the project include the following items as outlined below at a value of $3,625.96:

MH Supervision of MH Housing Program Staff @ .58%	$576.45
MH Housing Program Staff @ 2.88%	$2,058.39
MH Fiscal Officer Time @ 0.72%	$503.13
County Match (on State allocation)	$487.96

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 $2,324,870 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
$755,924
New Visions
$314,969
Keystone Service Systems
$925,537
HUD Grants Yearly
$311,748
HSBG Funded Housing Assistance
$16,692

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SAM, Inc. Provider BUDGET
Franklin/Fulton Counties PATH Program
FY 2019-2020 Budget

PERSONNEL Position	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL

Housing ACM Supervisor	$53,633.04	50%	$26,816.52	$26,816.52
Outreach Liaison (Certified Peer Specialist)	$0.00	0%	$0.00	$0.00
Outreach Liaison #2	$0.00	0%	$0.00	$0.00
Resource Specialist	$0.00	0%	$0.00	$0.00
sub-total	$53,633.04	50%	$26,816.52	$26,816.52
FRINGE BENEFITS Position				
Housing Case Manager	$17,928.96	50%	$8,964.48	$8,964.48
Outreach Liaison (Certified Peer Specialist)	$0.00	0%	$0.00	$0.00
Outreach Liaison #2	$0.00	0%	$0.00	$0.00
Resource Specialist	$0.00	0%	$0.00	$0.00
sub-total	$17,928.96	50%	$8,964.48	$8,964.48
TRAVEL				
Local Travel for Outreach	$2,412.04		$2,412.04	$2,412.04
Travel to training and workshops	$200.00		$200.00	$200.00
sub-total	$2,612.04		$2.612.04	$2.612.04
SUPPLIES/EQUIPMENT				
Consumer-related items	$9,977.20		$9,977.20	$9,977.20
Office supplies	$300.00		$300.00	$300.00
Cell Phone	$350.00		$350.00	$350.00
sub-total	$10,627.20		$10,627.20	$10,627.20
Other				
Staff training	$800.00		$800.00	$800.00
One-time rental assistance	$14,548.80		$14,548.80	$14,548.80
Outreach	$6,000.00		$6,000.00	$6,000.00
Security deposits	$0.00		$0.00	$0.00
Administrative Expense	$2,374.96		$2,374.96	$2,374.96
sub-total	$23,723.76		$23,723.76	$23,723.76
Total PATH Budget			**$72,744.00**	

NOT FINAL

Greene County Department of Human Services
19 South Washington Street
Waynesburg, PA 15307
Contact: Zabryna Karnes

Provider Type: Social service agency
PDX ID: PA-069
State Provider ID: 4269
Contact Phone #: 724-852-5276

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 31,802**	**$ 10,601**	**$ 42,403**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 31,802	$ 10,601	$ 42,403	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 31,802	$ 10,601	$ 42,403	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 31,802	$ 10,601	$ 42,403	

Source(s) of Match Dollars for State Funds:

Greene County will receive at total of $42,403 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 60

Estimated Number of Persons to be Enrolled: 30

Estimated Number of Persons to be Contacted who are Literally Homeless: 45

Number staff trained in SOAR in grant year ending in 2018: 1

Number of PATH-funded consumers assisted through SOAR: 8

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Greene Co Human Services
2019-2020 PATH IUP

Local Provider Description

PA-069 Greene County – Greene County Human Services, 19 South Washington Street, 3rd Floor, Waynesburg PA 15370. The Greene County Department of Human Services is the provider organization requesting $42,403 ($10,601 State PATH and $31,802 Federal PATH) to implement the PATH Intended Use Plan for Greene County. Greene County Human Services will be also allocating $16,498.00 from the DHS Block Grant for a total of $59,901.00 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, County Shared-Ride Transportation, Housing Program 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 (GCHS) 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 (Southwestern Regional Housing Advisory Board), the other is held by Connect Inc., our subcontracted agency for HUD awarded programs. As a voting member of the Southwestern Regional Housing Advisory Board, we are also a voting member of the Western Region COC which is the regional HUD Continuum of Care Program. Greene County Human Services Department actively participates in all monthly meetings and serves on subcommittees for the SWRHAB and bi annual meetings of the Western Region COC meeting Greene County Human Services works with other community programs such as the local Housing Authority, Catholic Charities, the Carmichaels Ministerium, United Way, Greene County ESG Program, the two local Oxford Houses; one for women and one for men, Voting member on the steering committee of the Greene County VOAD (Volunteer Organization Active in Disaster) team, Tri-County Patriots for Independent Living (TRIPIL), and the Salvation Army to identify resources to prevent homelessness. Greene County Human Services co-chairs the Local Greene County Housing Options Partnership (GCHOP/LHOT)/ Local Housing Options Team (LHOT) which

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brings together stakeholders from Mental Health, Drug and Alcohol, Intellectual Development Disabilities, Housing Authority, local CSP, Area Agency on Aging, Veterans Affairs, Greene Arc, Inc. and local individuals who have an interest in housing in the county. Greene County Human Services Administrator is a liaison to the Redevelopment Authority of Greene County. The Greene County's PATH Housing Outreach Specialist participates in the Local Greene County Housing Options Partnership GCHOP/LHOT, Block Grant Advisory Committee, Food Partnership Advisory Committee, the Permanent Supportive Housing Advisory Board, Communities that Care, the Red Cross Emergency Food and Shelter Program Advisory Committee, and the Co-Occurring Disorder Council.

Greene County Human Services Housing Program (GCHS-HP) has been named the Coordinated Entry access point for Greene County. Trainings and HMIS assignments have already been completed. Staff have been completing the assessments since January 2017 to make sure all of the kinks are worked out, but we will officially be administering the Coordinated Entry Assessments as of July 1, 2017. The GCHS-HP enters all Coordinated Entry Assessment into HMIS and the Western Region Prioritization waitlist, we maintain those who we enter onto the list and utilize this list to fill any openings that may occur into our HUD funded programs. The PATH Housing Outreach Specialist is already known in the community as the current centralized intake person for the county to complete a housing assessment on all those who are homeless or in imminent risk of being homeless, it will be a smooth transition. The PATH Outreach Housing Outreach Specialist will be responsible to enter the Coordinated Assessments into HMIS, and to maintain the list, ensuring it is current and accurate at all times.

Collaboration with Local Community Organizations

GCHS-HP partners with many local organizations providing key services to PATH eligible clients. Many of these services include Primary Health Care, Mental Health Services (In-patient, Out Patient, and Community Based), Case Management, Substance Abuse Treatment and Case Management, Employment and Housing organizations.

Physical health care in Greene County is provided by primary care physicians at Washington Health Systems of Greene County, clinics, and doctor's offices. Cornerstone Care, Blacksville Clinic and Carmichaels Clinic, a federally qualified health center, provides a majority of health care and dental services to our individuals.

Mental Health outpatient services are provided by Greene County Human Services Mental Health Program, Centerville Clinics MH, Inc., SPHS, The Stern Center, Washington Health System of Greene Hospital, Intermediate Unit One and Cornerstone Care. The local hospital, Washington Health Systems of Greene, has a Behavioral Health Unit and outpatient program. Greene ARC provides the following mental health services; psych rehab, social rehabilitation, peer support and oversight of the Open Arms Drop In Center. Value Behavioral Health Care, the Medicaid managed care organization, is a large payor of services for our individuals with behavioral issues.

The GCHS-HP administers the Housing Assistance Program (HAP), Children and Youth Special Grants for Housing and the MH Housing Contingency Program. The GCHS-HP also administers

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the ESG Program that targets families with children, case management, veterans, the forensic population, and single youth age individuals age 21-25, which includes some PATH eligible clients. Greene County Human Services through Connect Inc. provides the Permanent Supportive Housing Program, Transitional Housing, and Rapid Re-Housing for Greene County residents.

Greene County Human Services Drug and Alcohol Programs provide prevention, case management, intensive case management, level of care assessment, and resource and referral services. Clients are referred to SPHS C.A.R.E. for Drug and Alcohol outpatient services and various de-tox/ rehabilitation centers for inpatient services.

G-PATH (Greene County's Project to Assist in the Transition from Homelessness) eligible clients can utilize the local OVR program, Southwest Training program, Washington and Greene Job Training, and PA Careerlink and also have the opportunity to work with a trained Certified Peer Specialist that is able to assist with employment issues.

Greene County Human Service (GCHS) implements the County's ESG, and DHS HAP programs that provides funding to assist with rental and utility emergencies. The County also works with the Greene County Housing Authority and our SSVF Programs for those who meet eligibility. The County meets with local landlords on a regular basis to keep the lines of communication open and to encourage them to provide rental units to our low income individuals. HUD Permanent Supported Housing, Shelter Plus Care, and Transitional Housing also assist G-PATH eligible clients if they meet the eligibility guideline criteria. The Drug and Alcohol recovery community opened two Oxford Houses (3/4 House, one for men and one for women) and GCHS-HP assists prospective residents who meet eligibility.

GCHS has been a lead in pulling together a collaborative effort to create a warming center in Greene County. Through working with the Greene County United Way, Waynesburg University, Salvation Army, local churches, the local hospital, the Greene County Commissioners and other community volunteers we are able to provide a cold weather warming center that is called; Warm Night, 25 Degrees and Below. The program has a house that sits at the Greene County Fairgrounds, which is in the center of the county. This location is available when the temperature is 25 degrees and below according to www.accuweather.com for Waynesburg, PA. Our local Mental Health Hotline was the mechanism for clients to register. If persons or families registered before 4 PM, we were open from 7 pm until 7 am. We provide a warm place to sleep and referral information. So if need be we can help their situation long term.

The Greene County PATH Housing Outreach Specialist works with each of the programs/ agencies mentioned to provide each PATH eligible client with the services that they may need. This may include for example; a food box from the local food bank, working with MH/D and A providers to provide needed documentation or services, Catholic Charities for fuel assistance, and even possibly the CAO to help with Emergency Cash Allowance so a homeless individual can pay to get utilities and or security deposits.

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Service Provision

PATH eligibility determination
The participants in G-PATH will be homeless as defined under HUD and PATH/SOAR 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.) Individuals who are assessed by the PATH Housing Outreach Specialist will not only be assessed for the Coordinated Entry System but will also be assessed for PATH eligibility. Once a person is found PATH eligible (18+, SMI, homeless/imminent risk of homelessness), they will be entered into HMIS and enrolled. 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. GCHS-HP facilitates a quarterly landlord meeting to address the landlord's concerns and to assure better coordination and assistance for their tenants. GCHS-HP 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 GCHS.

Alignment with PATH goals
GCHS has implemented a single point of contact to provide coordinated and comprehensive services that are offered to PATH consumers as well as other homeless individuals. A PATH Housing Outreach Specialist provides outreach activities to homeless persons who are presented in various ways to the GCHS. 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 coordinated assessment. We are using the Coordinated Entry, Centralized Intake Assessment from the Western COC. We are also entering each assessment into the HMIS data system. The client is then referred to a program within the continuum of care that best fits their needs and that they are eligible for. Through this process clients "have one stop" to find the appropriate services that they are eligible for and will not have to do extra unwarranted leg work during their time of crisis. This enables service providers to have clients coming to them that are eligible for their programs, which saves a great deal of staff time since the initial screening and some of the intake paperwork, such as ID's income and verifications are already taken care of.

The 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

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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.

Maximizing use of PATH funds
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 GCHS-HP 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 GCHS-HP also administers the PHARE Veterans Program that targets families with children, case management, veterans, the forensic population, and single youth age individuals age 21-25, which includes some PATH eligible clients. Greene County Human Services through Connect Inc. provides the Permanent Supportive Housing Program, Transitional Housing for Greene County residents. Also through PCCD dollars a Master Leasing program is available with case management to those with a criminal background, this is offered through the Drug and Alcohol Program under Greene County Human Services. Also SSVF programs that cover our area are utilized when working with a Veteran. All of these services mentioned come from other funding areas and all help to support the PATH population.

Gaps in current service system
Currently Greene County has no shelters in the County. GCHS-HP works with Greene County Transportation to provide transportation to out of county shelters. The main shelters that we have used for many years, have closed in Washington and are slated to close by the end of the calendar year in Fayette, the two closest counties near us that have shelters.

We have a Women's Shelter in Washington County, but if a mother has a male child over the age of 8 then he cannot stay with her, the child would need to go to the over men in the Men's Shelter. Fair Housing is challenging this, but has not made much head way, they just find another reason not to take them.

GCHS-HP face a challenge when it comes to transportation. Many individuals who are homeless are reluctant to cross county lines and do not have transportation to an out of county shelter, this is also an excuse for some of our homeless individuals not to follow through with serves. GCHS-HP also administers the HAP program, which enables us to utilize that fund for

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Emergency Shelter in Hotels/ Motels, but we are challenged with this the availability of this resource due to the Marcellus Shall industry have these rooms occupied on a daily basis.

One way the we address the obstacle of no in-county shelters is by being a key part of a group of people, both from local services agency and community volunteers, who have come together to open a warming shelter. GCHS has been working with the Greene County United Way, Waynesburg University, Salvation Army, local churches, the local hospital, the Greene County Commissioners and other community volunteers to continue efforts for the second year of providing a cold weather warming center that is called; Warm Night, 25 Degrees and Below. FY 15-16 was our first year of offering this service. In 2016-2017 we expanded this program from 20 degrees to 25 degrees, from the months of January and February in 2016 to December, January, February and March this program year. This program is staffed with 31 volunteers trained by GCHS-HS. Residents who needed this service were invited to one location this year. The Greene County Commissioners allowed the program to utilize a house that is located at the Greene County Fairgrounds. This is another improvement from last program year. Last program year we had four locations. Every two weeks, volunteers moved all the supplies from one location to the next, which took a toll on the volunteers. This past year, being in one location was one of the reasons that we expanded the length of the program. A consistent "home" for our project has help with storage, transportation of supplies and possible hours of operation. This location was available when the temperature was 25 degrees and below according to www.accuweather.com for Waynesburg, PA. Our local Mental Health Hotline is the mechanism for clients to register. If persons or families registered before 4 PM we were open. During the four months of this program we were open 7 nights and served a total of 6 individuals. All individuals who utilized the program ended up accepting longer term housing help from Greene County Human Services. The house at the Greene County fairgrounds will remain set up in case of an emergency throughout the year. A small core of volunteers did agree to be called in necessary throughout the year, if an emergency did arise. This program was identified to be needed because there was no program or place in our county for people to go who did not have adequate shelter from the cold. Greene County Human Services was awarded 2018 PHARE funds to lease a two-bedroom apartment, so we can utilize it as an option for Emergency Housing.

Another challenge the GCHS-HP 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.

Co-occurring services available
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

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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.

42 CFR Part 2 regulations
Greene County Human Services (GCHS) follows the 42 CFR Part 2 Regulations. GCHS also includes under its umbrella of programs the Drug and Alcohol Program. This Drug and Alcohol Program coordinates trainings including a confidentially training specific to the 42 CFR 2 Part regulation and all staff of the G-PATH program have been trained. Also upon hiring each employee under the Human Services umbrella, regardless of program signs a Greene County Human Services Program Employee Statement of Confidentiality. Another more general confidentiality agreement is also signed with the County's Human Resource Department. Regular training is mandatory and followed.

Justice-involved
Clients with a forensic background are a population that is a challenge in our housing assistance efforts. It is difficult to find landlords, including subsidized housing facilities, that will work with this population and these criminal justice individuals have a difficult time finding jobs in our county to sustain the rent.

With the HUD definition of homeless, individuals coming out of incarceration and or long-term hospitalizations after more than 90 days are now not considered homeless until they leave that placement. If they were in placement for less than 90 days, they are not considered homeless unless they were homeless prior to incarceration or hospitalization. With this definition,

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individuals in these situations now will be a part of the large pool of individuals with housing needs, but also can be some of our most fragile. Their length of homelessness does not count until the day they are released from the institute they are in. Each homeless person completes the Coordinated Assessment and is placed on a prioritization list that includes homeless individuals from a 20 county region. The length of your homelessness does place you higher on this list. This in return means that those coming from long-term care or incarceration will need to go to a shelter in another county if we can find a bed available. This is not in the best interest of recidivism or recovery.

GCHS-HP had received a Master Leasing grant funded through PCCD that ended in July of 2017. The "Master Leasing" grant had helped 29 individuals with rental assistance for up to a 24-month time frame, while also "wrapping services" such as case management, job training, life skills, Drug and Alcohol and Mental Health services around a person as part of a home plan for the criminal justice population when released from incarceration. The Forensic Integrated Reporting Center (IRC) program was created at a local Mental Health and Drug and Alcohol outpatient facility to insure that once an inmate is released from incarceration, services can start immediately. Master Leasing units did follow the Bridge Subsidy model, where clients did not subleasing from the program but will be leasing under their own name, The Bridge Subsidy program is for non-violent offenders. Through our Master Leasing program clients had achieved such outcomes as buying a home, taking over their own rent, applying and receiving Social Security Income, maintaining employment. The Master Leasing Grant funds through PCCD end in July 2017, but the services that were created with these funds will be sustained.

To help combat this, GCHS-HP has obtained PHARE dollars. With these PHARE funds, we will not only be able to help sustain the Master Leasing model for individuals with forensic backgrounds but will also be utilized for those who are coming from long term behavioral health care and do not have a home plan.

GCHS-HP will utilize PHARE funds to provide rental assistance to 8 households who are experiencing homelessness or are at risk of being homeless. These funds will include but not be limited to working with the clients and families who have a forensic background. Individuals with a forensic background are a priority population of our GCHS-HP.

The G-PATH program meets with the Mental Health Director on a regular basis. The Housing Outreach Coordinator works with the Mental Health staff, is a part of any necessary Multi-Disciplinary Team Meetings, works with the local BHU and is a part of our Local Housing Team meetings to ensure that we are available for referrals, since those involved would work with those with Serious Mental Illness and or a Co-occurring Disorders. The PATH Housing Outreach Specialist also helps work the local Produce to the People Food Distributions, visit local soup kitchens at various churches, and works with various other Human Services agency in efforts to link this vulnerable population to other supportive services. The PATH Housing Outreach Specialist will arrange an appointment for individuals that may not have insurance to one of three programs to insure that they can receive the physical and mental health care that they need. SOAR services are also available through the GCHS system. With these collective efforts through outreach and referral the G-PATH program tries to help homeless individuals with

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serious mental illness secure safe and stable housing, improve their health and live life to the fullest.

The G-PATH Program staff is on both the Disaster Crisis Outreach and Referral Team (DCORT)and the Volunteer Organization Active in Disaster (VOAD) team. We are housed within the same department and stay in constant communication with the Mental Health Disaster Coordinator which is also out Mental Health Director and DCORT contact. We are current on trainings and we are on the Emergency Planning Team to assist those individuals that have been impacted by crisis or disaster by providing emotional and therapeutic activities to ease stress, foster a compassionate presence and to aid in community resilience.

Data

GCHS-HP currently has all appropriate staff trained and using the PA HMIS system (Client Track) and will continue to attend ongoing trainings such as the PA HMIS System Updates as offered. We will be able to train new staff with the help of the PA HMIS Data Entry Reference Guide and from the past webinars that are archived on the www.newpa.com/pahmis website. All GCHS-HP staff will continue to utilize HMIS on an ongoing base.

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.

The PATH Outreach Specialist will be utilizing the Coordinated Entry Assessment and entering the assessments into HMIS, where all chronically homeless individuals will be placed on a waiting list based on need. Services from the 20 county region can possibly be utilized for Housing First type of care once there is an opening.

Alignment with State Comprehensive Mental Health Services Plan

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 SW RHAB, We are Chair of our local GHCOP/LHOT teams and regularly attend trainings offered by HUD to stay current.

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We are the local contact for the County of Greene for the Coordinated Entry Process, all Coordinate Entry Assessments will follow the COC plan and be entered into HMIS.
An approach that is holistic and client centered:
We are client centered, we meet clients where they are comfortable and we listen to the needs that they feel need addressed.

Addressing all of the many facets of homelessness including different demographics, causes, geographic, forms and levels and a clear focus on homeless prevention;
We have a full Continuum of housing options in Greene County to services those with housing needs from Homeless Prevention, HAP dollars helping with eviction, to case management helping landlords and tenets to mediate differences, to helping those who are Chronically Homelessness.

The aggressive expansion of affordable housing opportunities;
Greene County Human Services works with local landlords to increase the safe and affordable rental stock in Greene County. With this program we work with landlords through PHFA dollars to bring rental units up to code once the unit is up to code the landlord agrees to work with us offering the units to our clients for up to three years at fair market rent.

Embracing the philosophy of Housing First;
All housing staff have been recently trained in Housing First and utilizes the principles in our practice.

The use of best practices in data gathering and strategic planning;
All staff have been trained and are using HMIS to collect data.

Other Designated Funds
There are Block Grant Dollars that are specifically ear marked for serving people who experience homelessness and have a serious mental illness, through the Mental Health Contingency Program and is operated by the Housing Program, these dollars can be used for Emergency Shelter, first month's rent or back rent for evictions. These dollars are available to PATH eligible clients and those who meet the criteria, of a Mental Health illness.

Programmatic and Financial Oversight
The GCHS-HP will utilize HMIS as a way to collect and review data. GCHS-HP does comply with all reviews that are scheduled by the Bureau of Policy, Planning, & Program Development. The PATH funds are also a part of the county audit, which occurs on June 30th for the prior fiscal year. The firm that is designated to complete the audit is a part of an RFP process, sent out by the County Controller's office. This year the firm is Zelenkofske Axelrod, LLC, 3800 McKnight East Drive, Suite 3805, Pittsburgh, PA 15237. In addition, this past fiscal year PATH did have a state site visit from SAMSHA.

The PATH Housing Outreach Specialist does have supervision weekly to review all housing intakes and referrals. Also the GCHP utilizes the GCHOP/LHOT monthly meeting as

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mechanism to report out to the community at large. GCHS does comply with all state and federal audit and reporting requirements.

SSI/SSDI Outreach, Access, Recovery (SOAR)

Greene County Human Services has a SOAR-certified Local Lead on staff paid for by the Greene County Human Services Block Grant. Referrals are currently being made to this person from the PATH staff and outside agencies. In 2013-2014 (March 4-5, 2013), Greene County Human Services had 9 individuals trained in SOAR. In February 2014, a new lead person was trained via web-based curriculum and has become certified, this role is shared with other roles that he has. Referrals are coming from the local hospital and other agencies to the lead person.

In FY 2017-18 the SOAR Local Lead was referred 9 individuals, of which 1 application was submitted, but denied; 4 SOAR applications have been initiated and are in process awaiting documentation; and 4 applications have been initiated, but contact with the homeless individuals have since lost. The SOAR Local Lead also completed 22 general Social Security applications for those who do not fit the Social Security and HUD homeless definition. These applications did not use SOAR methodology. Of those helped with general applications, 6 were awarded Social Security benefits. The SOAR Applications are still lengthy and do take a lot of man hours. This is because the homeless population are so transient after the initial assessment, but on average at least 35 hours is spent on each application.

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Housing

1. 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 GCHS-HP 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.
2. 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.
3. The County also utilizes personal care homes if that level of service is indicated.
4. 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
5. Throughout the months of November through March, a collaborative program called Warm Nights 25 Degrees and Below, help with giving individuals a safe warm night

sleep. These services helped anyone who registered through our MH CRISIS Hotline. It offered a warm safe place from 7 PM to 7 AM and also connected those who registered with services through G-PATH.

Coordinated Entry
GCHS-HP is the Coordinated Entry site for Greene County starting in July of 2017. This provides a single point of contact and assessment process that has been created by and has become standardized with in the Western CoC, of which we are a voting member. The Coordinated Entry process provides an assessment of coordinated and comprehensive services for those with a housing need. Clients in need of housing complete a centralized assessment. This assessment is provided by the PATH Housing Outreach Specialist. From this assessment, the client is then referred to a program in our continuum of housing programs that best fits their needs and that they are eligible for and are placed in the HMIS data system, which can open up housing opportunities within a 20-county region. Through this process clients are offered a "one door" approach to be assessed for services and will not have to do extra unwarranted leg work during their time of crisis. This enables our service providers to have clients coming to them that are eligible for their programs, which saves a great deal of staff time since the initial screening and some of the intake paperwork, such as ID's income and verifications are taken care of. Clients seeking assistance through CYS Contingency Funds, Mental Health Contingency Funds, PATH, ESG, HAP and all other programs in the housing continuum utilize this process.
The Coordinated Entry Assessment is actually beneficial to the PATH program, in regards to allowing for more comprehensive outreach. It also allows for individuals that are of higher needs to be scored higher, ultimately giving them a better chance to find permanent housing sooner than one without some barriers. Some of the reason one can receive more "points" is Behavioral health needs, age, and family status. The process also allows the PATH Housing Outreach Specialist to know exactly what HUD funded programs that individuals are eligible for.

Justice Involved
The Housing Outreach Specialist will refer eligible participants to the Forensic Reentry Specialist who is housed in the Drug and Alcohol/ Mental Health Program under Greene County Human Services. This person helps to coordinate treatment services for individuals involved with the justice system with drug or alcohol issues and/or mental/behavioral issues, develop Reentry plans, make referrals to treatment, monitor individuals progress in treatment and treatment reports to the court for monthly Reentry Court, assess individuals who are ordered by the court for D&A and make recommendations. This is also the same person who helps to coordinate an Integrated Reporting Center/IRC; This program serves individuals from both county and state parole who are in need of services upon release or as a sanction for individuals in jeopardy of violation because of their D&A or MH, until they can gain access to services. Approximately twenty percent of the PATH caseload has a criminal background. Crisis Intervention Team Training has not occurred in Greene County.

Staff Information

NOT FINAL

The PATH staff serving the targeted population consists of the Greene County Housing PATH Outreach Specialist. The Greene County PATH Housing Outreach Specialist is from Greene County, and she has previously been involved herself in the County's housing programs and systems. She is experiencing her own mental health recovery and has been certified by the state to be a Certified Peer Specialist. She has also been trained to administer SOAR applications. The Outreach Specialist was homeless (couch surfing) when she came to work for Greene County Human Services Department. She became involved in activities needed to be accomplished to be considered for our Permanent Supportive Housing Program. She completed 40 hours of peer certification and is current with all updates and additional trainings offered. She is currently using skills learned in peer certification, including WRAP, to provide outreach to the homeless. She is a single mother of two children.

Greene County Human Services Department has provided many trainings to stakeholders working with homeless including: SOAR training, Peer Employment Community Training, Drug Trends, Cultural Competence Capacity Building training, Homelessness Among Veterans Webinars, Community Builders (a ten week class that educates participants on the community, boards, and leadership) Finding Evidence Based Practices to Promote Public Health, Crisis Intervention Training, two HMIS trainings and PREP Training. The HMIS trainings the Homeless Outreach Specialist attended were entitled "Caseworker and Intake Procedure Training" Part I and II. The HMIS training that was received will help our Homeless Outreach Specialist with the basics needed information for when HMIS is a requirement of PATH. It has also helped with structuring the initial assessment. These trainings were attended in FY 2012-2013. In this past FY (2013-2014) she has attended: Motivational Interviewing, Psychological First Aid, PREP, IDD Cross Training, Substance Abuse STI's and Teen Pregnancy- Increasing Risk of HIV, and CTC 101.

During fiscal year 2014-2015, Greene County Human Services Department provided training to GPATH staff as well as providers of homeless services in: DCORT 101, PREP refresher, Understanding and Engaging Homeless Individuals, Drug and Alcohol rules of Confidentiality, Confidentiality and Boundaries in Recovery Oriented Service, Recognizing and Reporting Child Abuse and Mandated and Permissive Reporting in Pennsylvania, Point In Time Training, HIPAA and HMIS: Protecting and Securely Sharing Client Information training, HMIS training, and Community That Cares 101. DCED HMIS webinar trainings are at no cost, which has allowed Greene County Human Services to participate in the trainings and report all requested information into HMIS data system.

Within the current FY 2015-2016 our G-PATH program staff attended Youth Mental Health First Aid, Housing Options for Individuals with ID, Housing First, Warming Center Volunteer Training, Community Planning Part 1 and 2, PATH HMIS TA, Mental Health First Aide for Adults and Crisis Response DCORT Training.

Within FY 2016-2017 our G-PATH program staff have attended PATH Webinars Introducing the New PATH, Trainings on Benefit Programs and Other Resources for the Homeless, Benefit Programs and Other Resources for the Homeless: Employment Resources, PA HMIS: 2016 Update trainings, PAYS Training, PA PDX Technical Assistance Training, Equal Access and Gender Identity Rules Training, PATH HMIS Learning Community, PATH Data Flow Training,

NOT FINAL

PATH Contact HMIS Policy Development, PA HMIS Training Coordinated Entry Training, Western COC, Housing First Training, Addressing Circumstance of the Past training, DASH Training, Obsessive Compulsive Disorder Training. Youth Mental Health First Aid, Housing First, Warming Center Volunteer Training, Mental Health First Aide for Adults and Crisis.

The G-PATH Program Staff attended the following trainings in within FY 2017-2018: Medicaid Coverage and Financing of MAT, Current Status and Promising Practices, Put Yourself in Their Shoes: Experiencing Homelessness as an Older Adult, Mandated Reporting, Public Health 3.0, HMIS Learning Community, Understanding Hoarding Behaviors, Introduction to the Prepared Renter, SAMHSA Taking Care of Your Financial Wellness, Making Physical Health & Well-Being Matter for Youth & Young Adults Education/Prevention, FEMA Webinar for Housing Professionals: Resources to Help Individuals and Families with Financial Preparedness, and Housing Case Management Training, Homeless Diversion.

Greene County Human Services Department Housing Program co-chairs the GCHOP/LHOT meeting that currently has about 45 people/stakeholders on the mailing list, with a regular attendance of approximately 25. GPATH activities are an agenda item for every meeting. We utilize GCHOP which includes consumers to advise and ensure that our PATH information is dissemination and outreach materials are true to our philosophy on addressing areas of cultural competence. At the monthly GCHOP/LHOT meetings there is an educational, housing related, presentation. A report from GCHOP/LHOT is also given at every monthly Consumer Support Program (CSP) meeting with discussion and feedback being shared from consumers on housing issues.

The Greene County Human Services Department understands the cultural aspects of the community that will contribute to the program's success and this is evidenced by the background of the staff hired for outreach, the trainings that are planned and most of all, the utilization of feedback from consumers of service in planning. Greene County's SOC is required to develop a cultural competency plan and the PATH Housing Outreach Specialist participated in this process.

Currently, a multi-linguist population has not shown a need in our services. We have a plan that when this need arises, to utilize the services of the local university.

As a part of the Department of Human Services Block Grant, a work group for LGBTQI issues has been in operation. The initiative has offered and the PATH Outreach Specialist has attended specific trainings for professionals and support to individuals in the LGBTQI population. We will continue to attend training and be a part of this discussion. In June 2017, PATH staff hosted a meeting in collaboration with GHCHOP/LHOT, the topic of the presentation was Human Trafficking, with recent findings, the LGBTQI populations are found to be a large part of the victims of Human Trafficking. In November 2017, through the Block Grant, Greene County Human Services, which includes the GC Housing Program, are working collaboratively with an advocate group from Fayette County PA., to see how to further, needed services around this topic, here in Greene. This is now a priority of the 2018-2019 Block Grant proposal.

NOT FINAL

Client Information

Describe the demographics of the client population

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.

Project the number of adult clients to be contacted

The projected number of adult clients to be contacted using PATH funds will be 55.

Identify expected number of adult clients to be enrolled

Approximately 30 adult clients will be enrolled (as in seen for outreach services) using PATH funds.

Give estimated percentage of adult clients to be served using PATH funds who are literally homeless

Approximately 35% 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.

Health Disparities Impact Statement

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

During FY 2017-2018, as of May 25, 2018, GCHS-HP served 26 TAY individuals. We expect to serve approximately 22 individuals in 2018-2019.

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

PATH funds will be utilized to pay for the full time Greene County PATH Housing Outreach Specialist. 33% of PATH allocated funds will be focused on the TAY population, which will come to approximately $18,030.08. This number is based on the average of TAY served in both FY 2016-2017 and 2017-2018.

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

NOT FINAL

In our work with the Transitional Age Youth (TAY) population, access to housing services can be difficult; when our PATH Housing Outreach Specialist completes the Coordinated Assessment, the TAY population will receive more points if they are under the age of 25. GCHS PATH also works with the CYS Independent Living Program that serve youth age 18-21 if they meet the CYS eligibility requirements. GCHS Housing Program, including the PATH staff has attended numerous trainings focused on how to communicate and outreach to this population. When a TAY has a housing issue, the GCHS Housing Program reviews their eligibility in all of the housing programs and services within our housing continuum. GCHS Housing Program maintains collaboration with school districts, Mental Health Services, CYS, IDD, Probation and Drug and Alcohol programs when working with a TAY client. All professional that are involved with a TAY case meet together for a Multi-Disciplinary Team (MDT) meeting to ensure that all services are looked at to meet the needs of the TAY individual. In the upcoming year we will expand our outreach efforts through programs such as teen parenting, Communities That Care, and mental health initiatives such as H2O (Helping 2 Overcome) Drop in Center, High Fidelity Wrap around services and System of Care. These programs currently work with this population and are a good referral source. The GCHS Housing Program wants to research other best practice and housing models that are focused on this population as we are seeing an increase in the referrals of the TAY. A continued challenge is youth under the age of 18 and are unaccompanied by an adult. We are working with a shelter in Fayette County, but at this time it is the only resources that we have. We will continue to search as a whole Western Region for other resources, since this is a regional problem, not just Greene County specific.

A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the YYA population and in comparison to the general population.

In the past few fiscal years, the number of TAY individuals that have been identified as homeless has increased. The PATH Outreach Specialist utilizes the HMIS database to track this data. We strive to have all TAY individuals eligible for the same programs that a person older individual would have access too. The two barriers to this is or HUD funding is for 21 years and older, and most property owners will not rent to younger individuals. The Housing Outreach Specialist completes the Coordinated Assessment; the TAY population will receive more points if they are under the age of 25. In collaboration with the local CYS agency, funds through the CYA Needs Base Budget have been set aside to provide additional resources to the TAY population. These funds can be utilized for rent, security deposit, transportation, and household items. The GCHS Housing Program in collaboration with schools and the local Children and Youth Agencies helps to identify and utilize these funds. The GCHS Housing Program also has worked with landlords to insure rental of a unit is possible. We will continue to search as a whole Western Region for other resources, since this is a regional problem, not just Greene County specific.

Limited English Proficiency

Greene County Human Services Program has policies and procedures in place on taking

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reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs and other benefits. The policy of the GCHS is to ensure meaningful communication with LEP patients/clients and their authorized representatives involving their medical conditions and treatment. The policy also provides for communication of information contained in vital documents, including but not limited to, waivers of rights, consent to treatment forms, financial and insurance benefit forms, etc. All interpreters, translators and other aids needed to comply with this policy shall be provided without cost to the person being served, and patients/clients and their families will be informed of the availability of such assistance free of charge. This policy can be accessed on the Greene County website.

Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology and telephonic interpretation services. GCHS utilizes Waynesburg College Language Department, 51 W College St, Waynesburg, PA 15370 · (800) 225-7393 for the hours of 9-5pm. GCMHP will conduct a regular review of the language access needs of our patient population, as well as update and monitor the implementation of this policy and these procedures, as necessary.

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 or Fayette County is necessary to assess individuals in a shelter.

Supply costs are for general supplies needed to do business…phone, postage, copies, etc.

Greene County Human Services will allocate $19,617 from the Human Services Block Grant/County Match to ensure that the PATH program can operate to its fullest.

Our state Allocation will be $10,601.00, our Federal Allocation utilized will be $31,802.00 and Block Grant Allocation utilized will be $19,617.00.

NOT FINAL

Greene County Human Services BUDGET
Greene County
PATH Program
FY 2019-2020 Budget

PERSONNEL Position	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Case Manager-Outreach	$28,192	1.0	$28,192	$28,192
Case Manager Supervisor	$7,719	.14	$7,719	$7,719
sub-total	$35,911			$35,911
FRINGE BENEFITS Position				
Case Manager-Outreach	$24,088	1.0	$24,088	$24,088
Case Manager Supervisor	$ 946	.14	$946	$946
sub-total	$25,034		$25,034	$25,034
TRAVEL				
Local Travel for Outreach	$150		$150	$150
Travel to training and workshops	$150		$150	$150
sub-total	$300		$300	$300
SUPPLIES/EQUIPMENT				
Office supplies	$150		$150	$150
sub-total	$150		$150	$150
Other				
Staff training	$125		$125	$125
sub-total	$125		$125	$125
Total PATH Budget				**$62,020**

Greene County will utilize $31,802 Federal Path Allocation + $10,601 State Path Match + $19,617 Human Services Block grant funds to fund the PATH Program

NOT FINAL

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)				
i. Other	**$ 31,859**	**$ 10,620**	**$ 42,479**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 31,859	$ 10,620	$ 42,479	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 31,859	$ 10,620	$ 42,479	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	n/a
l. Grand Total (Sum of j and k)	$ 31,859	$ 10,620	$ 42,479	

Source(s) of Match Dollars for State Funds:

Huntingdon/Mifflin/Juniata will receive a total of $42,479 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 75

Estimated Number of Persons to be Enrolled: 25

Estimated Number of Persons to be Contacted who are Literally Homeless: 50

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Juniata Valley Behavioral and Developmental Services
Counties of Huntingdon, Mifflin and Juniata

Service Access and Management Inc.
PATH INTENDED USE PLAN
FY 2019-2020

Local Provider Description
Service Access and Management Inc., HMJ Base Service Unit
100 East Market Street
Lewistown, PA 17044

PATH PDX info: HMJ: Service Access and Management, Inc. PA-076

Service Access and Management Inc. (SAM Inc.) Base Service Unit is a locally based non-profit organization that provides emergency delegate services, case management services, housing specialist services and intake/assessment services in Huntingdon, Mifflin and Juniata Counties for individuals who are in need of access to local mental health services. Service Access and Management Inc. is currently providing specialized housing case management services to individuals residing in 14 Master Leasing apartment units within Huntingdon and Mifflin Counties as well as providing administrative oversight and transitional housing support to 10 individuals residing in our 2 local Community Residential Rehabilitation (CRR) homes. The Service Access and Management Inc. Base Service Unit Housing Specialist is the designated PATH Coordinator and assumes all responsibilities for coordination of PATH services in the Tri-County Area. SAM Inc. also coordinates the use of PATH resources for rental assistance, security deposits, first month's rent, and payment for PATH participants who receive drug and alcohol services.

Juniata Valley Behavioral Health and Developmental Services (JVBDS) is the fiduciary for the PATH program in Huntingdon, Mifflin and Juniata Counties. SAM Inc. works with JVBDS to create the PATH budget for the fiscal year.

Service Access and Management Inc. Base Service Unit Housing Specialist has demonstrated success in the management of the HMJ Master Leasing Program and has extensive knowledge of local community resources and housing options available within the three county area. PATH funding provides resources for Service Access and Management Inc. to maintain a dedicated case manager charged with these service linkages, assisting persons with a transition to permanent housing and follow-up with the individual for a period of time to ensure success. Because of the increase in the homeless individuals involved in the criminal justice system this has created a huge impact on our services. Service Access and Management Inc. Base Service Unit will be allocated $42,479 to provide PATH coordination services and funding to support PATH participants in obtaining and maintaining permanent housing within our 3 county service area. This allocation is broken down into $31,859 in federal funds with a state match of $10,620.

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Service Access and Management Inc. will work closely with the Shelter Services Inc. and Huntingdon County Community Action Center to promote and expand the current PATH program. Many of the individuals identified as eligible for the PATH program will also be eligible for the existing Master Leasing Program that is currently coordinated jointly by the BSU and Advocacy Alliance. The Master Leasing Program currently has 8 units to serve individuals who may otherwise not be eligible for subsidized housing options and 6 units to serve forensic population through a separate grant.

Collaboration with HUD Continuum of Care Program

The Tri-County is part of the Eastern Continuum of Care. Mifflin and Juniata Counties are part of the Central Valley RHAB, and Huntingdon is part of the South Central RHAB. Counties are in the process of joining the Coordinated Entry process by engaging in training and establishing an access site, which is Mifflin-Juniata Human Services, as well as 211. PATH will be a partner program and is working on gaining access to Coordinated Entry Data in HMIS and will be available to receive appropriate referrals. The goal of all stakeholders that serve PATH eligible individuals is for rapid re-housing following a period of homelessness with the appropriate supports in place. Through the PATH program, there is a continuum of care or, as we call it, intensive case management in which an individual's housing transition is followed. Participants are followed while living at the shelter, then through their transition into public housing, Section 8, Master Leasing, or private rental. We consider this intensive case management to be an extra layer of support while the individual is also being seen by other agency representatives.

Collaboration with Local Community Organizations

Service Access and Management Inc.'s Base Service Unit is an active participant on the Human Services Council in each of our three counties, Criminal Justice Advisory Boards in each of our three counties and holds Letters of Agreement with 44 Tri County Human Service providers as well as being an active member of Mifflin County Communities That Care.

The Base Service Unit Housing Specialist is a member of the local Housing Coalition in Mifflin County and the Community Action Center workgroup in Huntingdon County. The BSU is also a stakeholder in the Local Lead Agency (LLA) referral process that provide access to any potential HUD Section 811 programs that may be developed. The BSU will work with Mifflin/Juniata Human Services Department (LLA) for Mifflin and Juniata Counties and with the Center for Community Action (LLA) in Huntingdon County.

We provide outreach through presentations of housing related services and resources to local provider agencies and work to establish collaborative relationships with local landlords.

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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.

SAM, Inc. currently holds contracts with Clear Concepts Counseling for drug and alcohol services in Huntingdon, Mifflin, and Juniata counties.

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.
- **Enlighten:** Psychotherapy and Psychiatric Services
- **Brighter Visions Counseling:** Psychotherapy
- **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).
- **Merakey:** Blended Case Management.

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- **Keystone Human Services, CSG and Advocacy Alliance/Peer Star:** Certified Peer Specialist.
- **Primary Health Network:** Federally Qualified Health Care Center.
- **Clear Concepts Counseling:** Substance Abuse assessment and outpatient services in Mifflin and Juniata Counties.
- **Mainstream Counseling:** Substance Abuse assessment and outpatient services in Huntingdon County.

Service Provision

- PATH Eligibility Determination and Enrollment

  PATH eligibility is determined when the PATH Case Manager receives a referral from an outside agency. The PATH Case Manager follows up for more information regarding their current housing situation and requires proof of a mental health diagnosis from a Psychiatrist, Psychologist, or other licensed medical professional. Individuals who meet the criteria for enrollment and agree to participation go through the enrollment process with the PATH Case Manager. Enrolled individuals have paper chart, kept by the PATH Case Manager, and are also enrolled in HMIS for tracking and reporting.

- Alignment of Services with PATH Goals

  The majority of PATH funds are utilized to help homeless individuals secure housing or avoid eviction, through payment of security deposits and back rent. PATH Case Manager also spends time coordinating with Blended Case Management providers to identify chronically homeless individuals and determine eligibility and the possible benefits of their enrollment in the program. In addition, the PATH Case Manager works closely with the local homeless shelter to assist residents in obtaining housing and preventing future homelessness.

- Maximized Use of PATH Funds/Use of Alternate Funding

  Service Access and Management, Inc. attempts to utilize alternate funding prior to using any PATH funds to help with housing needs. Contingency funds are used frequently to assist individuals who are homeless and/or enrolled in the PATH program. Contingency funds come from CCBH Reinvestment Dollars and are managed by the Behavioral Health Alliance of Rural Pennsylvania (BHARP).

- Gaps in Current Service Systems

  PATH funds will be used to fill a gap that exists annually in Drug and Alcohol services for the target population. Individuals residing in the Shelter currently have access to Clear Concepts Counseling or Mainstream Counseling for assessment and counseling, but the funding is normally depleted each fiscal year by mid-April. PATH funds will be used, for PATH eligible clients, to ensure

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there is no loss of access to those services after Single County Authority (SCA) funding is depleted.

Transportation for individuals is limited to Mifflin Juniata CARS for medical assistance funded service appointments and Persons with Disability transportation also through Mifflin Juniata CARS. Both services have daytime hours, which run Monday through Friday 8:00 Am to 5:00 PM. Evening hours and some Saturday hours are available through CARS for emergent medical appointments. There is no affordable transportation available outside of these hours for regular doctor's appointments or other transportation needs. PATH Funding could be utilized for individuals needing to access transportation outside of what the current system provides for employment, evening support groups including AA, NA, Intensive Outpatient Program through Clear Concepts etc. PATH funding will be used to supplement the gaps in transportation services that may have presented a barrier to individuals seeking treatment or pursing employment.

The PATH Coordinator will work with all PATH enrolled individuals to complete benefits applications for all public benefits through the local county assistance office, Social Security Disability Income or SSI, Veterans Administration benefits. The PATH Coordinator will assist with linkage to various human service agencies including Veterans Multi Service Center Inc, local food banks, Salvation Army and PA Career Link.

The PATH Coordinator will be trained in Critical Time Intervention (CTI). The CTI training is being held at JVBDS on May 30th and May 31st of 2018. Other staff involved with PATH-enrolled clients will be trained in CTI, as well, including the 3 Blended Case Management agencies. 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.

- Available Services for Individuals with a Serious Mental Illness and Substance Use Disorder

NOT FINAL

From the inception of the PATH in HMJ and throughout the planning, the PATH program has focused on an integrated program for individuals with serious mental illness and substance use disorders (SMI/SA). A high percentage of individuals who meet the eligibility requirements for the program will have a dual-diagnosis of SMI/SA and meeting their needs will require well-coordinated and integrated services. The PATH case manager will work closely with Clear Concepts Counseling and Mainstream Counseling to access the appropriate services for each individual and will monitor participation and progress through team meetings and individual meetings with each client.

In addition to the integration of PATH case management and substance use disorder services, PATH eligible clients will have access to all of the services that are provided by the aforementioned community providers. Although not specifically designed as dual-diagnosis services, the mental health supports available in the Tri-County will be an integral part of supporting individuals as they transition from homelessness to permanent housing.

- 42 CFR Part 2 Regulations

  Service Access and Management, Inc. is not required to follow these regulations.

- Linkages for Clients with Criminal Justice Histories

  SAM Inc. employs a full-time Forensic Coordinator administrative case management position that works closely with the Housing Coordinator to meet the needs of individuals involved in the criminal justice system. The Forensic Coordinator works closely with the Criminal Justice System in Huntingdon, Mifflin, and Juniata counties, making referrals to appropriate programs and agencies following release. PATH receives referrals for those individuals with mental health, housing needs, and/or drug and alcohol services. Because both positions reside in the same Base Service Unit, coordination between the two is seamless.

Data

Service Access and Management Inc. enters all PATH data into the PA HMIS system, using Client Track software, which is administered by DCED. SAM Inc. began data entry into the PA HMIS system in July 2016 when they took over coordination of the program. Training materials are posted online for reference.

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.

NOT FINAL

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 empirically supported to prevent homelessness in persons with mental illness following an institutional stay, including stay in an emergency shelter or temporary housing situation.

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 case management services in the correctional facilities, 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. focuses on individuals with mental illness who are involved in the criminal justice system.

NOT FINAL

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.

Programmatic and Financial Oversight

JVBDS receives PATH funding from OMHSAS in the amount of $42,479. Service Access and Management is subcontracted for the full amount in order to fulfill the functions of the local PATH program. JVBDS works with SAM, Inc. prior to each Intended Use Plan submission in order to develop a budget that will support the position of the PATH coordinator, establish amounts meant for assisting consumers in transition from homelessness, and establish what funds will be used to support training. SAM, Inc. invoices JVBDS electronically each month for all PATH expenditures which are reviewed and monitored by the JVBDS fiscal department. The County and SAM, Inc. interface consistently to maintain programmatic goals.

SSI/SSDI Outreach, Access, Recovery (SOAR)

Local human service providers from multiple agencies were trained in SAMHSA's SSI/SSDI Outreach Access and Recovery (SOAR) initiative. Case management units, drug and alcohol providers and homeless assistance providers were trained on April 8th and 9th, 2013. For several reasons, SOAR has not gained traction in the Tri-County Area. Staff turnover and lack of coordination from local CAOs has not been conducive to maintaining a consistent and effective program. It should also be noted that many individuals were already in the appeals process for obtaining benefits at time of PATH enrollment. Initiating a SOAR application would re-start their application process and

NOT FINAL

many were not willing to do that. HMJ may re-visit SOAR in the future, but at this time it is not an active process.

Housing

In 2009, a Master Leasing Program was implemented to provide housing to individuals with serious mental illness and other co-occurring issues that would preclude them from accessing other subsidized housing options. The target population for master leasing is individuals who have past and present credit issues, criminal histories, poor rental histories, and substance abuse issues. Advocacy Alliance and the BSU develop each master leasing unit on an as-needed basis through well-established relationships with local property owners. The units are inspected prior to development to ensure cleanliness, safety and affordability. Advocacy Alliance then signs a lease with the property owner giving the mental health system the ability to house an individual who might not otherwise pass the scrutiny of a private rental background check. In return, the property owner is guaranteed rent whether the unit is occupied or not. Service Access and Management Inc Base Service Unit also guarantees the landlord that their property will be kept in good condition and that any damages cause by the client will be satisfactorily fixed. In addition, participants in Master Leasing are required to participate in team meetings and services recommended by the planning team of which they are a part. This model has insured the highest rate of success because participants are receiving assistance with problems that have previously contributed to their chronic homelessness. The Master Leasing Program will be the main strategy used to house PATH eligible clients as it builds skills, confidence and stability in an individual thereby giving them the best opportunity to remain in permanent housing.

A new housing program is being initiated in July 2018. The new housing program will include a 7-bedroom house located in Mifflin County. The house will have a common areas, shared bathrooms, and a shared kitchen. The program will target individuals with a serious mental illness and other co-occuring issues that may prohibit them from accessing other affordable housing. Advocacy Alliance will sign the lease for this housing project, similar to the way they handle the Master Leasing Program. All clients being considered for the program will be PATH-enrolled, as the program will also be targeting homeless or at-risk individuals.

Other housing options are available and can be accessed according to need and eligibility. Keystone Human Services provides Community Residential Rehabilitation Services (CRRS) in the Tri-County area. It is a 24/7 staffed group home model that provides support and skill building for individuals with SMI who are not yet ready to live independently. Placements into CRRS are temporary and transitional until stability is attained. The ultimate goal is for the individual to obtain and maintain safe, permanent and affordable housing.

Coordinated Entry

NOT FINAL

A Coordinated Entry program is being established for Mifflin and Juniata Counties. Mifflin-Juniata Human Services, as well as 211, will be the access site for individuals seeking assistance in obtaining housing or getting linked to other available services. While the Coordinated Entry program is still in the beginning stages, the goal is to have most, if not all, of the service providers in Mifflin and Juniata counties involved in Coordinated Entry in order to better assist these individuals. The PATH Case Manager is engaging in training and working on gaining access to the Coordinated Entry data available in HMIS in order to participate in Coordinated Entry and be available for appropriate referrals. At this time, participation in Coordinated Entry is encouraged, but not mandatory.

Justice Involved

Service Access and Management Inc. is currently providing specialized forensic case management services for local and state correctional facilities for the Tri County Area. The Service Access and Management Inc. Base Service Unit Housing Specialist has worked in coordination with the Mifflin County Human Services Department to develop 6 Forensic Master Leasing Units which have been at capacity serving individual in community reentry from institutional criminal justice settings. Individuals with criminal justice involvement have also been served in regular Master Leasing units and the Base Service Unit works in close coordination with probation departments and parole departments to monitor and support these individuals in maintaining community tenure.

Mifflin County has conducted two Crisis Intervention Team trainings that have trained approximately 20 local police officers. The first was held January 26-30, 2015 and the second was held May 16-20, 2016. Additional CIT trainings will be held as funding permits.

Staff Information

The Service Access and Management Inc. Base Service Unit Housing Specialist/PATH Coordinator is based out of the Mifflin County office location and travels to Huntingdon and Juniata county office locations on a minimum weekly basis or more if needed. The staff is experienced in working with a variety of populations and has specific course credits from Elizabethtown College in serving culturally diverse populations.

The PATH Coordinator has experience with providing blended case management services for 1 year and experience in intake and service planning.

Service Access and Management provides annual Cultural Competence training for all staff (completed May 2018). There are currently no PATH staff members who are Certified Peer Specialist or Certified Recovery Specialists.

PATH staff consists of the SAM, Inc. PATH coordinator position. Currently, this position is occupied by a Caucasian female in her mid-twenties.

NOT FINAL

Client Information
As reported in 2016 Census Data, the population in Mifflin County identified as 96.3% Caucasian, 1.4% Hispanic, and 0.6% African American. The population of Juniata County identifies as 95% Caucasian, 3.1% Hispanic, and 0.9% African American. The population of Huntingdon County identifies as 91.1% Caucasian, 1.9% Hispanic, and 5.1% African American. It is anticipated that the demographics of PATH eligible clients will be commensurate with these percentages.

Mifflin County has an estimated 14.7 % of the population living below the federally defined poverty level. Juniata County has an estimated 10.2% living below the poverty line, and Huntingdon County is estimated to have about 13.6% of the population living below the poverty line. According to 2017 HUD data, the average fair market rent in the Tri-County Area for a one-bedroom apartment was $548/month.

The Service Access and Management Housing Coordinator will be on site at the Mifflin County Shelter Services Inc. on a weekly basis at minimum to enroll any PATH eligible individuals and gather data regarding the number of homeless individuals being served through our local homeless Shelter. The Housing Coordinator will also provide monthly outreach to the 3 local Blended Case Management provider agencies to identify any PATH eligible individuals who may not be involved with the local homeless shelter. Based on the local homeless shelter being at full capacity during much of fiscal year 2017/2018 it would be expected that the anticipated number of individuals who will be enrolled in PATH during FY 2018/2019 could increase by as much as 50%. The percentage of clients to be served who are literally homeless is estimated to be 60%.

There are currently 5 individuals enrolled in the HMJ PATH Program, with 2 pending referrals. The projected number of individuals to be enrolled in PATH during 2018/2019 is 50, with the opening of a new transitional housing program in Mifflin County. The projected number of adult clients to be contacted in 2018/2019 is 100.

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.

NOT FINAL

Service Access and Management Inc. has developed a PATH program survey to be completed with all participants on an annual basis or upon exiting the program. The survey results will be shared with the Juniata Valley Behavioral and Developmental Services.

Health Disparities Impact Statement

The transition aged youth population has not been a focus of the Huntingdon, Mifflin, Juniata PATH program to date. While all adult providers serve individuals who are 18 years and older, there is no specific programming aimed at a transition aged population. Over the next fiscal year, data collection will take place within the context of the PATH program identifying participants who are 18-26 years of age and what specific needs they present. This age range of individuals can have a variety of backgrounds including residential treatment facility, involvement with Children/Family Services and even forensic involvement. In many cases, this population is in need of skill development to achieve success in independent living situations. PATH will develop a system that identifies individuals in the program who are of target age and in need of independent living skills. If data supports the development of special programming to meet the needs of transition aged youth, the PATH program will accommodate that need with programming that enhances activities of daily living as well as vocational rehabilitation and training. During the 2017-2018 fiscal year, there were five individuals served who were within the target age range. All have since been closed from the program. In 2018/2019, it is expected that around five individuals who are in the targeted population will be served using PATH funds, and it is expected that about $500 will be expended on services for these individuals.

Limited English Proficiency

Service Access and Management, Inc. uses the services of Interpretalk, which is a phone-based interpreter service that can be used for any language. In addition, all promotional materials and documents used for the program are available in Spanish.

NOT FINAL

SERVICE ACCESS AND MANAGEMENT, INC.

PATH 2019 – 2020 **Budget Narrative**

Funding Breakdown

Service Access and Management, Inc. will be allocated $42,479 in total PATH funds. $31,859 of these funds will be federal while $10,620 will be state match. There are no other funding streams attributed to the PATH program.

Personnel:

PATH Case Manager:

- Meet as needed (minimum bi-weekly) with individual participants in program to develop and monitor goals
- Link to needed services and monitor participation and progress; collect data
- Assist participants in finding appropriate affordable housing
- Attend housing meetings and appeals with participants
- Help participants who are transitioning with basic purchases to establish residency
- Assist with other activities including job search, job application assistance, CAO/HA application assistance, hygiene lessons, and budgeting
- Maintain tracking records for evaluation of program

Fringe Benefits (%):
Fringe benefits including dental/vision insurance, worker's compensation, life insurance and FICA taxes total $6,894.

Travel:
The PATH Case Manager will be responsible for assisting participants with activities vital to their housing transition which may include travel to different locations. Travel will be directly related to the goals of the individual and their housing transition. Examples may include trips to the grocery store, Social Security Office, Career Link, or County Assistance Office (CAO). When possible and appropriate, case management will assist people in accessing community transportation resources such as MATP for medically necessary appointments. The Case Manager will also attend meetings at provider agencies and trainings as necessary.

Supplies:

- **Equipment:** Cellular phone service and mobile data services.

- **Supplies:** The majority of supplies necessary for the function of the PATH Case Manager will be provided in-kind by Service Access and Management, Inc.

Other:

- **Security Deposit Assistance:** When necessary, these funds will be used to pay for a security deposit related to a participant's initial transition from homelessness. **Rental Assistance:** When necessary, these funds will be used to subsidize a rental unit when an individual is in danger of losing housing.

Purchase of Service Agreements

Service Access and Management will have purchase of service agreements with two local drug and alcohol providers, Clear Concepts Counseling and Mainstream Counseling Services. When a need is indicated during PATH intake and the participant is agreeable, a referral will be made based on consumer choice where assessment and treatment can be accessed when there is a lack of insurance coverage.

NOT FINAL

Service Access and Management, Inc.
Huntingdon/Mifflin/Juniata
PATH Program
FY 2019-2020 Budget

PERSONNEL Position	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
PATH Coordinator/Housing Specialist	$31,238	.60	$18,636	$18,636
sub-total			$18,636	$18,636
FRINGE BENEFITS Position				
PATH Coordinator/Housing Specialist				$6,894
sub-total				$6,894
TRAVEL				
Local Travel for Outreach				$750
Travel to training and workshops				$750
sub-total				$1,500
SUPPLIES/EQUIPMENT				
Cell Phone		.50		$289
sub-total				$289
Other				
Admin/Check Processing				$2,910
One-time rental assistance				$5,000
Security deposits				$5,000
Client transportation				$250
POS: Drug and Alcohol Assessment/Treatment				$2,000
sub-total				$15,160
Total PATH Budget				**$42,479**

NOT FINAL

Lancaster County
150 Queen Street
Lancaster, PA 17603
Contact: John Stygler

Provider Type: Social service agency
PDX ID:
State Provider ID:
Contact Phone #: 7172998027

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◯ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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

No Data Available

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 91,098**	**$ 30,366**	**$ 121,464**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 91,098	$ 30,366	$ 121,464	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 91,098	$ 30,366	$ 121,464	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	
l. Grand Total (Sum of j and k)	$ 91,098	$ 30,366	$ 121,464	

Source(s) of Match Dollars for State Funds:

Lancaster County will receive a total of $121,464 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0 Estimated Number of Persons to be Enrolled: 0

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

Number staff trained in SOAR in grant year ending in 2018: 0 Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Lancaster County
2019/2020 PATH Comprehensive IUP
Lancaster County PATH Programs Overview

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. This year, LCBHDS will eliminate ourselves as a PATH provider and will allocate all the PATH funds to two subcontracted housing/mental health provider agencies.

A. Tabor Community Services – is a local non-profit agency that provides supportive housing, transitional and permanent housing, credit counseling and homeless services to residents of Lancaster County. Tabor receives $76,709 for their PATH services. The allocation is as following: $55,277 in PATH Federal funds, $18,426 in State PATH funds and $3,006 in other funding to provide the PATH Critical Time Intervention service (PATH CTI).

   Tabor Community Services
   308 E King St
   PO Box 1676
   Lancaster, PA 17608
   717-397-5182

   PDX Name – PA-051 Lancaster: Tabor Community Services

B. Community Services Group – is a statewide provider of mental health, intellectual disabilities and children's behavioral health services. Community Services Group receives $49,555 per year. The allocation is as following: $35,821 in PATH Federal funds, $11,940 in state PATH funds and $1,140 in other funds for the PATH Homeless Outreach Case Management (PATH HOCM) services.

   Community Services Group
   320 Highland Drive
   Po Box 597
   Mountville, PA 17554
   717-299-4636

   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 FY 2019-20 is $126,105 of which $91,098 are federal PATH funds.

NOT FINAL

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 subcommittees identified in the Heading Home plan. LCBHDS's Executive Director, Deputy Director of Administration and Tabor's President are members of the Leadership Council for LCCEH. Community Services Group's President is a board member of LCCEH's board of directors.

Each agency utilizes Coordinated Entry and Assessment. Tabor is the Coordinated Entry organization for the CoC PA 510 and is accessed through the United Ways 211 system. Both PATH providers and LCBHDS regularly refer people experiencing homelessness to coordinated entry and assessment.

Tabor Community Services
Member of the Coalition to End Homeless. Provides housing supports, housing outreach services, subsidized housing, and budgeting services. Provider of coordinated entry and assessment services of the homeless system.

Community Services Group
Member of Homeless Provider Network and Homeless Support Network. Provides a large array of mental health services to include Intensive Case Management, Psychiatric, social and vocational rehabilitation, clubhouse, partial hospitalization, residential, supportive housing, outpatient services

LCCEH separated from LCBHDS and has become part of Lancaster General Hospital (LGH) under a contract with the County of Lancaster to provider oversight of the county's homeless system. Lancaster County contracts with Lancaster General Hospital for $724,000 to provide this oversight in FY 2018/19. LCBHDS will continue to meet on a quarterly basis with LCCEH, working on specific needs of the people experiencing homelessness in Lancaster county. All three agencies utilize the 211 system to access the homeless services funded through CoC, ESG and CDBG funds through a coordinated entry and assessment system funded by HSBG and CoC funds.

There are separate IUPs included on each provider regarding their responsibilities.

Collaboration with Local Community Organizations

Partnerships include:

- Lancaster County Coalition to End Homelessness (Lancaster General Hospital) – Coordination of the homeless system
- Community Services Group mental health treatment, rehabilitation and case management including PATH Case Manger dedicated to serving the people experiencing homelessness
- Tabor Community Services – Supportive housing, budget and credit counseling

NOT FINAL

- Recovery Insights – Peer support services
- Mid Penn Legal Services – Legal services to obtain entitlement and benefit income
- Office of Vocational Services – vocational services and funding
- Keystone Service Systems – mental health rehabilitation and long term housing support
- The Lodge Life Services– homeless outreach, HUD permanent housing, long term housing support, representative payee
- Water Street Rescue Mission – homeless shelter, drug and alcohol services, medical and dental services, furniture, clothing and food banks
- Salvation Army - Furniture and clothing bank
- Goodwill – vocational services, furniture and clothing
- Behavioral Healthcare Corp – mental health treatment and social rehabilitation services
- Southeast Clinic – medical services
- Ephrata Area Rehabilitation – vocational
- Lancaster County Housing Authority – housing subsidy
- Lancaster City Housing Authority – housing subsidy
- Arch Street Center – mental health drop-in center
- ICAN of Lancaster – mental health drop-in center
- Council of Churches – food bank, emergency winter shelter
- Philhaven Hospital – mental health treatment services, mental health diversion program
- Lebanon Veterans Administration – Federal veteran services
- Lancaster County Veteran Affairs Office – Local government veteran assistance office
- Various Landlords in the community
- Community Basics – housing development
- Housing Development Corp – housing development
- Lancaster County Drug and Alcohol Commission – drug and alcohol services
- Compass Mark – drug and alcohol services
- Various housing development companies
- Lancaster County Probation and Parole
- Lancaster County Prison – local jail
- Re-Entry Management of Lancaster – criminal justice reentry program
- Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
- Ingermen Housing Development – low income housing development

LCBHDS organizes several stakeholder meetings and other opportunities for networking with other outreach teams and community and natural resources. LCBHDS's Housing Specialist maintains an email listserv that allows communication across the entire mental health system, including all PATH providers, of different governmental and community resources to those who are being served. The PATH HOC meet with the local homeless emergency shelter provider every week to discuss current cases and how they can work together. Lancaster County named Lancaster Housing Opportunity Partnership (LHOP) the Local Lead Agency for housing under Department of Human Services housing initiatives to coordinate affordable housing for those with disabilities and accessing the PA's HUD 811 Demonstration Grant.

Service Provision

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A. PATH Critical Time Intervention Program (PATH CTI)

Critical Time Intervention (provided by Tabor Community Services) is on SAMHSA's National Registry of Evidence-based Programs and Practices as an effective model to work with people who are either homeless or institutionalized and are experiencing a serious mental illness. PATH CTI is a time limited supportive housing program for people who are experiencing or at risk for becoming homeless. The PATH CTI worker will be responsible for supportive housing, housing search, linking to non-mental health community and natural supports and teaching the person and their service/treatment team skills to work effectively together.

The services include: housing support to include housing search, community service and resource linkage.

B. Community Services Group Homeless Outreach Case Manager (PATH HOCM)

The PATH HOCM will outreach to people experiencing homelessness that may have a serious mental illness to access the mental health system. If the people meet the criteria of PATH, the PATH HOCM will enroll them in the program. This access includes supporting the person in obtaining mental health case management, applying for benefits including income, medical and other social service benefits, link the person to employment resources and to build relationship with people to increase their participation in social services that could benefit them.

The service includes: Outreach Case Management

There are separate IUPs included on each provider regarding their responsibilities.

PATH eligibility determination
Lancaster PATH programs determine eligibility in different ways. LCBHDS's Housing Specialist determines PATH CTI eligibility at the time of referral by Mental Health Case Managers. Enrollment occurs when the PATH CTI's supportive Housing Worker assesses the person and the person agrees to the services. PATH HOCM determines eligibility based on a face to face outreach assessment. Once the person is determined eligible and is in need of and will to accept PATH HOCM services, then the person is enrolled in the program. Both programs document eligibility of enrolled clients in HMIS, in both the PATH data points and a case note.

Alignment with PATH goals
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 currently have a significant number of chronically homeless adults (14, 2018 PIT Count; 6, 2017 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

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transitional age group who are literally homeless or significantly at risk of homelessness. This group might be accessing LCBHDS's HUD programs that would subsidized the person's housing and utilities until they obtain an income and other benefits that would allow them to become self-sufficient.

Maximizing use of PATH funds
LCBHDS, in coordination with the County of Lancaster has leveraged a great deal of funds to support PATH participants, which each contracted agency has access to. These funds include HSBG funds that funds the all of mental health services that are not treatment service. These services include: additional supportive housing services, drop-in centers, mental health and/or drug and alcohol treatment services, mental health and/or substance abuse case management, psychiatric rehabilitation services, supportive employment and other mental health and substance abuse recovery-oriented services. In addition, PATH participants have access to funds for first month's rent, security deposits, bridge subsidies and Master Leasing funded through HealthChoices housing reinvestment plan. LCBHDS has three HUD grants that provide full subsidies to people who are HUD defined homeless and have no income. Several transitional age people have been served by Tabor's CTI program and have participated in LCBHDS's HUD programs. PATH HOCM supports people to access not only mental health services but other community and public resources and/or services. All three agencies leverage funds and services from several non-profit and faith based organizations which include, food banks, clothing banks, rental assistance, furniture banks, medical services and dental services.

Gaps in current service system
A gap in services to those experiencing homelessness in Lancaster County is meeting the exact criteria of HUD's definition of homelessness. People who are homeless are not thinking about meeting a criterion; they are trying to survive by whatever means they have. This can include doing things that would make them ineligible for HUD funded services like doubling up with family or friends temporally, renting a motel or hotel room until their financial means are expended, moving into transitional housing that does not meet HUD definition of Transitional Housing or renting a room that far exceeds their ability to pay which results in them becoming homeless for a portion of each month due to using all their financial means. The PATH CTI can support people who fall into one of these gaps to support them in attaining permanent safe and affordable housing. An additional gap people open with LCBHDS have are services to support people who are in time limited residential programs and state institutions find safe and affordable housing. Housing search and developing relationships with landlords is a specialized set of skills. We have found that a good housing agency can work with landlords on behalf of the person in services to negotiate rent or utility reductions, special accommodations and other amenities that are a necessity to the success of many of the people who receive these mental health services. The housing agency can be the place the landlord can access when there are issues with the tenant versus the landlord starting the eviction process immediately.

Another gap identified in LCBHDS is that people experiencing homelessness lack street outreach that would engage them in moving toward recovery. People who are homeless are not thinking about treatment of their mental illness, they are trying to survive by whatever means they have. This can include behaviors that would increase the negative symptoms of mental illness which

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could include self medication with drugs and/or alcohol, developing poor relationships, remaining on the fringe of society where services are not available and committing minor crimes.

The last gap recently identified by Lancaster County are those who are homeless or at risk of homelessness that are transitional age, Lancaster identifies this group as 18-24. In the first year of focusing on this group has in theory significant results with a slight rise in last year. In 2018, this age group represented 7.7% (2017 PIT 9.4%, 2016 PIT 10%) of those who were in emergency shelter and 4.9% (2015 PIT 7.0%, 2016 PIT 6.4%) were in a homeless transitional housing program were 18-24. This group represent 6.4% (2017 PIT 8.4%, 2016 PIT 6.2%) of the total HUD defined homeless population in Lancaster County. This also represents a 3.7% decrease of those 18-24 who are experiencing homelessness from the 2018 PIT count to the 2017 PIT count and a 33.3% decrease from 2016 to 2017. The total increase of those people experiencing homelessness in Lancaster County and City CoC in 2018 was 27.4% and a decrease of 5.8% of people experiencing homelessness in 2017 from 2016. With LCBHDS's targeting of this population, we believe these specialized services and supports is having an impact on the transitional age homeless population which is very low numbers as compared to other subpopulations. LCBHDS has worked with the transitional age populations with mental illness through specialized programs to include targeted case management, residential rehabilitation and support groups. PATH CTI will continue to focus half the caseload on those in the transitional age group who are literally homeless or at significant risk of homelessness.

Co-occurring services available

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.

42 CFR Part 2 regulations

Both agencies are not drug and alcohol service providers and are not required to follow the 42 CFR Part 2 regulations.

Justice-involved

LCBHDS is very active with the criminal justice system. Lancaster County's criminal justice related services/resources for those with mental illness and/or drug and alcohol addictions include: Mental Health Forensic Case Manager, Mental Health Crisis Intervention Police Liaison, Mental Health Court, Drug Court, Veteran Court, Mental Health First Aid, Crisis Intervention Training to the local and state police agencies, Re-entry Management Program,

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Special Offenders Probation Parole Services, provide mental health groups and treatment in the local jail, Day Reporting Center at Career Link, Master Leasing Program for those discharged from local jail, Transition to Community (a RTFA serving people coming from local jail or prison who need mental health treatment), MISA Group which includes coordination between LCBHDS, Drug and Alcohol Programs, Lancaster County Prison, District Attorney, Probation Parole and the County Commissioners and serving on state committees that target prison reform and diversion for those with mental illness. These services, supports and planning activities are in coordination with local social service agencies, local jail, District Attorney's Office, Probation and Parole and elected officials.

LCBHDS is now targeting PATH CTI to work with some of the people referred through the MISA group. These people are currently incarcerated with high barriers to being released from jail to include no housing, significant behaviors and/or symptoms of mental illness and/or consistent drug and/or alcohol use, few or no positive natural supports, consistent negative interaction with law enforcement and other issues that cause them to be incarcerated repeatedly or for long periods of time. PATH CTI will work to find immediate permanent housing for them while they are still incarcerated, utilizing resources and funds by LCBHDS. Once released, the PATH CTI worker will engage with them frequently along with their other supports to increase their success in the community. The ultimate goal is for the person to reduce or eliminate negative interactions with law enforcement which results in incarceration.

LCBHDS is working with Lancaster Housing Opportunity Partnership to educate landlords, property manager and housing development companies about the realities of those with criminal histories who have a serious mental illness. This education will hopefully allow landlords to give people with criminal convictions an opportunity to rent from them.

Data

LCBHDS is integrally involved with HMIS having both PATH and HUD grants. The County of Lancaster is providing funding to the Lead Agency through HSBG funding and will continue in a lead role with the LCCEH. Michael Foley from LCCEH is the HMIS Lead and responsible for the HMIS system. Lancaster migrated to a new HMIS system, Case Worthy, July 1, 2015 that will better accommodate the new PATH data points.

All PATH staff have been trained in using HMIS being utilized by Lancaster County. LCBHDS is recommending that there will be on-going training for current staff, training new staff and providers as they enter the system. LCBHDS will work with the HMIS Lead Agency to encourage them to develop policies and procedures for training the staff and to include developing a training manual and online training. Each contract with the PATH providers requires the entry of data in HMIS as part of the service provision. LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. As of July 1, 2016, Lancaster PATH providers were fully utilizing HMIS for the PATH programs as developed by the software vendor.

Alignment with PATH goals

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Lancaster County has identified gaps in the service system to the most vulnerable adults who are literally homeless and meeting chronic at times. The PATH HOCM is meeting with people on the streets, at free meals, at MH drop-in centers and other locations that have literally homeless adults. The program is designed to develop relationships with those people who are literally homeless with a serious mental illness and/or substance abuse disorder. As relationships are developed, the PATH HOCM attempts to get the person to engage in treatment and social services.

Tabor's PATH CTI program prioritizes people who are literally homeless with a target of half the caseload working with adults 18-24 who are literally homeless or at significant risk of homelessness. We have also started targeting people who are currently incarcerated who do not have permeant housing upon release from local jail. This group can historically be released to temporary housing, including homelessness which increases their risk of recidivism and/or reincarceration.

Alignment with State Comprehensive Mental Health Services Plan

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS)identified in their PATH state plan in targeting adults who are in the category of transitional age, aged 18-30, and literally homeless as a priority group. Lancaster has dedicated several resource specific to PATH funding and specific to all adults in this category. Tabor's PATH CTI program has at least half their caseload dedicated to working with this priority group. In addition, several resources have been dedicated to assist those transitional age adults in obtain housing, utilizing the housing first model, while setting expectations on them in working toward become self-sustaining through attaining income, both competitive work and/or benefits/entitlements and learning how to be a good tenant, neighbor and member of their community. LCBHDS has also dedicated first month's rent, security deposits and bridge subsidies to this group who are literally homeless and have an income to sustain their own housing.

In addition to the state PATH goals, LCBHDS has also included both PATH programs as part of their Olmsted Plan submitted. These programs provide critical supports to reduce the need for those with mental illness for long term institutionalization, including state mental health hospitals, long term homeless shelters and transition housing and other setting that are not integrating them into our community. Lancaster submit both programs in the Human Services Block Grant plan submitted to the state every year outlining the service and programs planned for the next fiscal year including some outcomes. This is how the state provides updates on their initiatives and whether the counties are following their direction.

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 for a total of $462,708 with $115,677 local matching funds and/or in-kind provided through HSBG. While none of these funds are dedicated to PATH services specifically, these funds have direct impact on those people who are receiving PATH funded services. LCBHDS utilizes

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CMHBG funds for supportive housing and peer support for those who are not eligible for Medicaid or are uninsured. LCBHDS utilizes SSBG funds for supportive employment. LCBHDS allocates an additional $4,146 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded services $125,610. The state allocation of PATH funds is $30,366 and PATH federal allocation is $91,098.

Programmatic and Financial Oversight

The state of Pennsylvania provides both PATH federal and state PATH match funds to Lancaster County through the Human Services Block Grant. These funds are categorized as PATH and are only used for the providers and programs submitted through the PATH intended use plan. LCBHDS contracts with the providers through either a fee for service or program funding for the PATH services. As part of the contracting process, LCBDHS requires an annual budget submitted by the provider, a service description, quality assurance plan, outcome-based goals and other supportive documentation. The contract specifies that PATH funds can only be used for approved expenses as required by the PATH regulations. The provider is responsible to provide LCBDHS with a 6 month, 9 month and annual profit/loss statement. A copy of the provider's annual single audit is obtained by LCBHDS. Included in the contract is LCBHDS's right to audit the provider as needed. LCBHDS provides the state with how the funds were expensed through the annual Human Services Block Grant report, which shows which categorical the funds were expensed.

SSI/SSDI Outreach, Access, Recovery (SOAR)

As March 31, 2019, three of the three direct service staff funded by PATH have been SOAR trained as provided by Mid Penn Legal Services, Valerie Case. There were 6 consumers supported by PATH Outreach Case Management and 0 consumers through PATH CTI program with a SOAR application in 2017-18. 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 full SOAR process when time allows. Lancaster at this time is not collect data on SOAR and there are no staff solely dedicated to SOAR. While Lancaster understands the importance of data collection, with limited resources to enter into multiple electronic systems, data tracking has become overwhelming to our agency. Lancaster must enter information into a multitude of data collection systems and has prioritized those systems that are funded and require the information to be enter as a condition of funding. The SOAR process is not funded by any funding source and in itself is an extremely time-consuming process. Lancaster cannot even bill the BH-MCO for targeted case management for any part of the SOAR process. This means the use of limited state funding is the only source to pay for up to 20 hours of service within a 2-3 week period to complete the SOAR process. Lancaster has integrated SOAR into the mental health system through Case Management and outreach who assist with the process when available.

Housing

LCBHDS has significantly expanded their resources and partnerships with supportive housing providers, both housing authorities and housing development companies. These include Tabor

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Community Services, Community Basics, Lancaster County and City Housing Authorities, Ingerman and The Lodge Life Services. LCBHDS's HUD Permanent Supportive Housing Program which brings the number of available units to 47 for those single unaccompanied adults experiencing homelessness. LCBHDS is continuing looking at other funding opportunities in housing including partnering with a housing development corporation to set aside and a long-term, project-based subsidy of 6 units for people with mental illnesses. LCBHDS and Tabor have developed many more partnerships with local landlords and property management companies and have become agencies that the landlords are willing to partner with.

LCBHDS oversees the contract with Lancaster Housing Opportunity Partnership for their oversight as the Local Lead Agency. The Local Lead Agency is responsible for the oversight of the LIHTC properties set asides for those with a disability and for the management of Pennsylvania Housing and Finance Administration's 811 grant for subsidized housing for those with a disability. As part of this partnership, LCBHDS's Housing Specialist has developed literature on educating landlords about working with people who have mental illnesses and those who have experienced mental illness to include how to access community and crisis services when a tenant is experiencing symptoms that effect their other tenant's safety and rights and potential damage to their property. LCBHDS presents on how the community can support people with mental illness in being successful in their own permanent housing at the annual Disabilities in Housing conference. PATH funded positions has been meeting with potential landlords and having discussions about what mental illness is and how to decrease the stigma around mental illness and homelessness. This work has significantly expanded opportunities to people and landlords have been willing to take more risks with some of the individuals who do not have satisfactory rental histories, credit histories and criminal backgrounds.

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Coordinated Entry

Both providers participate in the coordinated entry program developed for the homeless system. The process includes calling the United Way 211 system to request support if a person is experiencing homelessness. If the person is assessed on the phone as meeting HUD defined homelessness, they are then referred to Tabor's Coordinated Housing Assessment Referral Team (CHART), for an intake worker to provide an intake and determine what homeless services a person might be eligible for. LCCEH oversees the contract with Tabor for CHART and is responsible for monitoring and governing under a contract with the County of Lancaster. Coordinated entry does not provide any barriers to PATH eligible participants since CHART and LCBHDS are in constant communication for all people who are open with LCBHDS or in need of outreach by the PATH outreach worker.

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 as needed for people they support who are not open with LCBHDS. When needed, PATH HOCM will refer people to CHART to access the Rapid Rehousing services and other homeless services and/resources that can support people in attaining permeant housing when they might not qualify or voluntarily engage in public mental health services. LCBHDS does support CHART in providing supportive housing to people who are homeless and on the CHART waiting list. LCBHDS is in the process of contracting with Lancaster County Coalition to End

Homelessness to access RRH funds while LCBHDS contracted provider will provide supported housing services. LCBHDS has invested in a vast array of resources for housing and/or resources for people open with LCBHDS. LCBHDS has relied less on the homeless system to serve the people open with the agency, this reduces the burden on the homeless system. Lancaster 2018 PIT count reflects this investment, in that only 14.5% of those counted reported a mental illness, while Pennsylvania is at 22.1% and the United States is at 20.1%. This was a 25.5% increase from the year before for Lancaster County PA 510 which had a 26.5% increase from the previous year. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's mental health case manager or LCBHDS's Housing Specialist.

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, LCBDHS has developed tools that help the justice system in determining the best course of action for someone who is being released from jail that has no permanent housing to return too.

LCBHDS estimates that nearly 80% of the people working with the PATH programs have some sort of criminal history. It is estimated that 25% have felonies. The group that Lancaster has found to have the greatest barrier to finding permanent housing are people with convictions that would place them on the Sexual Offender's list, arson, manufacture/sales/distribution of controlled substances and multiple conviction of domestic violence.

The County of Lancaster through Probation/Parole Services provide Crisis Intervention Training to both local and state law enforcement and the local prison guards. While not every officer or even police jurisdiction has participated in CIT, there have been well over 200 officers trained in the last 6 years the CIT program has been established. LCBHDS is coordinating two Mental Health First Aid training for local and state law enforcement, prison guards and probation and

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parole officers. It is hard to estimate the number of law enforcement officers who have been trained since there are so many jurisdictions of local, state and federal officers who are responsible to Lancaster County.

Staff Information
Tabor PATH CTI has one FTE supportive housing case manager who leads the CTI process and the team leader who supervises the case manager. Community Services Group PATH HOCM has 0.8 FTE Case Manager that will provide the outreach case management and a Supervisor who also works in the field a couple hours per week. Of the four employees being funded with PATH funds, the demographics include four females, all four are Caucasian with the ethnicity of four non-Hispanic. One person is Spanish/English bilingual. There are several opportunities to PATH staff to receive training on cultural competency through internal trainings and conferences they attend. The direct service employees, provider supervisors and LCBHDS's Housing Specialist will attend the annual Pennsylvania PATH Conference.

Lancaster County offers cultural competency training a minimum of annual to their internal employees. In addition to the annual training, our office encourages both internal staff and providers to attend the various cultural competency trainings and workshops offer by advocacy groups, providers, and County and State agencies. We disseminate training opportunities to the providers of the PATH grant through a local list serve email distribution by our office. None of the staff are Certified Peer Specialist or Recovery Specialist. PA is approved to bill Peer Specialist services under medical assistance, which allow PATH funds to be used for services not funded by third party options.

Client Information
Both programs will target people who are experiencing homelessness or are at risk of becoming homeless. For the PATH CTI service, the demographics will include any person residing in Lancaster County who is 18 years and over and of any race, gender, ethnicity, religious belief and meets the OMHSAS Serious Mental Illness criteria, which is defined as a person who has a diagnosis of psychotic NOS disorder, schizophrenia, major depression, mood disorder and/or borderline personality disorder and has a secondary history that impedes their ability to function in the community successfully. In addition, the person must agree to be open in LCBHDS's services for PATH CTI services. LCBHDS is dedicating half the PATH CTI case manager's caseload to those 18-24 years old. The PATH HOCM will target anyone over the age of 18 who is homeless and is in need of mental health supports.

The number of contacted clients for PATH CTI will be 40 and the projected number of enrolled clients that will receive PATH CTI services for FY 2019-2020 is 35. Estimated percent of the clients to be literally homeless is 60%.

The projected number of contacted clients that will receive PATH HOCM services for FY 2019-2020 is 220 people. The PATH HOCM will enroll an estimated 140 clients. Estimated percent of the clients to be literally homeless is 100%.

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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 Community Support Program, LCBHDS Advisory Board, NAMI Family Meeting and the Stakeholder's Planning Meetings. Family members are active members of all the groups/boards mentioned previously. The Housing Specialist attends the NAMI meeting four to five time a year to discuss housing initiatives with the family members, including all the PATH programs. Any of the PATH participants would be encouraged to participate in any of these advisory boards or committees. LCBHDS's Housing Specialist attends all the stakeholder meetings in order to discuss Lancaster's PATH programs and to receive stakeholder feedback on changes or current status Lancaster encourages Peer Support programs to recruit Certified Peer Support Specialist(s) that have experienced homelessness in their life.

Health Disparities Impact Statement
Lancaster County has already identified the Transitional Age Youth and those who are chronically homeless as subpopulations that our most vulnerable populations. In addition to those, Lancaster is also recommending rural homelessness as another subpopulation that is vulnerable. With most of the services and outreach done in the urban center, the outlining rural areas are not fully served. This population is extremely challenging to serve due to large geographical area, lack of community resource to identify those in need and a very different cultural identity to those in urban and suburban areas.

Both programs will serve TAY. PATH CTI will have at least 50% of their caseload dedicated to the TAY population. Tabor expects to serve 15 people in this subpopulation. Additionally, PATH HMHOC will serve approximately another 30 people within this subpopulation based on the percentage who are homeless within this age range. We project that the total amount expended on this subpopulation will be approximately $38,275 for Tabor's PATH CTI and $8,286 for CSG's PATH HOCM. These services will include outreach and supportive housing services but will be able to access any of the additional services and/or resource offered by LCBHDS if opened with the office. We will work with LCBHDS's and CSG's Transitional Age Case Mangers in linking these young adults to PATH services and other mental health and/or drug and alcohol services. If the young adult is identified as homeless and with mental illness and/or drug and alcohol issues, CSG's PATH HOCM will attempt to engage with them and linking them to community and public services. These contacts will be tracked in HMIS through entry exit and service provision entries.

LCBHDS has several services dedicated to the TAY population. These services include Transitional Age Intensive Case management, Transitional Age Residential Program, Transitional Age groups and skill building classes and the half a caseload of the PATH CTI dedicated to housing and follow-up of this age group. LCBHDS reviews these cases through a group of professionals who meet to discuss specific cases and current trends with this subpopulation.

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Limited English Proficiency
LCBHDS requires all contracted providers to provide services to limited English proficiency people. Each provider either accesses an interpretation service or employs bi-lingual staff to assure every person in services can be communicated with, including those who are deaf and hard of hearing. LCBHDS also contracts with interpretation service for every language, including sign.

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. This line item includes the following breakdown: $55,116 in Federal PATH, $18,372 in State PATH and $3,492 in other funding for a total of $76,080.

Fringe Benefits:
Cost associated with a portion of fringe benefits that include employer shared taxes, physical health, dental and optical insurance, employer shared retirement plans, worker compensation insurance and unemployment insurance for each of the above funded position. This is based on the same allocation methodology used to calculate the portion of the PATH grant that fund the salaries of each position. This line item includes the following breakdown: $13,405 in Federal PATH, $4,468 in State PATH and $0 in other funding for a total of $17,873.

Travel:
Provide mileage reimbursement to employees for utilizing their own vehicles to provide services to participants in the PATH funded program within the community or at their home in Lancaster County. This line item includes the following breakdown: $4,125 in Federal PATH, $1,375 in State PATH and $0 in other funding for a total of $5,500.

Equipment:
Cost of replacement and/or maintenance of existing equipment in supporting PATH funded positions and services. This line item includes the following breakdown: $378 in Federal PATH, $126 in State PATH and $0 in other funding for a total of $504.

Supplies:
Costs associated with office supplies needed to do day to day business of the PATH program. This line includes Consumer Related Supplies which are small household items and personal hygiene items. This line item includes the following breakdown: $538 in Federal PATH, $179 in State PATH and $654 in other funding for a total of $1,371.

Other:

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Staff training with provide for cost associated with training and education to increase the competencies of the staff to provide services to the participants of the PATH funded program. Building and equipment maintenance is for contract for equipment upkeep like copiers and scanners and for office building upkeep. Purchased services would be the professional services the organization need to maintain their computer technology associated with direct service provision, audits required by contract and regulations and other outsourced services to support the program under the agency. Protective Payee Services is a service offered to the participants of the PATH funded program to support them in managing their income to assure timely payment of rent, bills and other cost associated with maintaining a home. Communication cost would include telephone, cell telephone and internet access associated with direct service provision. Utilities are costs that include electric, gas, oil, trash removal, water and sewer associated to the office space used by the direct service staff. Office rent is the rent allocated to the program for space utilized by the direct service staff. Insurances would include professional liability, umbrella, property insurance and other liability insurance. Administrative costs would be allocated indirect costs associate with implementing the PATH funded program. These include salaries and benefits of the indirect or support staff and rent, utilities, communication, purchased services, supplies and equipment allocated in administrative support of the PATH funded program. This line item includes the following breakdown: $17,537 in Federal PATH, $5,846 in State PATH and $0 in other funding for a total of $23,382.

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.

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Lancaster County
PATH Program
FY 2019-20 Total Budget

*Please add additional rows as necessary

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
CTI Worker	$36,980	1 FTE	$36,980	$36,980
Team Leader	$57,592	0.07 FTE	$4,031	$4,031
Outreach Case Manager	$30,387	.8 FTE	$30,387	$30,387
Outreach CM Supervisor	$55,818	0.1 FTE	$5,582	$5,582
sub-total	**$180,777**	**1.97 FTE**	**$76,980**	**$76,980**
Fringe Benefits				
CTI Worker				$10,611
Team Leader				$1,962
Outreach Case Manager				$3,746
Outreach CM Supervisor				$1,554
sub-total				**$17,873**
Travel				
Local Travel for Outreach				$5,500
sub-total				**$5,500**
Equipment				
Replacement and/or maintenance of existing equipment				$504
sub-total				**$504**
Supplies				
Office Supplies				$717
Consumer related items				$654
sub-total				**$1,371**
Other				
Staff training				$1,100
Building and Equipment Maintenance				$2,287
Purchased Services				$4,201

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Communication				$2,289
Utilities				$702
Admin Costs				$11,560
Office Rent				$668
Insurance				$575
sub-total				**$23,382**
Total PATH Budget			**$125,610**	

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Lancaster County - Community Services Group
790 New Holland Ave
Lancaster, PA 17602
Contact: Kristin Labeziusk

Provider Type: Community mental health center
PDX ID: PA-065
State Provider ID: 4265
Contact Phone #: 7172935104

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◯ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Community Services Group will receive a total of $47,761 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 220

Estimated Number of Persons to be Enrolled: 140

Estimated Number of Persons to be Contacted who are Literally Homeless: 220

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

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Community Services Group
PATH Homeless Outreach Case Management
PATH Intended Use Plan FY 2019-20
Lancaster County

Local Provider Description

Community Services Group is a statewide provider of mental health, intellectual disabilities and children's behavioral health services. Community Services Group receives $49,555 per year. The allocation is as following: $35,821 in PATH Federal funds, $11,940 in state PATH funds and $1,140 in other funds for the PATH Homeless Outreach Case Management (PATH HOCM) services of PATH funds to deliver the PATH Homeless Outreach Case Management (PATH HOCM) services.

Community Services Group
320 Highland Drive
Po Box 597
Mountville, PA 17554
717-299-4636

PDX Name – PA-051 Lancaster: Tabor Community Services

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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 quarterly.

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

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. Arch Street Center – mental health drop-in center
18. ICAN of Lancaster – mental health drop-in center
19. Council of Churches – food bank, emergency winter shelter
20. Philhaven Hospital – mental health treatment services, mental health diversion program
21. Lebanon Veterans Administration – Federal veteran services
22. Lancaster County Veteran Affairs Office – Local government veteran assistance office
23. Various Landlords in the community
24. Community Basics – housing development
25. Housing Development Corp – housing development
26. Lancaster County Drug and Alcohol Commission – drug and alcohol services
27. Compass Mark – drug and alcohol services
28. Various housing development companies
29. Lancaster County Probation and Parole – criminal justice services
30. Lancaster County Prison – local jail
31. Re-Entry Management of Lancaster – criminal justice reentry program
32. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
33. Ingermen Housing Development – low income housing development

LCBHDS organizes several stakeholder meetings and other opportunities for networking with other outreach teams and community and natural resources. LCBHDS's Housing Specialist maintains an email listserv that allows communication across the entire mental health system of different resources to those who are being served.

Service Provision

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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 services include: Outreach Case Management

PATH eligibility determination
PATH HOCM determines eligibility based on a face to face outreach assessment. Once the person is determined eligible and is in need of and willingness to accept PATH HOCM services, then the person is enrolled in the program. Both programs document eligibility of enrolled clients in HMIS, in both the PATH data points and a case note.

Alignment with PATH goals
PATH HOCM will assist people in obtaining mental health supports that are literally homeless. PATH HOCM will be assisting people with accessing the mental health system, obtain benefits and link to housing services, especially those in the transitional age group and other vulnerable populations.

Maximizing use of PATH funds
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.

Gaps in current service system
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.

The last gap recently identified by Lancaster County are those who are homeless or at risk of homelessness that are transitional age, Lancaster identifies this group as 18-24. In the first year of focusing on this group has in theory significant results with a slight rise in last year. In 2018, this age group represented 7.7% (2017 PIT 9.4%, 2016 PIT 10%) of those who were in emergency shelter and 4.9% (2015 PIT 7.0%, 2016 PIT 6.4%) were in a homeless transitional housing program were 18-24. This group represent 6.4% (2017 PIT 8.4%, 2016 PIT 6.2%) of the total HUD defined homeless population in Lancaster

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County. This also represents a 3.7% decrease of those 18-24 who are experiencing homelessness from the 2018 PIT count to the 2017 PIT count and a 33.3% decrease from 2016 to 2017. The total increase of those people experiencing homelessness in Lancaster County and City CoC in 2018 was 27.4% and a decrease of 5.8% of people experiencing homelessness in 2017 from 2016. With LCBHDS's targeting of this population, we believe these specialized services and supports is having an impact on the transitional age homeless population which is very low numbers as compared to other subpopulations. LCBHDS has worked with the transitional age populations with mental illness through specialized programs to include targeted case management, residential rehabilitation and support groups. PATH CTI will continue to focus half the caseload on those in the transitional age group who are literally homeless or at significant risk of homelessness.

Co-occurring services available
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.

42 CFR Part 2 regulations
CSG is not drug and alcohol service provider and is not required to follow the 42 CFR Part 2 regulations.

Justice-involved
CSG is active with the criminal justice system under the guidance of LCBDHS. CSG opened the Transition to Community program in May 2017 that will serve people who are being released from incarceration but need continued mental health treatment but not in an inpatient setting. Lancaster criminal justice related services for those with mental illness and/or drug and alcohol addictions include: Mental Health Forensic Case Manager, Mental Health Crisis Intervention Police Liaison, Mental Health Court, Drug Court, Veteran Court, Crisis Intervention Training to the local and state police agencies, Re-entry Management Program, Special Offenders Probation Parole Services, provide Mental Health groups and treatment in the local jail, Day Reporting Center at Career Link, Master Leasing Program for those discharged from local jail, MISA Group which includes coordination between LCBHDS, Lancaster County Prison, District Attorney, Probation Parole and the County Commissioners and serving on state committees that target prison reform and diversion for those with mental illness. These services, supports and planning activities are in coordination with local social service agencies, local jail, District Attorney's Office, Probation and Parole and elected officials. CSG Outreach at

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times will see people in local jail but most these outreach services are performed by LCBHDS's Forensic Case Manager.

LCBHDS is working with Lancaster Housing Opportunity Partnership to educate landlords, property manager and housing development companies about the realities of those with criminal histories who have a serious mental illness. This education will hopefully allow landlords to give people with criminal convictions an opportunity to rent from them.

Data

LCBHDS is integrally involved with HMIS having both PATH and HUD grants. The County of Lancaster is providing funding to the Lead Agency through HSBG funding and will continue in a lead role with the LCCEH. Michael Foley from LCCEH is the HMIS Lead and responsible for the HMIS system. Lancaster migrated to a new HMIS system, July 1, 2015 that will better accommodate the new PATH data points. All PATH staff have been trained in using HMIS being utilized by Lancaster County. LCBHDS is recommending that there will be on-going training for current staff, training new staff and providers as they enter the system. LCBHDS will work with the HMIS Lead Agency to encourage them to develop policies and procedures for training the staff and to include developing a training manual and online training. Each contract with the PATH providers requires the entry of data in HMIS as part of the service provision. LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. As of July 1, 2016, Lancaster PATH providers were fully utilizing HMIS for the PATH programs as developed by the software vendor.

Alignment with PATH goals

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 or co-occurring mental health and substance abuse disorder. As relationships are developed, the PATH HOCM attempts to get the adults to engage in treatment and social services.

Alignment with State Comprehensive Mental Health Services Plan

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS)identified in their PATH state plan in targeting adults who are in the category of transitional age, aged 18-30, and literally homeless as a priority group. Lancaster has dedicated several resource specific to PATH funding and specific to all adults in this category. CSG'S HOCM works with several people who are PATH eligible and in the transitional age population. LCBHDS has also identified CSG's PATH HOCM in their Olmstead Plan as a resource to reduce a person with mental illness's likelihood of needing long term institutional care, becoming incarcerated and supporting them from homeless emergency shelters. LCBHDS has utilized several long term subsidized units through the HUD PSHP. LCBHDS has also dedicated first month's rent,

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security deposits and bridge subsidies to this group who are literally homeless and have an income to sustain their own housing. Lancaster submit PATH HOCM in the Human Services Block Grant plan submitted to the state every year outlining the service and programs planned for the next fiscal year including some outcomes. This is how the state provides updates on their initiatives and whether the counties are following their direction.

Other Designated Funds

CSG PATH HOCM can access any of the resources/services through LCBDHS if the person meets criteria for mental health services and is willing to receive services. While none of these funds are dedicated to PATH services specifically, these funds have direct impact on those people who are receiving PATH funded services.

Programmatic and Financial Oversight

The state of Pennsylvania provides both PATH federal and state PATH match funds to Lancaster County through the Human Services Block Grant. These funds are categorized as PATH and are only used by CSG for the OPATH HOCM as submitted though he PATH intended use plan. CSG, as a contrct provider with LCBDH, funds PATH HOCM through a program funding method of payment for the PATH services. CSG provides an invoice that details all the expenses for PATH HOCM the month prior. CSG submits an annual budget, a service description, quality assurance plan and goals and other supportive documentation. The contract specifies that PATH funds can only be used for approved expenses as required by the PATH regulations. CSG is responsible to provide LCBDHS with a 6 month, 9 month and annual profit/loss statement. CSG submits their annual single audit to LCBHDS. Included CSG's contract is LCBHDS's right to audit the CSG as needed. LCBHDS provides the state with how the funds were expensed through the annual Human Services Block Grant report, which shows which categorical the funds were expensed.

SSI/SSDI Outreach, Access, Recovery (SOAR)

As of March 31, 2019, 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 6 consumers supported by PATH HOCM with a SOAR application in 2017-2018. Lancaster estimates that 20-25 people could be SOAR eligible who have been enrolled with the PATH HOCM program. CSG does not have any staff dedicated to doing SOAR, it is integrated in Mental Health Case Manager's jobs for those that have been trained. Some of those people outreached we referred to other SOAR providers but no data was captured last fiscal year.

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

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person. All non LCBHDS housing resources are managed through the homeless system's coordinated entry program.

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. Coordinated entry does not provide any barriers to PATH eligible participants since CHART and LCBHDS are in constant communication for all people who are open with LCBHDS or in need of outreach by the PATH outreach worker.

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 2018 PIT count reflects this investment, in that only 14.5% of those counted reported a mental illness, while Pennsylvania is at 22.1% and the United States is at 20.1%. This was a 25.5% increase from the year before for Lancaster County PA 510 which had a 26.5% increase from the previous year. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's mental health case manager or LCBHDS's Housing Specialist.

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, LCBDHS has developed tools that help the justice system in

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determining the best course of action for someone who is being released from jail and has no permanent housing to return too.

LCBHDS estimates that nearly 80% of the people working with the PATH programs have some sort of criminal history. It is estimated that 25% have felonies. The group that Lancaster has found to have the greatest barrier to finding permanent housing are people with convictions that would place them on the Sexual Offender's list, arson, multiple convictions of aggravated assault, manufacture/sales/distribution of controlled substances and domestic violence.

Staff Information
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. None of the staff are Certified Peer Specialist or Recovery Specialist. PA is approved to bill Peer Specialist services under medical assistance, which allow PATH funds to be used for services not funded by third party options.

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 2019-2020 is 220 people. The PATH HOCM will enroll an estimated 140 clients. Estimated percent of the clients to be literally homeless is 100% for both contacted and enrolled.

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.

Health Disparities Impact Statement
Lancaster County has already identified the Transitional Age Youth and those who are chronically homeless as subpopulations that our most vulnerable populations. In addition to those, Lancaster is also recommending rural homelessness as another subpopulation that is vulnerable. With most of the services and outreach done in the urban center, the outlining rural

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areas are not fully served. This population is extremely challenging to serve due to large geographical area, lack of community resource to identify those in need and a very different cultural identity to those in urban and suburban areas.

PATH HMHOC will serve approximately another 30 people within this subpopulation based on the percentage who are homeless within this age range. We project that the total amount expended on this subpopulation will be approximately $8,286 for CSG's PATH HOCM. These services will include outreach and supportive housing services but will be able to access any of the additional services and/or resource offered by LCBHDS if opened with the office. We will work with LCBHDS's and CSG's Transitional Age Case Mangers in linking these young adults to PATH services and other mental health and/or drug and alcohol services. If the young adult is identified as homeless and with mental illness and/or drug and alcohol issues, CSG's PATH HOCM will attempt to engage with them and linking them to community and public services. These contacts will be tracked in HMIS through entry exit and service provision entries.

Limited English Proficiency
Under LCBHDS contract, CSG is required to provide services to limited English proficiency people. CSG uses a language line for non-English speaking and will access Deaf and Hard of hearing service for sign.

Budget Narrative

Personnel:
Cost associated with a portion of the salary for the Case Manager who will provide the direct service provision. This line item includes the following breakdown: $26,612 in Federal PATH, $8,870 in State PATH and $1,794 in other funding for a total of $35,608.

Fringe Benefits (37.5%):
Cost associated with a portion of fringe benefits that include employer shared taxes, physical health, dental and optical insurance, employer shared retirement plans, worker compensation insurance and unemployment insurance for the above funded position. This is based on the same allocation methodology used by the provider for the current contract with LCBHDS. This line item includes the following breakdown: $3,975 in Federal PATH, $1,325 in State PATH and $0 in other funding for a total of $5,300.

Travel:
Provide mileage reimbursement to employee for utilizing their own vehicles to provide services to participants in the PATH funded program within the community. This line item includes the following breakdown: $1,650 in Federal PATH, $550 in State PATH and $0 in other funding for a total of $2,356.

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Equipment:
Cost of replacement and/or maintenance of existing equipment in supporting PATH funded positions and services. This line item includes the following breakdown: $225 in Federal PATH, $75 in State PATH and $0 in other funding for a total of $300.

Supplies:
Costs associated with office supplies needed to do day to day business of the PATH program. This line includes Consumer Related Supplies which are small household items and personal hygiene items. This line item includes the following breakdown: $75 in Federal PATH, $25 in State PATH and $654 in other funding for a total of $754.

Other:
Staff training with provide for cost associated with training and education to increase the competencies of the staff to provide services to the participants of the PATH funded program. Communication cost would include telephone, cell telephone and internet access associated with direct service provision. Insurances would include professional liability, umbrella, property insurance and other liability insurance. Administrative costs would be allocated indirect costs associate with implementing the PATH funded program. These include salaries and benefits of the indirect or support staff and rent, utilities, communication, purchased services, supplies and equipment allocated in administrative support of the PATH funded program. This line item includes the following breakdown: $3,999 in Federal PATH, $1,334 in State PATH and $0 in other funding for a total of $5,333.

In – Kind Supports:
The participants who meet serious mental illness criteria for county mental health will have access to mental health services provided through county funding to include treatment, psychiatric rehabilitation, vocational, social rehabilitation, case management, housing supports and advocacy/self help services.

***See Sample Budget Table below**
***Please add additional rows as necessary**

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Community Services Group
2019-20 Budget
Lancaster County

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Outreach Case Managers	$30,387	0.8 FTE	$30,387	$30,387
Outreach CM Supervisor	$55,818	0.1 FTE	$5,582	$5,582
sub-total	**$86,205**	**.9 FTE**	**$35,969**	**$35,969**
Fringe Benefits				
Outreach Case Managers				$3,746
Outreach CM Supervisor				$1,554
sub-total				**$5,300**
Travel				
Local Travel for Outreach				$2,200
sub-total				**$2,200**
Equipment				
Replacement and/or maintenance of existing equipment				$300
sub-total				**$0**
Supplies				
Office Supplies				$100
Consumer-related items				$654
sub-total				**$754**
Other				
Staff training				$300
Communication				$910
Admin Costs				$3,573
Insurance				$250
sub-total				**$5,033**
Total Community Services Group PATH Budget			**$49,555**	

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Lancaster County - Tabor Community Services
308 E King St
Lancaster, PA 17602
Contact: Ann Linkey

Provider Type: Social service agency
PDX ID: PA-051
State Provider ID: 4251
Contact Phone #: 7173589391

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

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

Source(s) of Match Dollars for State Funds:

Tabor Community Services will receive a total of $73,703 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 40

Estimated Number of Persons to be Enrolled: 35

Estimated Number of Persons to be Contacted who are Literally Homeless: 24

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Tabor Community Services
Critical Time Intervention Program
PATH Intended Use Plan FY 2019-20
Lancaster County

Local Provider Description

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 $76,709 for their PATH services. The allocation is as following: $55,277 in PATH Federal funds, $18,426 in State PATH funds and $3,006 in other funding to provide the PATH Critical Time Intervention service (PATH CTI).

Tabor Community Services
308 E King St
PO Box 1676
Lancaster, PA 17608
717-397-5182

PDX Name – PA-051 Lancaster: Tabor Community Services

NOT FINAL

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 and Rapid Rehousing service through HUD CoC funding. Tabor is a leading agency within the coalition in designing programs that meet the community needs regarding homelessness. Tabor's President is on LCCEH Leadership Council and they participate in all levels of planning with the CoC.

Collaboration with Local Community Organizations

Tabor understands the importance of partnering with different community services that support people in need. The CTI model takes these partnerships to another level by assessing and planning with people to assure the available supports have been identified and who is responsible for supporting the person in accessing them. Partnerships include:

Partnerships include:

1. Lancaster County Coalition to End Homelessness (Lancaster General Hospital) – Coordination of the homeless system

2. Community Services Group mental health treatment, rehabilitation and case management including PATH Case Manger dedicated to serving the people experiencing homelessness
3. Lancaster County Behavioral Health and Developmental Service – county mental health and developmental agency
4. Recovery Insights – Peer support services
5. Mid Penn Legal Services – Legal services to obtain entitlement and benefit income
6. Office of Vocational Services – vocational services and funding
7. Keystone Service Systems – mental health rehabilitation and long term housing support
8. The Lodge Life Services– homeless outreach, HUD permanent housing, long term housing support, representative payee
9. Water Street Rescue Mission – homeless shelter, drug and alcohol services, medical and dental services, furniture, clothing and food banks
10. Salvation Army - Furniture and clothing bank
11. Goodwill – vocational services, furniture and clothing
12. Behavioral Healthcare Corp – mental health treatment and social rehabilitation services
13. Southeast Clinic – medical services
14. Ephrata Area Rehabilitation – vocational
15. Lancaster County Housing Authority – housing subsidy
16. Lancaster City Housing Authority – housing subsidy
17. Arch Street Center – mental health drop-in center
18. ICAN of Lancaster – mental health drop-in center
19. Council of Churches – food bank, emergency winter shelter
20. Philhaven Hospital – mental health treatment services, mental health diversion program
21. Lebanon Veterans Administration – Federal veteran services
22. Lancaster County Veteran Affairs Office – Local government veteran assistance office
23. Various Landlords in the community
24. Community Basics – housing development
25. Housing Development Corp – housing development
26. Lancaster County Drug and Alcohol Commission – drug and alcohol services
27. Compass Mark – drug and alcohol services
28. Various housing development companies
29. Lancaster Housing Opportunity Partnership – housing clearinghouse, fair housing
30. Ingermen Housing Development – low income housing development

Tabor provides homeless outreach services through the CoC and coordinates with other outreach services.

Service Provision

NOT FINAL

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.

PATH eligibility determination

Lancaster PATH programs determine eligibility in different ways. LCBHDS's Housing Specialist determines PATH CTI eligibility at the time of referral by Mental Health Case Managers. Enrollment occurs when the PATH CTI's supportive Housing Worker assesses the person and the person agrees to the services.

Alignment with PATH goals

The PATH CTI program is a medium term supportive housing service to support a person in identifying and accessing the community and natural supports a person has identified for their success in housing. The PATH CTI worker will provide this guidance during the nine months and once the team is established, the PATH CTI worker will back out to allow the longer term supports to continue to engage the person. 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.

Maximizing use of PATH funds

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.

Gaps in current service system

A gap in services to those experiencing homelessness in Lancaster County is meeting the exact criteria of HUD's definition of homelessness. People who are homeless are not thinking about meeting a criterion; they are trying to survive by whatever means they have. This can include doing things that would make them ineligible for HUD funded services like doubling up with family or friends temporally, renting a motel or hotel room

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until their financial means are expended, moving into transitional housing that does not meet HUD definition of Transitional Housing or renting a room that far exceeds their ability to pay which results in them becoming homeless for a portion of each month due to using all their financial means. The PATH CTI can support people who fall into one of these gaps to support them in attaining permanent safe and affordable housing.

An additional gap people open with LCBHDS have are services to support people who are in time limited residential programs and state institutions find safe and affordable housing. Housing search and developing relationships with landlords is a specialized set of skills. We have found that a good housing agency can work with landlords on behalf of the person in services to negotiate rent or utility reductions, special accommodations and other amenities that are a necessity to the success of many of the people who receive these mental health services. The housing agency can be the place the landlord can access when there are issues with the tenant versus the landlord starting the eviction process immediately

The last gap recently identified by Lancaster County are those who are homeless or at risk of homelessness that are transitional age, Lancaster identifies this group as 18-24. In the first year of focusing on this group has in theory significant results with a slight rise in last year. In 2018, this age group represented 7.7% (2017 PIT 9.4%, 2016 PIT 10%) of those who were in emergency shelter and 4.9% (2015 PIT 7.0%, 2016 PIT 6.4%) were in a homeless transitional housing program were 18-24. This group represent 6.4% (2017 PIT 8.4%, 2016 PIT 6.2%) of the total HUD defined homeless population in Lancaster County. This also represents a 3.7% decrease of those 18-24 who are experiencing homelessness from the 2018 PIT count to the 2017 PIT count and a 33.3% decrease from 2016 to 2017. The total increase of those people experiencing homelessness in Lancaster County and City CoC in 2018 was 27.4% and a decrease of 5.8% of people experiencing homelessness in 2017 from 2016. With LCBHDS's targeting of this population, we believe these specialized services and supports is having an impact on the transitional age homeless population which is very low numbers as compared to other subpopulations. LCBHDS has worked with the transitional age populations with mental illness through specialized programs to include targeted case management, residential rehabilitation and support groups. PATH CTI will continue to focus half the caseload on those in the transitional age group who are literally homeless or at significant risk of homelessness.

Co-occurring services available
People in the PATH CTI program will have access to the mental health services contracted with LCBHDS which includes supported housing, vocational rehabilitation, treatment services, social rehabilitation, Drop-in Centers and advocacy and self-help programs. In addition, the mental health case managers have experience in linking people who have substance abuse disorders to those services that are available to them. With the initiation of the HSBG program, Lancaster County now has some flexibility in moving funds to services that are needed by the residents of the county. Medicaid expansion has supported more people getting into drug and alcohol services. Lancaster has also seen a significant increase in PATH participants eligible for Medicaid through the Medicaid expansion initiated last fiscal year. Getting more people with disabilities

NOT FINAL

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.

42 CFR Part 2 regulations
Tabor is not drug and alcohol service provider and is not required to follow the 42 CFR Part 2 regulations.

Justice-involved
Tabor participates in several of the areas outlined below, with the support of LCBDHS. Lancaster criminal justice related services for those with mental illness and/or drug and alcohol addictions include: Mental Health Forensic Case Manager, Mental Health Crisis Intervention Police Liaison, Mental Health Court, Drug Court, Veteran Court, Crisis Intervention Training to the local and state police agencies, Re-entry Management Program, Special Offenders Probation Parole Services, provide Mental Health groups and treatment in the local jail, Day Reporting Center at Career Link, Master Leasing Program for those discharged from local jail, MISA Group which includes coordination between LCBHDS, Lancaster County Prison, District Attorney, Probation Parole and the County Commissioners and serving on state committees that target prison reform and diversion for those with mental illness. These services, supports and planning activities are in coordination with local social service agencies, local jail, District Attorney's Office, Probation and Parole and elected officials.

LCBHDS is now targeting PATH CTI to work with some of the people referred to the MISA (Mental Illness Substance Abuse) group. These people are currently incarcerated with high barriers to being released to include no housing, significant behaviors and/or symptoms of mental illness and/or consistent drug and/or alcohol use, few or no positive natural supports, constant negative interaction with law enforcement and other issues that cause them to be incarcerated repeatedly or for long periods of time. PATH CTI will work to find immediate permanent housing for them while they are still incarcerated, utilizing resources and funds by LCBHDS. Once released, the PATH CTI worker will engage with them frequently along with their other supports to increase their success in the community. The ultimate goal is for the person to reduce or eliminate negative interactions with law enforcement and incarceration.

LCBHDS is also working with Lancaster Housing Opportunity Partnership to educate landlords, property manager and housing development companies about the realities of those with criminal histories who have a serious mental illness. This education will hopefully allow landlords to give people with criminal convictions an opportunity to rent from them.

Data
Tabor defers issues and coordination with HMIS to LCBHDS. LCBHDS is integrally involved with HMIS having both PATH and HUD grants. The County of Lancaster is providing funding to the Lead Agency through HSBG funding and will continue in a lead role with the LCCEH.

NOT FINAL

Michael Foley from LCCEH is the HMIS Lead and responsible for the HMIS system. Lancaster migrated to a new HMIS system, July 1, 2015 that will better accommodate the new PATH data points. All PATH staff have been trained in using HMIS being utilized by Lancaster County. LCBHDS is recommending that there will be on-going training for current staff, training new staff and providers as they enter the system. LCBHDS will work with the HMIS Lead Agency to encourage them to develop policies and procedures for training the staff and to include developing a training manual and online training. Each contract with the PATH providers requires the entry of data in HMIS as part of the service provision. LCBHDS will continue to work with LCCEH and Case Worthy in improving the HMIS system to accommodate the required PATH data points. As of July 1, 2016, Lancaster PATH providers were fully utilizing HMIS for the PATH programs as developed by the software vendor.

Alignment with PATH goals

Tabor's PATH CTI program prioritizes people who are literally homeless with a target of half the caseload working with adults 18-24 who are literally homeless or at significant risk of homelessness. We have also started targeting people who are currently incarcerated and do not have permeant housing upon release from local jail. This group historically has been released to temporary housing, including homelessness which increases their risk of recidivism and/or reincarceration.

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.

In addition to the state PATH goals, LCBHDS has also included both PATH programs as part of their Olmsted Plan submitted. These programs provide critical supports to reduce the need for those with mental illness for long term institutionalization, including state mental health hospitals, long term homeless shelters and transition housing and other setting that are not integrating them into our community. Lancaster submit PATH CTI in the Human Services Block Grant plan submitted to the state every year outlining the service and programs planned for the next fiscal year including some outcomes. This is how the state provides updates on their initiatives and whether the counties are following their direction.

NOT FINAL

Other Designated Funds
Tabor PATH CTI participants have full access to LCBHDS services and/or resources as they are open with the county agency. Tabor receives funds through the CoC to provide coordinated assessment, rapid rehousing, permanent supportive housing and outreach services dedicated to those who are HUD defined homeless. While none of these funds are dedicated to PATH services specifically, these funds have direct impact on those people who are receiving PATH funded services. LCBHDS allocates an additional $2,847 to PATH funded services from Lancaster's HSBG to make the total spent on PATH funded for Tabor's services $76,550. The state and federal allocation is $73,703.

Programmatic and Financial Oversight
Tabor is a contracted provider with LCBHDS for the PATH grant funds. The state of Pennsylvania provide both PATH federal and state PATH match funds to Lancaster County through the Human Services Block Grant. These funds are categorized as PATH and are only used for PATH CTI as submitted through he PATH intended use plan. LCBHDS contracts with Tabor through as a fee for service program for the PATH services. Tabor bills LCBDHS based on a contracted rate developed by the approved budget for only services provided. As part of the contacting process, LCBDHS requires tabor to submit an annual budget, a service description, quality assurance plan and goals and other documentation. Tabor's contract specifies that PATH funds can only be used for approved expenses as required by the PATH regulations. Tabor is responsible to provide LCBDHS with a 6 month, 9 month and annual profit/loss statement. Tabor provides an annual single audit to include how the PATH funds were spent. Included in Tabor's contract is LCBHDS's right to audit the provider as needed. LCBHDS provides the state with how the funds were expensed through the annual Human Services Block Grant report, which shows which categorical the funds were expensed.

SSI/SSDI Outreach, Access, Recovery (SOAR)
As of March 31, 2019, the CTI worker funded by PATH has attended the SOAR training provided by Mid Penn Legal Services, Valerie Case. There were 0 consumers through PATH CTI program with a SOAR application in 2018-19. We estimate that around 1 person per year could be SOAR eligible, as 60% the caseload is for those who are HUD defined homeless but majority of the people enrolled will have income due to changes in how LCBHDS administers their HUD PSH programs with changes in CoC funding and match requirements. Tabor has no staff solely dedicated to SOAR and does not use the OAT system at this time. There were no people referred to SOAR providers in 2018-19, as all participants of PATH CTI had income at a level to sustain their own housing. All SOAR information is stored in HMIS.

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

NOT FINAL

experts, with nearly 300 landlords in Lancaster County they work with in order to link housing up with people who are homeless or at risk of becoming homeless. Tabor does provide Rapid Rehousing services and the PATH participants might utilize those resources in accessing funds. Tabor will also work with Lancaster County's Local Lead Agency, Lancaster Housing Opportunity Partnership, to access LIHTC set asides for those with disabilities and the PHFA 811 PSH program funds.

Coordinated Entry

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. Coordinated entry does not provide any barriers to PATH eligible participants since CHART and LCBHDS are in constant communication for all people who are open with LCBHDS or in need of outreach by the PATH outreach worker.

PATH CTI is not directly receiving referrals from CHART because of the requirement of being open with LCBHDS. LCBHDS has invested in a vast array of resources in housing and/or resources for people open with LCBHDS and has relied less on the homeless system to serve the people open with the agency. Lancaster 2018 PIT count reflects this investment, in that only 14.5% of those counted reported a mental illness, while Pennsylvania is at 22.1% and the United States is at 20.1%. This was a 25.5% increase from the year before for Lancaster County PA 510 which had a 26.5% increase from the previous year. LCBHDS accepts referrals from CHART for LCBHDS's services through the person's Mental Health Case Manager or LCBHDS's Housing Specialist.

Justice Involved

Tabor work with a significant number of people who are currently in the criminal justice system or have convictions that could present barriers to obtaining housing. LCBHDS's Housing Specialist provides a full housing assessment of a person referred to Tabor's PATH CTI that include a full criminal background check to assist the person's team to work through potential barriers to housing. Pennsylvania has a Unified Justice Portal, in which any person has access, including landlords and property managers, so being upfront of criminal history has been very important in developing relationships with the landlords and property managers.

Tabor works closely with the local courts, prison and probation/parole services to improve a person's chance of being successful in reentry back into their community. Lancaster has a great number of jail diversion and justice related programs for those with mental illness and/or substance abuse disorders. These programs include Mental Health Court, Drug Court, Special Offenders Probation and Parole Services for those with mental health and/or intellectual disabilities, Mental Health Forensic Case Management, and Mental Health Hospital/Forensic

NOT FINAL

Intake Worker. In addition, LCBDHS has developed tools that help the justice system in determining the best course of action for someone who is being released from jail and has no permanent housing to return too. Lancaster has an active CIT training offered to local and state police officers by Lancaster County Probation and Parole. We estimate that 20% of Lancaster County's law enforcement has been trained in CIT. CIT has been effective as per an antidotal perspective but no outcomes or measures have been done to prove its effectiveness in Lancaster County.

Tabor estimates that nearly 80% of the people working with the PATH programs have some sort of criminal history. It is estimated that 25% have felonies. The group that Lancaster has found to have the greatest barrier to finding permanent housing are people with convictions that would place them on the Sexual Offender's list, arson, multiple convictions of aggravated assault, manufacture/sales/distribution of controlled substances and domestic violence.

Staff Information

Tabor PATH CTI has one FTE supportive housing case manager who leads the CTI process and the team leader who supervises the case manager. Of the two employees being funded with PATH funds, the demographics include two females, two are Caucasian with the ethnicity of two non-Hispanic. One person is Spanish/English bilingual. There are several opportunities to PATH staff to receive training on cultural competency through internal trainings and conferences they attend. The direct service professionals, provider supervisors and LCBHDS's Housing Specialist will attend the annual Pennsylvania PATH Conference. None of the staff are Certified Peer Specialist or Recovery Specialist. PA is approved to bill Peer Specialist services under medical assistance, which allow PATH funds to be used for services not funded by third party options.

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 40 and the projected number of enrolled clients that will receive PATH CTI services for FY 2018-2019 is 35. Half of those people will be the targeted priority group of transitional age 18-24. Estimated percent of the clients to be literally homeless is 60%.

Consumer Involvement

NOT FINAL

Tabor has hired people who have experienced homelessness in their own life for direct service professionals and support staff. Tabor is required to have a person who had or is experiencing homelessness on their board as per HUD. Tabor frequently utilizes client satisfaction and follow up surveys where a client has the opportunity to share new ideas for the program.

Health Disparities Impact Statement

Lancaster County has already identified the Transitional Age Youth and those who are chronically homeless as subpopulations that our most vulnerable populations. In addition to those, Lancaster is also recommending rural homelessness as another subpopulation that is vulnerable. With most of the services and outreach done in the urban center, the outlining rural areas are not fully served. This population is extremely challenging to serve due to large geographical area, lack of community resource to identify those in need and a very different cultural identity to those in urban and suburban areas.

Tabor's PATH CTI will have at least 50% of their caseload dedicated to the TAY population. Tabor expects to serve 15 people in this subpopulation. We project that the total amount expended on this subpopulation will be approximately $38,275 for Tabor's PATH CTI. These services will include supportive housing services but will be able to access any of the additional services and/or resource offered by LCBHDS. Tabor will work with LCBHDS's and CSG's Transitional Age Case Mangers in linking these young adults to PATH services and other mental health and/or drug and alcohol services. These contacts will be tracked in HMIS through entry exit and service provision entries.

Limited English Proficiency

Under the contract with LCBHDS, Tabor is required to provide services to limited English proficiency people. Tabor accesses a language line for interrupting services, relies on Deaf and Hard of Hearing for sign language and the one direct service professional is bi-lingual in Spanish.

Budget Narrative

Personnel:

Cost associated with a portion of the salaries for the Critical Time Intervention Worker who will provide the direct service provision. Cost associated with a portion of the Team Leader who provide direct supervision to the CTI Worker. This line item includes the following breakdown: $28,995 in Federal PATH, $9,664 in State PATH and $2,352 in other funding for a total of $41,011.

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

NOT FINAL

of the PATH grant that fund the salaries of each position. This line item includes the following breakdown: $9,430 in Federal PATH, $3,143 in State PATH and $0 in other funding for a total of $12,573.

Travel:

Provide mileage reimbursement to employees for utilizing their own vehicles to provide services to participants in the CTI program within the community or at their home in Lancaster County. This line item includes the following breakdown: $2,475 in Federal PATH, $825 in State PATH and $0 in other funding for a total of $3,300.

Equipment:

Cost of replacement and/or maintenance of existing equipment in supporting PATH funded positions and services. This line item includes the following breakdown: $378 in Federal PATH, $126 in State PATH and $0 in other funding for a total of $504.

Supplies:

Costs associated with office supplies needed to do day to day business of the CTI program. This line includes Consumer Related Supplies which are small household items and personal hygiene items. This line item includes the following breakdown: This line item includes the following breakdown: $463 in Federal PATH, $154 in State PATH and $0 in other funding for a total of $617.

Other:

Staff training with provide for cost associated with training and education to increase the competencies of the staff to provide services to the participants of the PATH funded program. Building and equipment maintenance is for contract for equipment upkeep like copiers and scanners and for office building upkeep. Purchased services would be the professional services the organization need to maintain their computer technology associated with direct service provision, audits required by contract and regulations and other outsourced services to support the program under the agency. Protective Payee Services is a service offered to the participants of the PATH funded program to support them in managing their income to assure timely payment of rent, bills and other cost associated with maintaining a home. Communication cost would include telephone, cell telephone and internet access associated with direct service provision. Utilities are costs that include electric, gas, oil, trash removal, water and sewer associated to the office space used by the direct service staff. Office rent is the rent allocated to the program for space utilized by the direct service staff. Insurances would include professional liability, umbrella, property insurance and other liability insurance. Administrative costs would be allocated indirect costs associate with implementing the PATH funded program. These include salaries and benefits of the indirect or support staff and rent, utilities, communication, purchased services, supplies and equipment allocated in administrative support of the PATH funded program. This line item includes the following breakdown: $13,536 in Federal PATH, $4,513 in State PATH and $0 in other funding for a total of $18,049.

NOT FINAL

Lancaster County
Tabor Community Service
Critical Time Intervention PATH Program
FY 2018-19 Total Budget

*Please add additional rows as necessary

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
		Position		
CTI Worker	$36,980	1 FTE	$36,980	$36,980
Team Leader	$57,592	0.07 FTE	$4,031	$4,031
sub-total	**$94,572**	**1.07 FTE**	**$41,011**	**$41,011**
Fringe Benefits				
CTI Worker				$10,811
Team Leader				$1,762
sub-total				**$12,573**
Travel				
Local Travel for Outreach				$3,300
sub-total				**$3,300**
Equipment				
Replacement and/or maintenance of existing equipment				$504
sub-total				**$504**
Supplies				
Office Supplies				$617
sub-total				**$617**
Other				
Staff training				$800
Building and Equip Maintenance				$1,987
Purchase Services				$4,201
Protective Payee Services				$1,800
Communication				$1,379
Utilities				$702
Admin Costs				$7,987
Office Rent				$668

NOT FINAL

Insurance				$325
sub-total				**$18,049**
Total Tabor PATH Budget	**$76,550**			

NOT FINAL

Lehigh County - Lehigh County MH/ID/D&A/HealthChoices Program
17 South 7th Street
Allentown, PA 18101
Contact: Wendy Mingora

Provider Type: Social service agency
PDX ID: PA-014
State Provider ID: 4214
Contact Phone #: 6107823135

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◯ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 51,680**	**$ 17,227**	**$ 68,907**	

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

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

Source(s) of Match Dollars for State Funds:

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

Estimated Number of Persons to be Contacted: 100

Estimated Number of Persons to be Enrolled: 40

Estimated Number of Persons to be Contacted who are Literally Homeless: 50

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Lehigh County MH/ID/D&A PATH Intended Use Plan
FY 2018-2019

Local Provider Description

Lehigh County MH/ID/D&A/HealthChoices Program is the sole recipient of PATH funding. Lehigh County Mental Health, Lehigh County Government Center, 17 South Seventh Street, Allentown, PA 18101. In PDX we are listed as: PA-014 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 $51,680 and a state match of $17,227 for a total of $68,907 for the fiscal year 2018/2019.

Collaboration with HUD Continuum of Care (CoC) Program

Lehigh County MH is now a coordinated entry site in our county. Homeless individuals can walk in to our Information & Referral waiting room to see a caseworker. The caseworker will then complete the online questionnaire/application with the individuals. This will then place them on lists for further services. Lehigh County participates quarterly in the CoC meetings held at Wernersville State Hospital. Lehigh County actively participates in the Homeless Intervention & Client Case Planning (HICCP) meeting. We track all outreach referrals received through Homeless Support Services. Additionally, The Lehigh County Reinvestment Housing Plan entails a comprehensive plan to address the need for decent, safe, and affordable housing for mental health individuals in our community. Consumer representatives actively participate in the planning process. Our Lead Agency for Continuum of Care is Diana T Meyers & Associates, Lehigh Howard is the President and can be reached at 215-576-1558. The Eastern CoC #509 is the CoC for Lehigh Co.

Collaboration with Local Community Organizations

The County of Lehigh works and partners with many community organizations that provide services to our PATH eligible individuals. These services may include outreach, primary health care, behavioral health services, housing supports, and employment and/or life skills services. The agencies providing these services include: local hospitals, hospital programs, food banks, outpatient clinics, shelters, vocational programs, etc. Lehigh County currently has a caseworker that attends our local soup kitchen on a weekly basis. She is working with local agencies to connect individuals with housing resources including PATH funding.

Service Provision

PATH eligibility is determined by reviewing if an individual is homeless or at imminent risk of homeless and when the person is identified as having serious and persistent mental illness. Enrollment occurs when the individual agrees to enrollment. Usually this will be the same day

NOT FINAL

they sign the PATH enrollment/release forms and do the PATH goal plan. We will then require documentation of homelessness through an eviction notice or homeless letter. We will also collect documentation from the mental health treatment provider of the serious and persistent mental illness.

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. One of our PATH case managers goes to the soup kitchen twice a week to work with individuals there and screen for services we can provide. We have developed relationships with these agencies and have made them aware of the availability of PATH funds. Conference of Churches targets street outreach. Our priority at initial contact is to provide case management services which may include other case managers in our agency working closely with our housing staff to discuss situations when they have an individual who is homeless. Our county case managers work with the Conference of Churches housing Clearinghouse case manager to provide maximum use of PATH money and other available resources.

Lehigh County maximizes the use of PATH funds by leveraging use of other available funds for PATH services. Agencies we connect individuals with include but are not limited to: Goodwill, Office of Vocational Rehabilitation, Recovery Education, D&A services, Clubhouse, Daybreak, Drop In Centers, Food Banks, Veterans Affairs, Clearinghouse, Conference of Churches, Furniture Depot, Soup Kitchens, VNA nurses, Health Clinics, Street Medicine, Specialized Case Management, Partial Hospitalization Programs, Peer supports, Valley Housing, Section 8, Overlook Housing Authorities, Social Security, Department of Public Welfare, Unemployment Compensation, Domestic Relations, Turning Point, Pathways, Homeless Support Services, Representative Payee, Guardianship……

There are many gaps in our current service systems. We struggle to work effectively with transitional age youth that often have no income and have to endure homelessness to be eligible for Social Security benefits. There is not enough housing that is affordable for individuals with Social Security incomes. We are in great need of Section 8 housing vouchers. Our Section 8 wait list has been long for years. Housing eligibility requirements can limit people's access to housing including individuals with criminal records being barred from site-based subsidies. We do not have programs/resources to support people experiencing a financial or personal crisis that may cause them to lose their housing. Individuals with Mental Illness and chronic homelessness may struggle to maintain a steady source of income. There is a lack of furnished single room occupancies (SROs) that are affordable.

The PATH program provides case management, screening, and referral to individuals with mental illness and/or substance abuse disorders who are homeless or in danger of becoming homeless. Additionally, there are many community programs that we refer to. Some of those include: Step-by-Step – which offers a dual program where individuals can access treatment and case management services; The Lehigh Valley D&A Intake Services – which assesses individuals with co-occurring disorders, makes recommendations regarding D&A treatment or rehabilitation placement, and provides intensive case management services, this is done through various agencies in our county; The Allentown Rescue Mission – which offers a D&A residential program in addition to shelter services; and outpatient clinics such as Hispanic American

NOT FINAL

Organization and Haven House – which have programs and groups which include Drug & Alcohol treatment components.

The Lehigh County Mental Health office is not required to follow 42 CFR Part 2 regulations. We are not collecting records on Drug and Alcohol Treatment for individuals. Lehigh County follows the Health Insurance Portability & Accountability Act of 1996 (HIPAA). We notify each individual of what the Act means and their rights under the Act.

Lehigh County offers several programs to directly assist individuals with criminal justice involvement. We offer MISA, Re-Entry and SPORE. Team MISA has an initial goal of diverting low risk MH offenders from incarceration or in the very early stages of incarceration. The meetings are scheduled weekly as a "think tank" for the involved parties to streamline processes and expedite appropriate releases from jail. The success of the group hinges on collaboration and ensuring that there are decision makers, as well as front line staff, at the table. The team meets weekly to discuss new referrals and any updates on "old" referrals. Each team member collects all information from their respective office, has information releases signed when necessary, and collectively, the team discusses the most appropriate and expeditious approach to manage the case. Recommendations for any type of release do not require unanimous agreement; however, if any member believes that the defendant presents a threat to self or others, the release is tabled. Plans of action are developed. The Re-entry Committee is a multi-disciplinary team that meets every other week to discuss and develop re-entry plans for inmates who have a variety of needs including mental health and/or intellectual disabilities. S.P.O.R.E. is a joint program that supervises those offenders that have mental illness and/or mental retardation that have received a county term of probation or parole. S.P.O.R.E. integrates the criminal justice system of Lehigh County and the Mental Health/Intellectual Disability systems of Lehigh County. This collaborative effort combines the resources of two systems in order to provide a greater positive impact on behalf of the client. Adult S.P.O.R.E. can provide two main functions; one being a diagnostic function and the other a case management/supervision function.

Data

Our PATH staff are entering all PATH individuals in the PA HMIS system. We are using the Client Track System. Our case managers work with each other on being sure individuals are led to access any available applicable services for them. Lehigh County will continue to participate in any web trainings available for the HMIS system. DCED is the PA HMIS Administrator.

Alignment with PATH goals

Lehigh County is providing housing case management to our individuals that are most vulnerable risk for homelessness. We currently have a case manager that is stationed at the soup kitchen program to work with individuals and refer them to programs such as PATH. PATH services are a priority in our office. Our case managers are available to immediately meet with individuals and can enroll them in the PATH program on the same day they are presenting to our office.

NOT FINAL

Alignment with State Mental Health Services Plan

Our PATH program supports the efforts to reduce/eliminate chronic homelessness in the state by providing and linking to all services in our community that are available. Our goal in Lehigh County is to house the most chronically homeless and mentally ill. Some of the programs helping individuals are through Seneca House and our MISA programs. PATH integrates with the Continuum of Care (CoC) planning through RHAB. The CoC also provides housing (subsidies, master leases) for people who are homeless. In regards to disaster preparedness, Lehigh County meets with the City of Allentown and County of Lehigh Emergency Management staff as part of the homeless, winter sheltering workgroup. PATH can be used to house people who are displaced and become homeless in an emergency. We work with prioritizing the Transitional Age Youth (TAY) population that is homeless.

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. PATH funding is kept separate. We do give providers funds through our Block Grant that are earmarked to serve people with homelessness and serious mental illness. We work with Valley Housing and our Health Choices programs provides money for Conference of Churches Clearinghouse program. These additional funds are not specifically for PATH.

Programmatic and Financial Oversight

Lehigh County Mental Health is the provider organization that is using the PATH funds through our program. We are internally auditing our program through many levels of services including case management, supervision, our fiscal department and our fiscal officers. This auditing is on a monthly and quarterly basis along with PATH case managers that work with the organizations daily.

SSI/SSDI Outreach, Access, Recovery (SOAR)

In Lehigh County, we work with staff at Conference of Churches in order to assist individuals in the SOAR application process. Conference of Churches does have trained SOAR staff. PATH staff directly assist individuals in reviewing their individual situations in order to help them apply for benefits they may qualify for. At this time, we do not have any workers completing the SOAR process.

Housing

PATH funds are utilized for security deposits and rental assistance to prevent eviction. The Lehigh County PATH case managers maintain an extensive list of landlords and constantly update lists of available housing. Lehigh County has used reinvestment dollars to fund housing programs partnering with PHFA, Allentown Housing Authority and Pennrose Management. We have been able to provide and maintain about 40 individuals in subsidized housing units. The Fountain Street Bridge Program continues to offer a transitional housing program and allows individuals the ability to have access to decent, safe and affordable housing on a short-term basis

NOT FINAL

while waiting for a permanent housing option. The PATH case managers work with each individual Case Manager to ensure that housing goals are met.

Coordinated Entry

Lehigh County is now a site for the Continuum of Care Coordinated Entry for Homeless Services. Individuals will come to our Information and Referral office. By coordinating entry we can prioritize housing and services for families and individuals based on vulnerability and severity of need. We do consider housing for the most needy person first. We screen within our agency. Only outdoor homeless and individuals living in shelters are eligible for some of our available programs.

Justice Involved

Crisis Intervention Team training has been in operation in Lehigh county since 2014. We have had 5 classes and have trained 88 officers representing 14 different police departments. Officer safety has increased, subject injury has decreased and subject diversion from the jail has increased. Collaboration among the systems involved has greatly increased. In Lehigh County, many of our enrolled PATH individuals are criminally involved and or have a criminal history. We have a program called Team MISA (Mental Illness Substance Abuse). Team MISA is comprised of a variety of disciplines within the County, including the District Attorney's Office, Lehigh Valley Pre-Trial Services, MH/ID, SPORE, D&A, Lehigh County Prison (treatment, administration, and case managers), Probation/ Parole and the Public Defender's Office. The meeting is chaired by the first Assistant DA. The success of the group results from the collaboration and participation of department heads, as well as front line staff, at the table. The team meets weekly to discuss new referrals and any updates on ongoing cases that are involved in the criminal justice system. Members collect and present pertinent information from their office which the team discusses to develop the most appropriate plan to most appropriately address the individual's situation in the most clinically appropriate manner.

Staff Information

Staff serving the PATH individuals at the county and at the various community organizations are of both sexes, a variety of ethic backgrounds and between the same age ranges as the individuals they serve. Our PATH staff are involved in ongoing trainings offered through the county, community and most recently through webinars. PATH staff provides services sensitive to age, gender, racial/ethnic diversity by being seasoned workers who have been trained in gender/age/cultural competency. We have the ability to use other case managers to do translating and to use a telephone service that allows us to communicate with a person speaking any language. We have paperwork that is printed in English and Spanish, as those are the languages that are most consistent with the population we serve. Staff have received training in cultural competency and sensitivity and are encouraged to attend "refresher" courses on an annual basis. PATH staff are well versed on the unique needs of people with a mental illness and are able to assist staff of other agencies in their sensitivity working with all populations. We do not have PATH staff that are peers directly working for Lehigh County MH.

NOT FINAL

Client Information
In FY 2018/19, we project serving around 100 individuals. We project enrolling about 40 individuals. From recent years, we have found that about 50% of the individuals served with PATH funds are "literally" homeless, 72% of individuals enrolled by PATH were Caucasian, 25% were Hispanic/Latino/Black or African American, with many individuals falling into more than one category. All individuals served were between the ages of 18 to 64 years, 85% were 35 years of age or older, and both females and males are served close to equally.

Consumer Involvement
Persons who are homeless and have serious mental illness and family members are involved in the planning, implementation, and evaluation of PATH funded services through active participation in Mental Health Planning process. Individuals and/or family members are represented on the Mental Health and HealthChoices Advisory Boards and are well represented on the Mental Health Planning Committee. Individuals will continue to provide the actual direction of the Reinvestment Plan Housing Initiatives by identifying their needs and collaborating with the stakeholders regarding their services.

Health Disparities Impact Statement
We work with many subpopulations in working with the Serious Mentally Ill population. One of the subpopulations we are working with is the Transitional Age Youth (TAY) Population. Based on previous years, we would predict serving around 4 TAY this year. Last year about 7% of the people serviced were in our Transitional Age Youth group.

The funds expected to be used for them would be around $1500. An individual in the TAY population may need PATH funds for security deposit or rental assistance. We are attempting to make the community aware of the availability of PATH funds for individuals in the TAY population.

Limited English Proficiency
Lehigh county staff are called upon in order to provide direct Bi-Lingual services to individuals when they come in the Government Center. We have a diverse speaking group of staff who are willing to act as an in person translator when needed. If a translator is not available, we use Propio Language Services to get a translator on the phone line whether we are in the community or in the main office building. We have paperwork that is written in English and Spanish. We connect individuals to ongoing services in their native language. This might include case management, therapy, doctors, etc.

NOT FINAL

Lehigh County MH/ID/D&A – Budget Narrative
FY 2019-2020

Personnel:
A portion of the 2 Senior Housing Case Managers and of the 1 Program Specialist/Supervisor's salaries are PATH funded.

Travel:
Our travel expense is used mainly for traveling to meet with possible PATH eligible individuals. It would also include: Travel to housing meetings and to give presentations at provider meetings and other community agencies.

Rental assistance:
The rental assistance is used to assist eligible PATH individuals for the purpose of preventing eviction and subsequent homelessness.

Security Deposits:
The security deposit assistance is used to make a one-time payments directly to the landlord or housing manager.

Utility Assistance:
Utility Assistance is used to make a one-time payment directly to a utility company in the case where the individual would have been evicted due to utility non-payment. This would be the case in which an individual got behind but is now able to show how continued payment will occur in the future.

Postage:
The postage expense is used to send out information on the PATH program. This may include: mailing rental and security deposit checks, sending correspondence to individuals, and mailing housing grant information.

Training:
The training expense includes covering the registration costs accrued as the housing case manager attends necessary workshops, trainings and conferences that will enhance the ability of the housing case manager to provide PATH effective services.

NOT FINAL

Lehigh County MH/ID Program
PATH Budget
FY 20019-2020

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Sr. Case Manager 3	$75,366	.5 FTE	$15,073	$15,073
Sr. Case Manager 2	$65,124	.3 FTE	$7,815	$7,815
Program Specialist/Supervisor	$85,363	.1 FTE	$3,415	$3,415
sub-total				**$26,303**
Fringe Benefits				
Case Mngr Benefits	$27,426		$2,743	$2,743
Case Mngr Benefits	$23,699		$1,422	$1,422
Prog Spec Benefits	$31,064		$621	$621
sub-total				**$4786**
Travel				
Travel-train/workshps/mtgs				$200
sub-total				**$200**
PATH Assistance Payments				
Rental Assistance				$21,883
Security Deposits				$13,600
Utility Payments				$2,000
Sub-Total				**$37,483**
Other				
Postage				$35
Trainings				$100
Sub-total				**$135**
Total PATH Budget			**$68,907**	

NOT FINAL

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 51,680**	**$ 17,227**	**$ 68,907**	

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

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

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

Source(s) of Match Dollars for State Funds:

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

Estimated Number of Persons to be Contacted: 350

Estimated Number of Persons to be Enrolled: 210

Estimated Number of Persons to be Contacted who are Literally Homeless: 108

Number staff trained in SOAR in grant year ending in 2018: 3

Number of PATH-funded consumers assisted through SOAR: 2

NOT FINAL

Luzerne/Wyoming Counties
Children's Service Center
2018-2019 PATH IUP

Local Provider Description
Children's Service Center 335 S. Franklin St. Wilkes-Barre, PA 18702– PDX: Luzerne/Wyoming: Children's Service Center- a community mental health center offering clinical and case management services. Children's Service Center is a large community mental health center offering clinical and case management services to upper Luzerne County and all of Wyoming County. Children's Service Center 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. Total PATH funding is expected to be $68,907 (Federal $51,680, State $17,227). PDX provider # is. PDX Provider name is Luzerne/Wyoming: Children's Service Center.

Collaboration with HUD Continuum of Care (CoC) Program
The Luzerne County CoC (Wilkes Barre, Hazleton, and Luzerne County CoC) is the CoC for Luzerne County. The Luzerne County CoC meets monthly to advance the coordination of services for the homeless. Children's Service Center 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 CSC is an active participant. Children's Service Center 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. Children's Service Center 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. Luzerne County Continuum of Care contact is through Commission on Economic Opportunity 570-826-0510.

Collaboration with Local Community Organizations –

Mental Health:

- Children's Service Center/Robinson Counseling Center – home agency – full service community integrated mental health agency servicing children and their families and adults, ability to facilitate rapid involvement in services.
- Community Counseling Services—community mental health agency in northern Luzerne county—provide coordination when their consumers are in shelters/SOAR consultations

NOT FINAL

- Northeast Counseling Services – community mental health agency in southern Luzerne County – provide coordination when their consumers are in shelters/SOAR consultations

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. VA Transitional Housing Programs.
- 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.
- Catholic Social Services Bridge to Independence—provides housing and supportive services for young adults ages 18-26 who have mental health concerns.
- Domestic Violence Service Center: -Emergency Shelter/Transitional Housing for single women 18 and older and female parent with child/children who are experiencing domestic violence.
- Catherine McAuley House—emergency shelter for women with children.
- Volunteers of America—Manna House—Transitional housing for ages 18-25.
- Keystone Mission—Transitional housing for males.
- Valley Youth House—Transitional housing for transition age youth
- Salvation Army Kirby Family House—Transitional housing for families

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
- The Wright Center—walk in healthcare clinic located at Children's Service Center

NOT FINAL

Substance Abuse:

- Choices Drug & Alcohol Services (inpatient and outpatient) – mutual referrals based on consumer need
- Wyoming Valley Alcohol & Drug 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
- Robinson Counseling Center—Outpatient Drug and Alcohol services/CRS services

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 Children's Service Center. Children's Service Center is also the lead SOAR agency for the county, coordinating training and offering consultative assistance to other agencies with SOAR eligible consumers.

- PATH eligibility is determined through the engagement process. There is no requirement that all intake form, demographic sheets, etc. be completed upon first meeting. As soon as a diagnosis of serious mental illness is determined, housing status confirmed and participant consents to enrollment they deemed PATH eligible and is documented in a service document.
- The PATH funds support a full time Homeless advocate whose primary responsibility is identifying and engaging homeless individuals. There are no limits on the location of her contacts.
- The Homeless Advocate has13 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

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often difficulty problems of mental illness, substance abuse and legal issues 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 Children's Service Center consumers/community agency 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 Children's Service Center itself and community agencies. Detox, inpatient rehab, intensive outpatient, individual outpatient and methadone/suboxone are all available through community agencies. Children's Service Center offers Drug and Alcohol services, Certified Recovery Specialist services and co-occurring case management services. Individuals also have access to case management through Luzerne County Drug and Alcohol and Wyoming Valley Alcohol & Drug Treatment Services.
- Children's Service Center is required to follow 42 CFR Part 2 regulations. Consumers must sign a D&A Consent for Release of Confidential Information in order for any information to be disclosed. 42 CFR Part 2 prohibits the unauthorized disclosure of patient records except in limited circumstances.
- When encountering PATH eligible individuals with criminal justice histories, the PATH case manager has resources within the agency and with the CoC to access programs and resources to best link them with treatment, housing, and vocational opportunities. Examples include the Luzerne County Mental Health Treatment Court, Volunteers of America's Master Leasing Program, and Catholic Social Services Employment for the Homeless program.

NOT FINAL

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 2019. In addition to having access to the expertise of the lead agency, CSC will have a copy of the HMIS user manual. The Commission on Economic Opportunity is the lead HMIS agency and Roderick Blaine is the HMIS director.

Alignment with PATH goals
The Homeless advocate will go to wherever there are reports of homeless individuals often with representatives of other CoC participating agencies to ensure meeting the diverse needs of the individual or family.

Alignment with State Comprehensive Mental Health Services Plan
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. Children's Service Center actively participates in Luzerne County emergency preparedness programs and drills. We work with both Luzerne County Emergency Management Agency and the CoC in the planning and implementation of drills for a number of natural disasters i.e. flooding, wildfires. Our participation is to help with rumor control hot line and to make sure that the specific needs of those with SMI and the homeless.

Other Designated Funds
While PATH funds are used exclusively for the outreach and engagement of homeless individuals, many homeless individuals connect with Children's Service Center/community agencies through self-referral, Crisis Services, and other methods. Direct referrals to traditional Case Management bypass the Homeless Advocate but can be referred to the advocate if housing is a primary need. These entries into service are funded through county base dollars as well as Health Choices. There are no other funds specifically earmarked for PATH use.

Programmatic and Financial Oversight
Children's Service Center receives its PATH Funding through the Luzerne/Wyoming Counties Mental Health/Developmental services. Children's Service Center submits and RFP for these services and service provision is monitored through the Counties' contract monitoring program.

SSI/SSDI Outreach, Access, Recovery (SOAR)
Since July 2015, 10 SOAR applications have been completed with 9 positive results. In 2018, 2 applications were completed with both being approved for Social Security benefits. We have consulted with one other agencies on 1 application which was denied. 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 Children's Service Center, we will train at least 30% of the Case Management Department before the end of 2019/2020. We currently have 3 staff trained in SOAR. Approval rate of initial application is 90% with turnaround of 90+ days.

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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 implementation 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. The CoC continues to follow the "No wrong Door" approach so that individuals are not bounced from agency to agency without a clear handoff to an identified representative. This has been shown to reduce barriers to accessing services.

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. Children's Service Center 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. Crisis Intervention Training has been active in Luzerne/Wyoming counties for 7 years. 2 trainings have been held each year with participation of 90% of municipalities in the 2 counties. Anecdotally officers report feeling more confident in their interactions with persons in crisis. No specific outcomes have been measured.

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. Cultural Competency is also part of the mandatory annual education for the agency. No current PATH staff are CPS's or CRS's.

Client Information
Children's Service Center reported 230 individuals contacted through outreach of the PATH funded Homeless Advocate and 175 linked with services at community mental health services. Of these individuals 108 were in emergency shelter or living outdoors. Based on past years encounters we would anticipate 2019-2020 outreach contacts to total @350 individuals with a linkage rate into services of 60%which would translate to 210 enrolled. Approximately 20% will

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be staying in emergency shelter or outdoors. The average age of the individuals is 34 and consistent with the make-up of Luzerne and Wyoming Counties the majority will be Caucasian. The sex of individuals is split about 61% female, 38% male, with 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.

108Health 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 30, enrolled is 15
- 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.

CSC works closely with Community Counseling Services and Northeast Counseling (adolescent Mental Health providers) to ensure seamless transition in housing and treatment. We also work with Valley Youth House, Manna House and Bridge to Independence who provide transitional housing to homeless TAY to connect with appropriate services.

Limited English Proficiency

Children's Service Center provides services to many consumers with limited English proficiency. We do have some bi-lingual staff, professional medical translation is accessed through Language Line. This service is available via telephone 24 hours per day.

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. $34,000 pays the salary of the Homeless Advocate and $34907pays 33% of 2 supervisors' salaries. The supervisors participate in CoC meetings, and other meetings related to homeless topics such as the Homeless Coalition meetings, CJAB meetings, etc. One supervisor is the lead SOAR contact for our agency as well

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as other providers in the county who need assistance. The Homeless Advocate and Supervisors are located at Children's Service Center. Total request for salaries is $68907. There are no requests for fringe benefits, travel, supplies, or other.

Children's Service Center
PATH Program
FY 2019/2020 Budget

	Annual Salary	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Position				
Housing Case Manager	$33000	1.0		$34000
2 Supervisors	$88497	.3		$34907
sub-total				$68907
Fringe Benefits				
FICA Tax				
Unemployment				
Retirement				
Life Insurance				
sub-total				
Travel				
Local Travel for Outreach				
Travel to training and workshops				
sub-total				
Supplies/Equipment				
Consumer-related items				
sub-total				
Other				
Staff training				
One-time rental assistance				
Security deposits				
sub-total				
Total PATH Budget			**$68907**	

NOT FINAL

NOT FINAL

Mercer County
8362 Sharon-Mercer Road
Mercer, PA 16137
Contact: Anna Shears

Provider Type: Social service agency
PDX ID:
State Provider ID:
Contact Phone #: 7246621550

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 56,180**	**$ 18,727**	**$ 74,907**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 56,180	$ 18,727	$ 74,907	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 56,180	$ 18,727	$ 74,907	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 56,180	$ 18,727	$ 74,907	

Source(s) of Match Dollars for State Funds:

Mercer County overall will receive a total of $74,907 in federal and state PATH funds.
Mercer County Behavioral Health Commission will receive a total of $29,907 in federal and state PATH funds.

Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

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

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

MERCER COUNTY
COMPREHENSIVE PATH INTENDED USE PLAN
2019-2020

Local Provider Description

The Mercer County Behavioral Health Commission, Inc. (MCBHC) is the provider organization receiving PATH funds within Mercer County. The MCBHC was originally incorporated by the Mercer County Board of Commissioners in 1979 to administer the county's substance abuse services, and later integrated to include mental health and intellectual disability services (1998). As the initial point of contact for the three programs, the MCBHC provides administrative oversight, centralized program intake functions, case management services, mental health emergency crisis services, peer support services, mobile psychiatric nursing services, early intervention services, and prevention education programs. For 38 years the MCBHC has outreached, engaged, intervened, and has been a partner in recovery with the targeted population. The MCBHC is a private, non-profit organization that administers the county's Mental Health, Developmental Services, and Substance Abuse services. The organization has long-standing experience and a positive track record of involvement with the targeted population. The MCBHC serves the entire Mercer County region of Pennsylvania.

The MCBHC serves as the Single County Authority (SCA) for drug and alcohol program funding through the PA Department of Drug and Alcohol Programs. As the SCA, the MCBHC is responsible for planning, administering, funding and evaluating the drug and alcohol service programs within Mercer County.

The MCBHC functions as the fiduciary for Mercer County and will receive a federal allocation of $56,180 and a state allocation of $18,727 totaling $74,907. MCBHC will provide $33,750 in federal funds and $11,250 in state funds to Community Counseling Center and the remaining $29,907 ($22,430 - federal and $7,477 state) will be used by MCBHC for provision of the PATH program. The attached line item budget reflects the detail funding for the MCBHC. One (1) MCBHC staff member, who coordinates PATH for other staff members at the MCBHC, is funded with PATH funds.

The mailing address for the MCBHC is:

Mercer County Behavioral Health Commission
8406 Sharon-Mercer Road
Mercer, Pennsylvania 16137

The MCBHC is identified in PDX as "PA-016: Mercer County MH/MR, Mercer Co. Behavioral Health Commission."

The MCBHC subcontracts with one in-county provider for PATH-funded services and supports. Community Counseling Center (CCC) will receive $33,750 in federal funds and $11,250 in state funds (totaling $45,000) to support PATH-funded services. This is reflected within the attached budget detail under the "*Contracts/Purchase Services*" line item.

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Community Counseling Center (CCC) is a non-profit agency that has been providing comprehensive community behavioral health services since 1957. CCC provides mental health and substance use disorder treatment, rehabilitation and support services through a wide range of services for children, adults, and families. There are service locations throughout Mercer County. A large area of focus for CCC is providing services to individuals with mental illness who are experiencing homelessness or to prevent homelessness. CCC assists individuals through Supported Housing, Community Residential Rehabilitation, Fairweather Lodges, and Enhanced Personal Care Boarding Homes. Please refer to CCC's Intended Use Plan for more comprehensive information.

The mailing address for CCC is:

Community Counseling Center
2201 East State Street
Hermitage, Pennsylvania, 16148

Community Counseling Center is identified in PDX as "PA-005 Mercer: Community Counseling."

NOT FINAL

Collaboration with HUD Continuum of Care (CoC) Program –
It is recognized that the Pennsylvania Continuum of Care (CoC) identified goal is to reduce homelessness by 50% by the 2022. The Housing Coordinator within the Mercer County Behavioral Health Commission has participated in the Western Region Continuum of Care meetings within the 2018-2019 fiscal year. This participation has provided the MCBHC an opportunity to be a resource of information for the staff within the MCBHC, as well as to the local Housing Coalition. The Housing Coordinator is also an active member of the local Housing Coalition.

Mercer County participates in the monthly Northern Regional Housing Advisory Board meetings. Mercer County participates in the Coordinated Entry Process, using the coordinated assessment, as of 6/30/17. The single point of entry allows for an easier flow of assisting homeless individuals within the county.

Additionally, the MCBHC Housing Coordinator participates regularly in the webinars provided by SAMHSA, which allows the MCBHC to maintain alignment with not only the state goals, but also with federal expectations.

Mercer County participates in the Western PA CoC, and its CoC number is: PA-601.

Collaboration with Local Community Organizations –
Local efforts for reducing homelessness within Mercer County are driven by the Mercer County Housing Coalition (MCHC). The MCHC meets monthly to discuss planning activities, program coordinator initiatives, updates within each participating organization, and other concerns. The current roster of participants at the MCHC meetings are representatives from: Mercer County Area Agency on Aging, Adult Probation and Parole, AWARE, Mercer County Behavioral

Health Commission, Community Action Partnership of Mercer County, Community Counseling Center, Mercer County Housing Authority, Primary Health Network, Prince of Peace Center, the Self Determination Housing of PA, Southwest Legal Services, and U.S. Department of Veterans Affairs.

One of the main functions that the Mercer County Behavioral Health Commission (MCBHC) provides is case management. It is imperative that the case management staff be aware of local community organizations and agencies which provide housing supports. The MCBHC Housing Coordinator is an additional resource for the case management staff when housing issues arise. Additionally, the MCBHC conducts a Utilization Review and authorization process for some housing related services. This allows greater oversight to providers who receive funding from the county for housing related services and ensures that the dollars received are being utilized effectively.

Master Lease and Bridge Housing

The Mercer County Behavioral Health Commission implemented Master Leasing and Bridge Subsidy programs in FY 2018-2019. The programs began July 10, 2018. Through the use of its Health Choices reinvestment funds, the Mercer County Behavioral Health Commission provides temporary tenant-based rental assistance to qualified individuals until they are able to receive a Section 8 Housing Choice Voucher or other type of rental subsidy or have obtained access to a subsidized unit. The target population served by the Bridge Subsidy program is adult, Medical Assistance eligible, residents over the age of eighteen (18) struggling with mental health, substance use, or co-occurring disorders who are in need of housing and supports at all stages of the recovery process. The primary purpose of the master Leasing and Bridge Subsidy programs is to provide permanent supportive housing for these priority consumers while creating a structured link to a more permanent subsidy.

The Mercer County Behavioral Health Commission works with a contracted "Housing Manager" from Community Action Partnership of Mercer County to develop and implement the Bridge Subsidy program. The program will be regularly assessed to ensure that it is effectively achieving identified goals. These goals include increasing the availability and access to housing options that are safe, integrated, affordable and accessible for the target population. Financial oversight is provided to the program internally through the Chief Financial Officer of the Mercer County Behavioral Health Commission, and externally through Southwest Behavioral Health Management, Inc.

The Master Leasing and Bridge Subsidy Programs have housed 16 applicants and their families thus far and has successfully transitioned one applicant (and family) to traditional tenancy.

Although participation in treatment is not required, applicants are encouraged to partake of Blended Case Management (BCM). The assistance BCM affords can aide in their stability and help transition the participants out of these programs and into traditional housing since these programs are time limited. Participant follow up on a quarterly basis has been implemented and

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is occurring in cooperation with active Blended Case Managers or the Housing Coordinator and Community Action Partnership Housing Specialist.

Additionally, Health Choices reinvestment funds have been targeted for use as Contingency Funds and have assisted 52 individuals and families obtain or maintain housing to date. The criteria for eligibility and goals for this program are the same as the Master Leasing and Bridge Subsidy Programs.

All of these programs are available to eligible PATH recipients.

Below are the key services provided by local community organizations throughout Mercer County with whom the MCBHC collaborates and coordinates with regularly:

Primary Health Providers
The Mercer County Assistance Office (through the PA Department of Human Services) 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 (PHN) 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 through the Mercer County Assistance Office helps to eliminate the barrier to treatment. Additionally, PHN has received special grant funding 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 PHN staff who determines eligibility for this grant program is also a Certified Health Care Navigator, and is an active member and participant at the Mercer County Housing Coalition meetings. Primary Health Network also provides transportation to medical appointments for PHN patients.

Mental Health Providers
The MCBHC provides Intake and Assessment, Blended Case Management, Certified Peer Specialist, Crisis Intervention, and Mobile Psychiatric Nursing services 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) located in Sharon, PA. The SRHS inpatient facility has both children and adult units. SRHS's Behavioral Health Services offer partial programs for children, adolescents, and adults. Outpatient mental health medication management is also provided by SRHS and serves as one of four licensed providers. The other three remaining licensed providers of outpatient mental health services are: Associates in Counseling and Child Guidance located in Sharon, PA, Community Counseling Center, with locations in Hermitage, PA, Greenville, PA and Grove City, PA, and Paoletta's Counseling

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Service, located in Mercer, PA. 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

The MCBHC provides 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. Gaudenzia, located in Sharon, PA, and Community Counseling Center, a PATH funding recipient with locations in Hermitage, PA, Greenville, PA and Grove City, PA, both provide these levels of care for substance abuse treatment. Mercer County also has two licensed Methadone providers: Discover 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.

The MCBHC collaborates with all the agencies in the community that provide housing supports and services 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. Their services specific to housing include: supportive housing services, respite rooms, enhanced personal care boarding home, Fairweather Lodges, and full and partial Community Residential Rehabilitation programs. All programs are designed to meet the individual's needs and are intended to be structured and recovery-oriented. CCC is a recipient of PATH funding to support the housing programs that they offer. Please refer to CCC's Intended Use Plan for more specific details of the housing supports offered.

Other county organizations that offer housing services and supports, but are not subcontracted to provide PATH funded services and supports include: AWARE, City of Sharon Community Development Department, Community Action Partnership of Mercer County, Good Shepherd Center, Guardian's Nest, Joshua's Haven City Mission, Mental Health Association, Mercer County Housing Authority, Prince of Peace Center, Reaching Up and Out's Manna House, Salvation Army, Shenango Valley Urban League, VA Butler Healthcare Center, and Youth Advocate Program. All individuals served within these county organizations may be eligible for PATH funded assistance and programming as well.

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- **AWARE** provides emergency shelter for women, men and children fleeing from domestic violence situations. The organization partners with local school districts, allied health, medical and mental health, law enforcement and justice systems, and faith institutions as part of their larger mission to prevent domestic and 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 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 that enable them to move into stable and permanent housing.

- **The City of Sharon's Community Development Department** oversees the Community Development Block Grant (CDBG) funds. The City of Sharon offers a Housing Rehabilitation Program which provides a low interest installment loan of up to $10,000 for qualified individuals in the City of Sharon to improve the safety and sanitary conditions of their home.

- **Community Action Partnership of Mercer County (CAPMC**) offers a wide variety of housing supports and services. CAPMC Housing Counselors assist with housing counseling, senior housing, special needs housing, and single family rental housing. The agency owns and/or manages 275 units of senior housing at 10 locations. This program provides independent living housing units for income-qualified seniors aged 62 and older. Additionally, the agency owns and manages 22 units of special needs housing at five locations: Florence Street Apartments, Independence Park, and Permanent Supported Housing for Persons with Serious Mental Illness inclusive of eight units at two locations in which Community Counseling Center provides the supportive services. Additional 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 to offer decent, safe and affordable housing for five families. Rents are subsidized and based on household income. Further, CAPMC is a certified HUD Housing Counseling Agency and provides services under contract with the Mon Valley Initiative, PA Housing Finance Agency and City of Sharon.

- Additionally, CAPMC assists military veterans who are experiencing a housing crisis. CAPMC employs a veteran who does street outreach, assists veterans in navigating the Veteran's Administration (VA), and links veterans to additional supports offered by the VA.

- **The Good Shepherd Center** addresses the physical needs of the economically challenged in the greater Greenville area. Greenville is located in the Northern part of Mercer County. Services offered include: food pantry, thrift store, hot meals program, free medical clinic, and limited emergency housing/utility assistance. The medical clinic serves Greenville community members who have no Medical Assistance or other insurance, and who qualify within the income guidelines. If an individual goes to the

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Good Shepherd Center and is in a housing crisis, Good Shepherd Center can pay for lodging for one night and works with other agencies to coordinate housing services.

- **Guardian's Nest** – The newest housing service for Veteran's is currently in the development stages. A Mercer County veteran recognized a need for housing options for homeless veterans and started a non-profit agency called Guardian's Nest. This endeavor will include a Veteran's Resource Center in order to connect veterans with available resources. The housing portion of the project will offer six transitional housing units. Four will be single male rooms, and two will be for couples or families.

- **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. A free medical clinic is also available to provide physicals and health screenings.

- **The Mental Health Association of Mercer County (MHA)** 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. MHA currently has two locations which provide a shared living situation where individuals have their own bedrooms and share the living areas, bathroom and kitchen. One location has three bedrooms and the other has five bedrooms. MHA offers four individual apartments, three of which are Section 8-approved. Additionally, they provide respite that MCBHC funds

- **The Mercer County Housing Authority (MCHA)** administers the Homeless Prevention and Rapid Re-Housing Program. MCHA also oversees the Section 8 Housing Choice Voucher program and public housing. To date there are 20 public housing properties available throughout Mercer County which are managed by the MCHA. In additional to providing housing, the MCHA offers a Resident Services Department which provides supportive services and programs to residents to promote self-sufficiency and housing stability. The MCHA offers a program which provides beds to children that move into a MCHA property with little or no furniture and without the means to obtain a bed. In addition, MCHA offers a Section 3 program which links individuals residing in MCHA properties to employment, training and contractual opportunities with projects and activities in their neighborhood.

- **The Prince of Peace Center** provides emergency services, Family Supportive Services (FSS), thrift store, and food services. Prince of Peace provides a program within the community entitled AWESOME (Assistance With Education, Shelter, Organization, Money management, and Employment). The program provides the participants with educational classes on a wide array of topics, including proper nutrition, financial planning, and informed decision making. When an individual successfully completes the class, they are awarded $125 to be put towards a utility bill or rent.

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- **Reaching Up Reaching Out**, a non-profit organization, recently opened the **Manna House** in 2018. It is a faith-based Life Recovery Program which offers transitional housing to women in recovery who have been recently released from incarceration. The Manna House offers case management services, supportive counseling, work assistance, transportation, housing assistance and referral services and can house up to six women.

- **The Salvation Army** operates a worship center and thrift store. It also provides housing assistance, emergency disaster services, emergency food assistance including hot meals to those in need, clothing assistance and home heating and utility assistance.

- **The Shenango Valley Urban League** exists to ensure equal access and opportunity to African Americans and others in need. The Shenango Valley Urban League provides comprehensive housing counseling services as they are a Certified HUD Counseling Agency. The Shenango Valley 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 assistance with one month's rent or security deposit.

- **VA Butler Healthcare Center** offers programs to Veterans through the U.S. Department of Veterans Affairs such as housing solutions, employment opportunities, health care, and justice- and reentry-related services. The VA also has a housing program for eligible veterans (HUD-VASH) which operates in collaboration with HUD in the form of rental assistance vouchers and supportive housing services to promote housing stability.

- **Youth Advocate Program (YAP)** offers two mental health housing support services: Mental Health Habilitation and Mental Health Chore and Homemaker Services. One of the identified needs for housing supports is a "hands on" approach in order to assist individuals in maintaining independent living. The MH Chore and Homemaker service helps adults with mental health challenges maintain their homes 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

<u>Employment Providers</u>
PA Career Link has an office in Sharon, PA, and 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. PA Career Link also houses the Office of Vocational Rehabilitation, Veterans Affairs, and Aging Division of Employment services at their Sharon, PA location.

Community Counseling Center (CCC), a recipient of PATH funding, is an employment provider for individuals with disabilities through their Employment Resource Specialists (ERS) program. After an individual completes an assessment through the Office of Vocational Rehabilitation,

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they can be referred to CCC for employment services. ERS is an employment placement service benefitting both the potential employee and the potential employer. ERS will assist with interviewing candidates, provide on the job training and educate potential employers about the benefits of hiring individuals with disabilities. CCC's vocational services assists individuals with disabilities to find and maintain gainful employment. The largest disability group served through this program is behavioral health consumers; however, other disability groups also served include: 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 agencies provide 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

A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients

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 provided they meet the PATH eligibility criteria. These individuals have been identified as having a serious mental illness in order to be eligible for case management services through the MCBHC. The Case Management department staff are aware of PATH funded services being available. The case managers meet with the PATH Coordinator and make applicable referrals for PATH assistance in order to provide support to the individual who may be at risk of homelessness, or who is homeless.

The PATH Coordinator at the MCBHC receives referrals for the PATH program through Blended Case Managers. PATH eligibility is determined through an individual being deemed as literally homeless or at imminent risk of homelessness, and the determination of a serious mental illness, age 18 or older and agreement to PATH services. The Case Managers have direct contact with the clients and work with them closely. The PATH Coordinator communicates directly with the Case Managers when a referral is made for PATH. Eligibility determination is done by the PATH Coordinator. Case notes done by the Case Managers for individual consumers reflect PATH related services. Housing services related to planning of housing, costs associated with matching eligible homeless persons with appropriate housing situations, technical assistance in applying for housing assistance, improving the coordination of housing services, re-establishment of utility services, and one-time only assistance with security deposits or first month's rent are PATH funded services provided to individuals who meet eligibility criteria. PATH funds are never paid directly to the PATH individual, but rather are paid directly to the vendor. Individual's information is entered into HMIS once the PATH application has been accepted.

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Alignment with PATH goals
Street Outreach is not a service performed through the MCBHC. When a consumer receiving services through MCHBC is also experiencing a housing crisis, a referral to the PATH program is made. During the time of determining PATH eligibility, the PATH Coordinator meets with the staff person who is making the referral in order to discuss additional supports that the individual may benefit from. Examples of additional services includes educational classes on topics like budgeting, housekeeping, and credit counseling provided by a variety of community organizations or suggested linkages with other housing supports within Mercer County. The case manager assists the individual with applying for those classes or making referrals for additional housing supports.

Community Counseling Center (CCC) is able to support staff needed to do the outreach into the community to locate and assist those who have a mental health diagnosis and are homeless through the use of PATH funds. CCC staff meet individuals where they are in the community, and once completing the initial contact with the individual, determine their eligibility into the program and make needed referrals. The individual's information is entered into HMIS and the coordinated entry system to accurately collect data needed to complete the PATH application.

Maximizing of PATH funds
The Mercer County Behavioral Health Commission (MCHBC) maximizes the use of PATH funds for the individuals being served because they are also receiving services and supports of Mental Health Blended Case Management, Mental Health Certified Peer Specialist, Drug and Alcohol Case Coordination, and/or Drug and Alcohol Certified Recovery Specialist services. The funds that support these 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 MCHBC is also experiencing a housing crisis, a referral to the PATH program is made. During the time of determining PATH eligibility, the PATH Coordinator meets with the staff person who is making the referral in order to discuss additional supports that the individual may benefit from. Examples of additional services includes educational classes on topics like budgeting, housekeeping, and credit counseling provided by a variety of community organizations or suggested linkages with other housing supports within Mercer County. The case manager assists the individual with applying for those classes or making referrals for additional housing supports.

Gaps in current service system
Gaps existing within the current service system include emergency housing specific to: women, women with children, men with children, and entire family units. A sub-committee of the Mercer County Housing Coalition was formed to pursue funding to address these gaps. At this time, the committee continues to search for a suitable building and location for this project. Historically, one barrier for identifying a location is lack of local community support for a homeless shelter. Many community members publicly opposed a site that the committee had identified and acknowledged that while they are aware that the need exists for a homeless shelter, they do not want a shelter located in their neighborhood.

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A second identified gap is reaching the transitional age youth, which 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 upon reaching adulthood. As these transitional age youth attempt to survive independently without supportive services, many meet obstacles in achieving a self-sufficient, healthy and satisfying life. In regards to housing, this priority population begins to "couch surf" – living in households in which their name does not appear on the lease. Due to HUD changing the definition of homelessness, couch-surfing is no longer considered being homeless. Therefore, those individuals would not qualify for HUD homeless housing services. Mercer County Children and Youth Services (CYS) has the only Independent Living Program for transition age youth in the county. This program is only available to youth with an open case through Mercer County CYS and assists youth to remain in care and/or youth leaving care with obtaining and maintaining safe and affordable housing. The program can provide transitional housing and supportive services to eligible transition age youth.

Finally, there remains a problematic gap in securing housing for individuals with mental health diagnoses and having criminal histories (felony offenses and sex offenders).

Co-occurring services available
Services for individuals with co-occurring disorders of mental health and substance abuse are available through a variety of providers throughout Mercer County. Individuals experiencing a co-occurring mental illness and substance use disorder can access appropriate treatment through the Base Service Unit of the Mercer County Behavioral Health Commission (MCBHC), also known as the Central Intake Unit. MCBHC remains the gatekeeper and initial point of contact for persons in need of such services. The assessment process is conducted to ensure that individuals with co-occurring needs have access to services in a full continuum of care by identifying, referring, and authorizing appropriate levels of care. The Central Intake Unit provides intake, evaluation and referrals. As previously mentioned, MCBHC provides Certified Recovery Specialist services and Drug and Alcohol Case Coordination for drug and alcohol services in addition to the mental health services available. The staff are cross-trained in both substance abuse and mental health co-occurring disorders in order to be better prepared to address the specific needs of this population. The case management supervisors are also cross-trained and supervise both mental health and drug and alcohol staff. This cross-training allows the staff and supervisors the knowledge of resources available and knowledge of skills in working with the dually diagnosed populations. MCBHC works collaboratively with Community Counseling Center, which is the only local provider with a dual license for providing outpatient drug and alcohol services and mental health services. Additionally, the MCBHC contracts with multiple co-occurring residential treatment providers. All of those providers are outside of Mercer County.

The Housing Coordinator at MCBHC participates regularly in the webinars made available through the SAMHSA Homeless and Housing Resource Network in order to keep apprised of new services, issues and programs. Additional trainings that are offered by the Department of Drug and Alcohol Programs, as well as the Office of Mental Health and Substance Abuse Services are offered to MCBHC staff and providers throughout the year. Examples of trainings include areas such as: Dual Diagnosis, PTSD and Addiction, and Forensics and Addiction. Staff monitors the websites for upcoming relevant trainings and register for them as they become available.

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42 CFR Part 2 regulations

The MCBHC is 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 capture 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.

Justice-involved

The MCBHC coordinates with individuals being released from the county prison who meet the criteria for Vivitrol. A mobile Vivitrol van comes to the MCBHC monthly in order to provide the medical-assisted treatment and to link individuals with ongoing outpatient treatment within the community. Because the van is located at the MCBHC, the individuals are able to have immediate access to the Central Intake Unit, where additional referrals can be made to other community mental health, drug and alcohol, and community resources in order to have a continuity of care.

Mercer County recognizes that there are a large number of inmates incarcerated within the county jail who have mental health and/or drug and alcohol concerns. In working to address this, the President Judge requested an increase in supportive services to reduce the number of individuals in jail who have committed crimes because of unaddressed mental health and/or drug and alcohol conditions. Mercer County initiated a "Community Integration Project" in October 2016. The project is aimed at working more closely with identified individuals who are returning to the community from the county jail. Prior to discharge, the individuals meet with their Blended Case Manager, Certified Peer Specialist or Recovery Specialist, and Mobile Psychiatric Nurse. The case manager links the person with Medical Assistance and ensures that SSI/SSDI (if eligible) is re-activated soon after release. One of the identified barriers prior to this project was mental health and drug and alcohol consumers who were incarcerated were not linked with those important services soon enough and therefore were not receiving the needed medical care upon release.

Since June 1st, 2018 the project has served a total of 33 individuals being released from the Mercer County Jail. Seventeen of them were primarily identified as having mental health needs and 16 were identified as having substance abuse issues. At the present time there are 22 participants in the jail project; 13 have MH diagnoses and 9 have a D&A diagnosis. There have been 3 successful closures that were individuals with MH needs; one individual is employed and 2 have completed all legal obligations. There have been 2 successful closures of individuals with D&A needs; both are working and have completed all legal obligations.

The MCBHC provides co-occurring mental health and drug and alcohol intervention with the county jail. The Forensic Intervention Specialist conducts mental health and drug and alcohol evaluations per court orders, mental health psycho-educational groups, coordinates mental health hearings as needed at the jail for involuntary commitments, and is able to make referrals prior to release from the jail for outpatient services, case management, peer support, and other supportive

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services that are available. For fiscal year 2019 through 4-30-2018, a total of 311 inmates were assessed. The breakdown of assessment types provided is: 143 Drug and Alcohol, 54 Driving while Under the Influence, 38 Mental Health, and 76 Dual. In addition to the assessments, psycho-educational groups were provided. A total of ten drug and alcohol psycho-educational groups were provided. There were a total of 62 participants in those ten groups, for 91 total hours.

The MCBHC allocates a clerical staff's time for visiting the jail to assist all individuals with mental health or drug and alcohol issues in filling out their COMPASS applications. This eliminates any loss of benefit coverage for services and assures eligible patients utilize their full Medicaid benefits as soon as they need them. This not only provides them quick access to behavioral health services but, as a supplemental benefit, they are also immediately able to access any physical health services they may need.

Housing continues to be an obstacle for individuals with a criminal record. The Director of Probation and Parole is a current and active member, and chair, of the Mercer County Housing Coalition. One of the many barriers inmates face upon release from incarceration is lack of income. If an incarcerated individual has an identified mental health or co-occurring drug and alcohol diagnosis, and a doctor has determined the individual unable to work due to the disability, SSI/SSDI Outreach, Access and Recovery (SOAR) could be utilized within the prison system, prior to release, in order to establish SSI or SSDI, thereby reducing the barrier of financial burden relating to finding housing. SOAR is a very time burdensome service and is not reimbursable through Health Choices; therefore, it has not been utilized to its fullest capacity within Mercer County.

Forensic Certified Peer Specialists (CPS) have received specialized training in order to work more effectively with individuals involved with the justice system. At this time, Community Counseling Center (PATH provider) employees CPS' who have that specialized training.

Consumer stakeholder groups had identified the need for a Mental Health Court or a Drug Court. Having a mental health or drug court established could make effective use of limited criminal justice and mental health resources, to connect individuals to treatment and other social services in the community, to improve outcomes for offenders with mental illness in the criminal justice system, to respond to public safety concerns, and to address jail overcrowding and the disproportionate number of people with mental illness in the criminal justice system. Often times, inmates are released from prison after they have "maxed out" and there are no aftercare services, including housing supports, set up for them. Treatment Court served its first participant in January, 2019; has 7 active participants, and 5 pending participants.

Data

The MCBHC has been entering data into PA-HMIS since December 2011. CCC is also an established user of PA-HMIS. All PATH-eligible individuals are entered into the PA-HMIS system using ClientTrack. The Housing Coordinator at MCBHC has been trained on entering data into ClientTrack. As additional training for updates become available, the MCBHC Housing Coordinator participates in order to stay apprised of any new requirements or updates to

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the system. The PA-HMIS user manual is available for reference by the MCBHC Housing Coordinator.

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" with friends or family.

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 provided they meet the PATH eligibility criteria. These individuals have been identified as having a serious mental illness in order to be eligible for case management services through the MCBHC. The Case Management department staff are aware of PATH funded services being available. The case managers meet with the PATH Coordinator and make applicable referrals for PATH assistance in order to provide support to the individual who may be at risk of homelessness, or who is homeless. PATH eligibility includes age 18+, SMI, homeless or at imminent risk of homelessness, and agreement to receiving PATH services.

Alignment with State Comprehensive Mental Health Services Plan
Services provided within Mercer County related to housing are consistent with the State Comprehensive Mental Health Services Plan. The housing agencies available within the county coordinate services and promote targeting the resources available. Additionally, assessing the effectiveness of the current housing services is completed on a regular basis. The Mercer County Housing Coalition supports local efforts to end homelessness. The collaborative agencies are continually engaging in efforts to work towards ending homelessness to a functional zero. Additionally, all mental health and drug and alcohol housing services provided in Mercer County are recovery-oriented. Those recovery-oriented services are fostering empowerment of the individual to understand what recovery means and how stable housing promotes and builds their personal recovery.

The MCBHC staff plays a major part in coordinating, planning, and writing of the mental health services plan section within the Mercer County Human Services Plan. The Housing Coordinator assists with the housing section of the plan. Because of this, the narrative of the mental health section is all inclusive of housing supports provided in Mercer County including PATH funds. It is widely known that the Housing First approach is the most effective way to improve individual mental health recovery. As case managers meet with mental health consumers, housing is always at the forefront of service planning and coordination of services in order to ensure that individuals are receiving the housing supports needed.

The MCBHC provides multiple services and supports which are consistent with the state initiatives to prevent or reduce homelessness. The PATH Coordinator/Housing Coordinator and the case management department link homeless individuals, or individuals who are at imminent risk of homelessness, with supports and services that exist within the county. The support provided intends to encourage the individuals and families to break the cycle of entering back

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into situations that may lead to a housing crisis. Additional support provided by the MCBHC includes direct financial assistance for individuals who are facing eviction, or who are currently homeless. The financial assistance is never paid directly to the individual, but rather to the vendor. This financial assistance is most frequently used for first month's rent, rental assistance to prevent an eviction, or utility assistance.

The staff providing services through the MCBHC are providing case management services and are able to identify individuals that are homeless or at risk of homelessness throughout their daily work functions. When individuals are identified as possibly qualifying for PATH services, the MCBHC staff will meet with the PATH Coordinator in order to make that determination and referral.

Individuals and families are referred to other providers who may be offering educational classes on topics such as budgeting skills, tenant/landlord agreements, or how to find an apartment. The campaign of the United Way of Mercer County is "Lifting Families Out of Poverty." The organizations throughout Mercer County who receive funding from the United Way are encouraged to provide learning sessions. Those sessions are geared to promote financial stability and independence. By providing ongoing learning sessions and educational opportunities, people within the community – including those with mental health conditions – will be less likely to become homeless or face eviction. The MCBHC has been a long-standing member of the United Way and supports those efforts.

The MCBHC has an excellent collaborative and working relationship with the Mercer County Department of Public Safety and Program Director. The MCBHC has worked 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 over 70 identified 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. Local law enforcement personnel and other public safety staff would assist with identifying individuals who are at the highest risk of needing assistance, which would include those who are homeless, and would provide assistance to secure their safety. When needed, the Department of Public Safety would coordinate services and activities related to disaster response within the PA Disaster Mental Health and Human Services Coordinator.

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 called into situations within the county where behavioral health intervention may be needed. The Disaster Crisis Outreach and Response Team (DCORT) is a sub-group of CIRT. This state trained team is utilized for more specific disasters and would be utilized as part of the County Disaster plan, if needed. There are staff members at the MCBHC that are trained and actively serve on both CIRT and DCORT. Additionally, two employees at Community Counseling Center serves on both CIRT and DCORT.

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There are multiple individuals, groups, organizations and churches who participate and are trained for CIRT. There are currently 15 individuals trained in Mercer County in the basic National Organization for Victim Assistance (NOVA), 7 have the advanced NOVA training, 12 are DCORT trained, 11 are trained in Psychological First Aid, and 36 are trained in Grief and Bereavement. A total of 52 individuals serve on the CIRT Team.

Community Counseling Center provides regular emergency drills within their housing programs. This allows the residents within the variety of housing settings an opportunity to learn about emergency preparedness and to practice it. As those individuals move into the community and to less restrictive settings, they have experience with those educational and practice opportunities.

Other Designated Funds

Mercer County is not a Block Grant county and does not receive Block Grant funding.

The MCBHC maximizes the use of PATH funds for the individuals being served because these individuals are also receiving services and supports of Mental Health Blended Case Management, Certified Peer Specialist, Drug and Alcohol Case Coordination, and Certified Recovery Specialist services. The funds that support these other programs are provided by the Managed Care Organization and base funds from both the Mental Health and the Department of Drug and Alcohol Programs, but are not earmarked for PATH services specifically.

The MCBHC also receives federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars. Those funds are used for Case Coordination, Prevention and Intervention/Treatment of alcohol and drug use. Those funds are not earmarked for PATH services specifically.

Programmatic and Financial Oversight

Within the MCBHC, financial oversight is provided to the PATH program. Housing and PATH-related service expenditures are coded to a separate cost center to enable the financial information for the PATH program to be tracked and monitored. Additional oversight is provided by the Chief Financial Officer, who reviews and approves PATH dollars needed to support PATH referrals for services.

The MCBHC is familiar with the services Community Counseling Center (CCC) is providing to their supported living/housing program related to PATH individuals. Monthly invoices and their annual audit are reviewed. Please refer to CCC's IUP for additional information related to how CCC monitors the utilization of PATH dollars.

Additional programmatic and financial oversight is provided by the State PATH Coordinator. Regular monitoring is completed for all PATH recipient organizations in Mercer County.

SSI/SSDI Outreach, Access, Recovery (SOAR)

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There are currently five known individuals in Mercer County trained in SOAR. One staff member at the MCBHC, the previous PATH Coordinator, received the certification in 2014. To date, there are no PATH-funded consumers assisted using SOAR through the MCBHC because all of the PATH funded individuals receive SSI, SSDI and/or are employed.

SOAR can be very time consuming, and none of the case management staff currently employed at the MCBHC are able to take on additional responsibilities to successfully complete SOAR applications. The MCBHC Case Management department often assists their clients in accessing benefits through the Mercer County Assistance Office and/or the Social Security Office. The individuals that have been assisted with PATH funds through the MCBHC already have benefits in place due to the case management services they have been participating in, so there have been no individuals in need of SOAR to date.

Housing

The PATH staff through the MCBHC and CCC are kept apprised of the various housing services available within Mercer County. Staff are able to make appropriate referrals and linkages based on the information they are provided and knowledge of the local housing providers, which are listed in the "Collaboration with Local Community Organizations" section of the Intended Use Plan. Both the MCBHC and CCC actively attend and participate in the monthly Mercer County Housing Coalition Meetings as well as the Western PA CoC meetings, which allows everyone to be kept apprised of other housing agencies, projects and programs in the area and region.

The MCBHC PATH Coordinator is able to offer an individual who is facing eviction or is currently homeless and is eligible for PATH services direct financial assistance. The financial assistance is never paid directly to the individual, but rather to the vendor. This financial assistance is most frequently used for first month's rent, rental assistance to prevent an eviction, or utility assistance.

Community Counseling Center (CCC) is able to offer a person eligible for PATH services several different housing options. Please refer to CCC's IUP for additional information related to how CCC makes suitable housing available for PATH clients.

Coordinated Entry

Mercer County is part of the Northern Regional Housing Advisory Board. Mercer County began utilizing a Coordinated Entry Program as part of the Western CoC on 6/30/17. Four local agencies are able to enter homeless individuals into the Coordinated Entry system: Community Counseling Center, Community Action Partnership of Mercer County, AWARE and the Mercer County Housing Authority. The MCBHC PATH Coordinator attends monthly Mercer County Housing Coalition Meetings, where the Coordinated Entry Program is discussed. The MCBHC PATH Coordinator works with the CIS Administrator for CCC and CAP as the Coordinated Entry Point of Contact. No barriers have been identified as a result of the Coordinated Entry Program.

NOT FINAL

Both the MCBHC and CCC utilize Pennsylvania 2-1-1 Southwest as often as possible. This United Way funded service provides individuals who call 2-1-1 resources available within the county related to the identified need. One of the most frequently requested services is related to housing needs.

Justice Involved

The Mercer County Criminal Justice Advisory Board (CJAB), Community's that Care (CTC), and the Mercer County Behavioral Health Commission collaborated to support the local police departments and other first responders to receive Crisis Intervention Team (CIT) trainings. In the fall of 2017, 15 police officers were trained in CIT. The training was very well received by those who participated at that time. In April 2018, 21 additional trainees completed the 40-hour training: 13 were police officers from across the county, three were from the county jail, three from a local provider, one Juvenile Probation Officer, and one adult Probation Officer. A third training was held in October 2018 and a fourth in April 2019 with 23 individuals participating and graduating from this class. The CIT trainings have provided an increase in collaboration between the police departments and the local mental health Drop-In Center, where the mental health consumers want to build a good relationship with the police officers.

Staff Information

Specific to the Mercer County Behavioral Health Commission (MCBHC), PATH is administered by one individual housed within the MCBHC. There is a total of 99 part-time and full-time staff employed by the MCBHC. 83% of the workforce is comprised of females and 17% males. Regarding race, 97% of the staff are Caucasian and 3% are unknown (refused). There are no PATH staff at MCBHC that are Certified Peer Specialists or Certified Recovery Specialists. Please reference CCC's Intended Use Plan for the respective staff demographics.

The PATH organizations provide their staff with regular trainings to keep up to date of the changing culture and to maintain cultural sensitivity. At least one Mercer County PATH staff is registered with the Think Cultural Health in order to stay apprised of upcoming trainings and to ensure that agency staff serving the targeted population is able to address any health disparities and maintain cultural competency.

Trainings are made available to staff through a variety of venues that include: on-site trainings, conferences, regional meetings, webinars, PATH technical center, etc. Training opportunities on effective outreach such as being person-centered, recovery oriented and highly informed on trauma, as well as gender, age, and cultural competency are highly valued within the MCBHC.

Client Information

The individuals served in the PATH program will have either a serious mental health or a co-occurring substance abuse and mental health disorder. The age range of PATH clients being served is 18 and over. Clients served by PATH funds are typically at imminent risk of homelessness. They are generally either "couch surfing," in a doubled-up living arrangement where their name is not on a lease, living in a condemned/substandard dwelling and have no

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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 a health care facility or criminal justice institution without a place to live. Others served are those considered “literally homeless.” This refers to individuals who are staying in a temporary shelter, or those who are in transitional housing. It is estimated that the total number of individuals to be contacted, or to contact MCBHC and CCC will be 78. The individual organizational breakdown of the total number of individuals estimated to be contacted is MCBHC – 23; CCC – 55. It is estimated that the total number of individuals in Mercer County who will become enrolled in PATH services in the upcoming fiscal year will be around 73. Estimating that of those 73 clients, 87% will be literally homeless. The individual organizational breakdown of the total number is: MCBHC – 28 individuals; CCC – 45 individuals.

The unduplicated number of individuals (18 and older) enrolled in Blended Case Management, Peer Specialist, Drug and Alcohol Case Coordination, and Drug and Alcohol Recovery Specialist services within the 2017-2018 fiscal year (enrolled through 6/4/19) is 633. Of the individuals enrolled in the services identified above provided by the Mercer County Behavioral Health Commission, 20 individuals were enrolled in the PATH program. This equals 4% of individuals served at MCBHC received PATH funded services.

Demographics of PATH individuals (17 individuals) served through the MCBHC from 2017-2018 fiscal year (enrolled through 06/07/19):

Age:		**Race:**		**Ethnicity:**		**Gender:**	
18 – 45	41%	Black or African American	23%	Non-Hispanic/Non-Latino	71%	Male	1%
46-62	53%	White	65%	Refused	24%	Female	94%
63+	1%	Other	12%				

Consumer Involvement
The New Freedom Initiative (NFI) is Mercer County’s Community Support Program. The local committee is comprised of 50% of individuals in recovery from mental health disorders and/or co-occurring disorders. NFI is partly responsible for developing the local Human Service Plan where housing is a component within the plan and is a well-known problem area for many of the individuals receiving services. Many of the individuals who participate in the monthly NFI meetings have had housing crisis experiences. These lived experiences can assist with providing that unique and specific perspective. NFI reports to the county Administrative Entity and to the Mercer County Behavioral Health Commission administrator any proposals, concerns, areas of need, etc. that would assist in the recovery of individuals with mental health and/or co-occurring disorders.

Additionally, local Mercer County mental health consumers attend the Western Regional Community Support Program (WRCSP) monthly. One of the committee’s formed within the WRCSP is a group addressing homelessness and looking at ways to end homelessness. The

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ideas and suggestions shared at the WRCSP are shared at the local NFI committee. There is also representation at the WRCSP meetings by OMHSAS who are also able to hear what the mental health consumer's ideas and planning efforts and thoughts are.

Health Disparities Impact Statement

A subpopulation identified in HMIS data are LGBTQI individuals. The LGBTQI community within Mercer County has formed a support network for individuals. Some of this was an extension of a shooting incident in November 2016 involving a LGBTQI individual. This has offered greater support for individuals identifying as LGBTQI.

At a public hearing held as part of the planning process for the Human Services Plan, much discussion and thought was given on the needs of this population. This was one of the areas during the public hearing that attendees were asked to rate - the areas that Mercer County should focus and expand upon. Training needs was the highest rated area. Specifically, on understanding the population needs and awareness to the general population. The second area was for school support. Students who are struggling with their sexuality are having increased difficulties in the schools.

Efforts to support YYA Individuals

It is estimated that the unduplicated number of Transition-Age Youth (TAY) served using PATH funds in Mercer County is expected to be eleven. The breakdown is an estimated 8 individuals will be served through CCC and 3 individuals will be served through MCBHC. The PATH funded services for TAY are the same services provided to non-TAY: first month's rent, security deposit and utility assistance. Additional services are referrals to other agencies to provide assistance with obtaining and maintaining independent living. Supports offered through other agencies include supportive housing, housing counseling, outreach services, staff training, psychiatric rehabilitation, referrals to community mental health services, which may include case management, and additional housing supports. All services are used in order to prevent homelessness, or to establish housing and are never paid directly to the individual.

A sub-committee of NFI is the Transition-Age Workgroup (TAWG). TAWG was developed many years ago in an effort to identify and address the needs faced by the Transition-Age Youth population. This has proven to be very challenging for the committee and involved agencies. One major area of difficulty is getting individuals within the ages of 14-26 to participate and attend any meetings in order to share their specific needs. TAWG has proposed a number of options to address needs of this population. Some of the suggestions are: Big Brother/Big Sister program and Youth Peer Specialist.

TAWG developed a resource directory of services available within Mercer County for the TAY population. This resource directory was distributed in multiple places throughout the county, including, but not limited to: mental health providers, schools, churches, and libraries. It has also been posted on the MCBHC website. The use and availability of the resource directory is one effort completed by the TAWG workgroup.

NOT FINAL

TAWG advocated for many years the need for a Transition Age Coordinator. The needs identified were for supporting individuals and family's transitioning from school age to adult services. Some areas identified for families and individuals were the need to learn where to go for supports, when and how to re-apply for benefits, access to employment and/or further educational services, educating schools on transition services and being a point of contact. This position was created within the 2017-2018 fiscal year and the Transition Age Coordinator has been actively involved in engaging schools, providers, learning of services and supports related to transitioning and making it known that she is a point of contact for the county.

Mercer County Children and Youth Services (MCCYS) has contracted with the Youth Advocate Program (YAP) to provide supportive services to youth ages 18- 21 who are leaving placement and do not have suitable or stable housing options. Once a youth has been identified to be an appropriate candidate for the program, MCCYS Independent Living (IL) Program refers the youth to YAP's housing assistance program. The YAP worker coordinates with the youth to see and secure safe, affordable housing. MCCYS covers the cost of the youth's rent for a period up to 12 months, by using a housing initiative grant, as well as IL grant money. Once the youth has moved into their own apartment, the YAP worker provides case management services to assist the youth in becoming more independent. All supportive housing participants are provided with the assistance necessary to access community resources, including, but not limited to, employment assistance, social security, Department of Public Welfare, and transportation services.

Due to the waiting list for subsidized housing, the youth is placed on the housing list upon entering the supportive housing program. This will be an option for the youth, if they do not anticipate taking over their supportive housing lease at the end of the 12-month period.

Housing continues to be a need in all categories, but especially with the TAY population. Even more alarming is that Mercer County is a pass through county for human trafficking and TAY are often targeted. Youth who are homeless are often targeted for human trafficking. Continued education to the community, families, and to youth themselves is needed to reduce the risk of being a victim of human trafficking.

NOT FINAL

Limited English Proficiency

At this time, Mercer County has not required the need for assistance in providing meaningful access to limited English proficient persons within the PATH program. All individuals served speak English as their first language or when it is not, are proficient in speaking and understanding English. If the need does develop, resources available include Mango, which is a free translating service, or Language-Line, which is a fee-for-service cost. Additionally, for individuals who may be in need of sign-language, Community Counseling Center (a PATH recipient) is able to provide American Sign Language interpreters.

Budget Narrative

The money received through the contract with the Mercer County Behavioral Health Commission will be used for salaries and benefits of the case workers who will be assisting the individuals referred for services. Within the Mercer County Behavioral Health Commission, a

portion of PATH funds are also utilized for one-time assistance to qualified individuals for rental payments, security deposits, or other special needs payments which would prevent eviction. The PATH coordinator at MCBHC will also ensure that referrals are being made to local agencies, as needed and accepted, for such areas as budgeting skills, independent living skills, mental health services, drug and alcohol services, etc. The overall budget consists of $56,180 – federal allocation and $18,727 – state match allocation. The budget does not include local match required for the state portion of the budget.

Personnel & Employee Benefits

This line item includes the cost of salary for one individual. The 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 individual listed under the salary line item. These are based on actual costs and are listed out in detail.

Travel

This line includes travel at .50 per mile, which is the current agency reimbursement rate for use of personal vehicles at the MCBHC. If an agency vehicle is used, the rate is .58 cents per mile, which is the 2019 government reimbursement rate. This line item includes attending meetings for the MCBHC PATH Coordinator.

Contracts/Purchase Services

MCBHC will be contracting with one local provider for PATH funded services for 2019-2020.

Community Counseling Center – Supportive Housing Services for this population are funded with PATH dollars. Community Counseling Center (CCC) is estimating contacting 55 individuals in the upcoming fiscal year. Of those individuals, CCC estimates that 45 individuals will become enrolled in PATH.

Supplies

Office Supplies – Basic supplies to run the program and to provide training material.

Other

One-Time Rental Assistance – 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.

Occupancy

This line item includes workspace for employees attributed to the PATH program.

NOT FINAL

Mercer County Comprehensive
PATH Program FY 2019-2020 Budget

*Please add additional rows as necessary

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Housing Coordinator	42,835	.40 FTE	$17,134	$17,134
sub-total			**17,134**	**17,134**
Fringe Benefits				
FICA Tax			1,311	1,311
Health Insurance			2,114	2,114
Retirement			420	420
Life, Disability & Misc. Benefits			190	190
PA Unemployment			96	96
Workmen's Compensation			66	66
sub-total			**4,197**	**4,197**
Travel				
Travel to trainings and meetings			548	548
sub-total			**548**	**548**
Contracts/Purchase Services				
Community Counseling Services			45,000	45,000
sub-total			**45,000**	**45,000**
Supplies				
Office Supplies			725	725
sub-total			**725**	**725**
Other				
One-time rental assistance			6,000	6,000
Occupancy			1,303	1,303
sub-total			**7,303**	**7,303**
Total PATH Budget				**$74,907**

NOT FINAL

Mercer County - Community Counseling Center
2201 E State St
Hermitage, PA 16148
Contact: Fran Billen

Provider Type: Community mental health center
PDX ID: PA-005
State Provider ID: 4205
Contact Phone #: 7249816193

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

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

Source(s) of Match Dollars for State Funds:

Community Counseling Center will receive a total of $45,000 in PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 55

Estimated Number of Persons to be Enrolled: 45

Estimated Number of Persons to be Contacted who are Literally Homeless: 45

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

2019-2020 PATH IUP
Community Counseling Center of Mercer County

Local Provider Description

Community Counseling Center of Mercer County (CCC) is a comprehensive mental health non-profit agency. It is located at 2201 East State Street, Hermitage, PA 16148. CCC is identified in the PDX as PA-005 Community Counseling Center. The agency has been providing community services to persons with mental illness for over 60 years. Residential Services, specifically Permanent Supportive Housing, was started in the late 1990's. Community Integration Services were available in the early 1980's with its Community Residential Program. All services are available to any resident of Mercer County with housing services provided in both the urban and rural areas.

Annually the agency receives $45,000 in PATH Funding. This funding is used to provide housing services to individuals with mental illness living in Mercer County who are homeless or at risk of homelessness. All referred individuals are entered into the coordinated entry system as part of the HMIS database.

The funds are used to maintain staff members that assist eligible individuals to locate and secure safe affordable housing. If unable to provide services to any individual, staff members will complete a referral to an agency that could provide those services. Also, staff members provide outreach services through the members of the local Housing Coalition, the churches and other local contacts in the county.

CCC is able to provide these services through a contract with the Mercer County Behavioral Health Commission who does not inform us of the federal and state spilt in funding.

Collaboration with HUD Continuum of Care (CoC) Program

As a member of the Western PA Continuum of Care (CoC) PA 601, CCC's Supportive Housing Staff will represent the mental health component of the Northwest Region. The Supportive Housing Staff will be member of the Northwest RHAB board and attend the monthly meeting either by phone or in person. These meetings usually occur at Stairways in Erie, PA.

Locally, Supportive Housing Staff are members of the Mercer County Housing Coalition. The local Housing LHOT for Disabilities is a sub-committee of the local coalition and meets on an as-needed basis. The Supportive Housing Staff relay information from the RHAB and CoC to the local housing coalition as well as provides updates of relevant postings to the state website and trainings available. The Staff also keeps the regional entities updated on the activities of the Mercer County Housing Coalition that affect the CoC and housing opportunities.

With the addition of Coordinated Entry, CCC is a member of the CE Committee. The Staff meets with the other entities doing coordinated entry on a monthly basis to discuss issues and concerns regarding the system. Staff also participates in the monthly meetings that are held via webinar by Lawrence County Community Action Partnership.

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Collaboration with Local Community Organizations
The local housing coalition, Mercer County Housing Coalition (MCHC) has an active membership which includes the following agencies: Community Counseling Center, Mercer County Behavioral Health Commission, Veterans Services of Butler, PA, Community Action Partnership of Mercer County, AWARE, Prince of Peace Center, Adult Probation and Parole, Primary Health Network, Self Determination Housing Project, Mercer County Housing Authority, Fair Housing Law Center, Northwest Legal Services and local realtors.

The MCHC 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. Information from the RHAB and CoC regarding new funding, additional housing options and trainings is also provided.

Because of the relationship among the members of the MCHC, when an agency has a person that they are unable to service, that agency is able to make an appropriate referral. The outreach of one agency provides referrals to other services to ensure that an individual has access to assistance from all resources in the area. Referrals can be made to Community Counseling Center for Mental Health Services; domestic abuse victims are referred for shelter through AWARE; and others such as those seeking Veteran's services will be made to Community Action Partnership for their specialized programs. This network of agencies coordinates referrals to assist those in need to navigate the multiple resources available with less frustration. Pennsylvania 2-1-1 Southwest is utilized in the area to refer individuals for appropriate services and for Coordinated Entry after business hours.

Service Provision
A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients
Through the use of PATH funds, Community Counseling Center of Mercer County (CCC) is able to support the staff needed to do the outreach into the community to locate and assist those who have a mental health diagnosis and are homeless. We are able to serve any individual who is 18 years of age or older, homeless or at risk of being homeless, has a mental health diagnosis and lives within Mercer County. CCC staff is able to meet the individual wherever they are, as transportation is limited especially in the more rural parts of the county. Once staff has completed the initial contact with the individual and has determined their eligibility into the program, the individual's needs are assessed and the necessary referrals completed. The individual's information is entered into HMIS and the coordinated entry system to accurately collect the data needed to complete the PATH application.

Maximizing of PATH funds
PATH funds are used to support staff assigned to the Emergency Shelter unit and the 30-day Respite Rooms for mental health individuals who are homeless. CCC staff assesses the needs of the individuals and make needed referrals. Staff starts the process to help these individuals find and secure safe affordable housing and to access resources available in the community. Once enrolled in the Supportive Housing Program, County Base Funding for mental health services is

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used to support the person. Medicaid dollars are also accessed to provide therapy and medication management as well as other rehabilitation services.

CCC has been contracted as the sub-grantee in several HUD grants with the first starting in 1999. CCC has provided outreach services with use of PATH Dollars to support its staff in the following ongoing projects:

- Permanent Housing with Supports for 8 single individuals with mental illness with Community Action Partnership of Mercer County;
- Northwest Rapid Re-housing project has contracted with McKean County Housing Authority. At the present time five households are being served;
- The 811 project built through Community Action Partnership of Mercer County. This project is for individuals with mental illness and consists of 8 single apartments and 2 two bedroom apartments for those with families; and
- Housing Now is a collaboration with CHAPPS of Crawford County to provide housing for five chronically homeless persons with mental illness. This is a master leasing project.

Gaps in current service system
Over the past years, the housing gap in Mercer County has not changed. The county continues to experience an increasing number of homeless families and individuals without the shelter beds to accommodate them. It has been the goal of the Mercer County Housing Coalition (MCHC) to establish a shelter for these individuals. Unfortunately, the MCHC has not been successful due to lack of funding and an agency willing to assume the liability. Currently in Mercer County, there are a large number of individuals in the criminal justice system, who are both homeless and mentally ill, who are facing barriers to housing. Because of the crime(s) they have been convicted of, their options are limited for housing. CCC has joined CJAB of Mercer County and the Integration Sub-Committee for Housing to address this need.

At the present time, CCC has one efficiency apartment designated as a 30 day shelter for families and individuals. There are also two respite rooms located at CCC's Mercer Community Residential Rehabilitation facility, which permit a 30 day stay. AWARE has two shelters in the county but they are only for victims of domestic violence. There are a few private shelters for males in the county. Many agencies or faith-based organizations 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 depleted.

Co-occurring services available
CCC 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 group and individual sessions, individuals are assigned a psychiatrist for Medication Checks and evaluations to address their mental health needs. In 2018, CCC started providing

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alternative therapy to those individuals dealing with opioid addiction through a grant that was received by the agency.

- **The Community Residential Rehabilitation (CRR) program** is used by individuals as a stepping stone between the hospital and re-integration into the community. The CRR 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 rehabilitation 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** located within the CRR 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 CCC. It is an efficiency unit which has the capacity to house one individual or a family of four or less. The length of stay at the shelter is 30 days and can be utilized only once per year by each individual or family. There is a caseworker assigned to the unit whose position is supported by PATH Funding. The caseworker assists the individual(s) to find permanent housing and to access mainstream resources.

CCC provides training and supports evidence-based practices through several other funding sources. Through CCC's partnership with other agencies to provide Supportive Services in several HUD projects, funding is received to support staff and evidence-based services provided to their participants. CCC also receive mental health base funding through Mercer County Behavioral Health Commission which supports training for staff and activities associated with the collection of PATH data in the HMIS System. Lastly, CCC provides evidence-based practices such as Psychiatric Rehabilitation Services which are billable services through Beacon Behavioral health, the MCO.

42 CFR Part 2 regulations
CCC is required to follow 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. There is also firewall protection and password protocols in place to provide security.

Justice-involved
In Mercer County, the Mercer County Behavioral Health Commission has a staff member within

NOT FINAL

the criminal justice system who makes the referrals to CCC for housing and services through their jail re-entry project. Both CCC's respite room and the emergency shelter have been utilized to assist with an individual's re-entry into the community. The CCC staff works with the individual to meet their housing needs and to refer them to other services such as therapy, drug and alcohol programs, medication management, employment and life skills development. CCC is assisting CJAB in their attempt to secure additional funding through a PCCD grant for a re-entry coordinator to work with the individuals while incarcerated.

The challenge with the criminal justice population is due to the restrictions that apply when an individual has a criminal record. Many landlords will not rent to them and the local Housing Authority reviews each case to determine eligibility. In these instances, CCC utilizes its Master Leasing Program, where CCC holds the lease and the individual enters into a sublease as a participant in that program. CCC has also admitted many individuals into the CRR Program to help individuals learn daily living skills and then transition back into the community.

Data

At present time, CCC staff are entering data in the HMIS system for individuals who are entered into the PATH program. All of the outreach contacts made at CCC are entered into HMIS. The data includes individual contact information as well as all referrals made and attained by the program participants. CCC has multiple users imputing data into HMIS and a Supportive Housing Clerical Staff is the local system manager. The Supportive Housing Staff are able to run reports to ensure that data is entered and individuals are exited from the program in a timely manner. All HMIS users have viewed the needed trainings listed on the PA HMIS website through DCED and will attend all additional and updated training as needed. ClientTrack maintains its user manual on the site.

Alignment with PATH goals

Through the use of PATH funds, Community Counseling Center of Mercer County (CCC) is able to provide the staff needed to do outreach in the community to locate and assist those who are disabled and homeless, which aligns with PATH goals. CCC is 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. CCC often receives many referrals through HUD's annual Point in Time Survey due to outreach to the local police departments and food pantries. Once that relationship is established, it is utilized throughout the year. Because transportation is limited, especially in the rural areas, CCC staff will make arrangements to meet homeless individuals where it is most convenient for the individual. Once staff has met with the individual and has determined their eligibility into the program, the individual's needs are assessed and necessary referrals completed.

Alignment with State Comprehensive Mental Health Services Plan –

The State Comprehensive Mental Health Services Plan states that counties should have goals and objectives for preventing and ending chronic and episodic homelessness that reflect the state's commitment to the recovery model for all people with serious mental illness. CCC implements

NOT FINAL

the Evidence Based Model of Supportive Housing and embraces the CSP Principles of Recovery that are consistent with the state plan.

Other Designated Funds

Community Counseling Center of Mercer County (CCC) receives mental health base dollars through the Mercer County Behavioral Health Commission to enhance the services provided to those individuals who are eligible for PATH assistance. CCC also receives a small amount of Community Mental Health Block Grant money, which is used for the same population. None of these funds are earmarked specifically for PATH services, but are used in the Supportive Housing program. Through two HUD grants (Permanent Supportive Housing and Master Leasing for Chronically Homeless) that CCC is the sub-recipient for, funding is received for supported services. These dollars are specific to dealing with homeless individuals that are also eligible for PATH services.

Programmatic and Financial Oversight

CCC receives PATH monies through the Mercer County Behavioral Health Commission on behalf of the county. The PATH monies are allocated as part of the Supportive Housing budget and is used to support the staff in that program. The state PATH Coordinator annually monitors the program through a site visit and reviews all charts for program participants and all eligible expenses.

SSI/SSDI Outreach, Access, Recovery (SOAR)

During the fiscal year 2019-20, Community Counseling Center of Mercer County will be training a newly employed Supportive Housing worker in the SOAR program.

During grant year 2017-18, CCC had only one individual trained to complete SOAR applications. No SOAR applications were completed due to none of the participants requiring this service. However, if this service is indicated for any participants in the program, the SOAR process will be implemented.

NOT FINAL

Housing

Community Counseling Center of Mercer County (CCC) is able to offer an individual eligible for PATH services several different housing options. This includes the Emergency Shelter at the ECHO Center or one of two respite rooms available. These sites are available for 30 days while permanent housing is sought. If neither housing option is available, other agencies through the local housing coalition will be contacted to provide emergency shelter for the individual. Other agencies such as Prince of Peace Center, Salvation Army, Good Shepherd Center of Greenville and AWARE may be able to assist with housing through their homeless programs. There are a few men's shelters in the Mercer County Area, but no adequate shelters for families or single women. If no other option is available, then housing through a faith-based organization is explored. Faith-based organizations can sometimes offer funds to provide one or two night's stay at a local hotel/motel. Once the immediate housing need has been met, the individual will meet with a caseworker to discuss their housing needs and what services are appropriate for

them. If there is an opening in any of the HUD projects, the individual will be referred if they meet the criteria. Last year, CCC started a partnership with with another member of the CoC to provide Rapid Re-housing for those individuals who are homeless. These individuals will receive rental assistance for up to 18 months but must have a plan or means to assume that amount once the grant period has expired. If all of the projects are filled, then the caseworker will work with the individual to find a private landlord, or the Mercer County Housing Authority to find a housing situation that they can afford.   If they meet the qualifications and are in need the services, a person can be referred to CCC's Community Residential Rehabilitation program.

Coordinated Entry

Community Counseling Center of Mercer County (CCC) is a member agency in Mercer County for Coordinated Entry. CCC has partnered with AWARE, Mercer County Housing Authority, and Community Action Partnership of Mercer County to collect and enter all homeless data into the system. Coordinated Entry meetings are held on a monthly basis to discuss the process and review any changes. CCC participates in the monthly webinar conducted by Lawrence County Community Action Partnership to stay up to date on the issues. Because we have housing options available to the consumers that are not associated with HUD Funding, the CoC's assessment and prioritization process does not produce any barriers to housing for those we serve through PATH.

Justice Involved

During the grant year 2018-19, Mercer County held two CIT trainings for law enforcement. There was an average of 20 officers in enrolled in each class, which was approximately five percent of all law enforcement in the county. All of the feedback was positive and some of the officers are actually interested in becoming trainers for future events. It is hoped that two sessions will continue to be held each year.

Staff Information

Community Counseling Center of Mercer County (CCC) staff who are working in the PATH program come from Mercer County with a variety of different backgrounds. They are hired on their ability to be flexible and sensitive to the cultural differences of the individuals they work with and to set their goals accordingly. They are required to attend four hours of orientation training dealing with cultural competencies. CCC staff is also able to access Relias Learning, which is a web based educational site for additional training in these areas. 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 is provided on site at the Community Counseling Center or in the community and staff is encouraged to attend.

At the present time the PATH staff does not include a Certified Peer Specialist or Recovery Specialist but we do have access to both services through our agency.

NOT FINAL

Client Information
All of the persons served through the PATH Grant by the CCC's Supportive Housing Program will be individuals with any mental health diagnoses that are homeless in Mercer County. CCC is projecting to contact or be contacted by 55 individuals. Of those individuals, 45 will be enrolled in the PATH program and 100% of those enrolled will be literally homeless.

Consumer Involvement
CCC believes strongly that individuals 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.

In addition, 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
During the PATH grant year 2019-20, CCC expects to serve 5-10 individuals who are considered Transition Age Youth (TAY). The PATH funds used to support these individuals will be proportional to the percentage of individuals in total served for the year. All services funded by PATH are available to the TAY individuals. These services include but are not limited to: assessment and referrals to mainstream resources, emergency and 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.

At present time, CCC does not encounter any other subpopulations that may have a health disparity that adversely affects their ability to access use of, or outcomes from provided services.

In Mercer County, as part of the New Freedom Initiative a subcommittee has been developed to specifically deal with youth and young adults and the additional services available to them.

Limited English Proficiency
During the past grant year, CCC did not have any participants who had limited English proficiency. If staff did experience such a person, they would contact individuals who would be able to assist in their communication with the individual. Technology would also be used that is available on the computers or cell phones to help with proper communication.

NOT FINAL

Budget Narrative
PATH funds which are federally funded will be used to support a portion of the Supportive Housing caseworker's salary and their health care benefits. This caseworker works 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 necessary referrals to appropriate agencies for assistance that CCC is unable provide.

Included in the budget are monies for transportation. As stated in the narrative, staff must go to where the person is located due to the lack of public transportation. Mercer County is largely a rural county and traveling large distances is a common occurrence. The county has a total area of 683 square miles.

Additional budget expenses are for electronic devices and their connection to the internet. The Supportive Housing staff each has a cell phone and iPad to help with documentation and communication to assist the participants. Each device has a monthly charge, and other basic office supplies are needed to provide services to the participants.

NOT FINAL

Community Counseling Center
Mercer County PATH Program
FY 2019 - 2020 Budget

PERSONNEL Position	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Housing Case Manager	$38,556	.70	$26,991	$26,991
Outreach Liaison (Certified Peer Specialist)				
Outreach Liaison #2				
Resource Specialist				
sub-total			**$26,991**	**$26,991**
FRINGE BENEFITS Position				
Housing Case Manager		Health Care Benefits	$7,100	$7,100
Outreach Liaison (Certified Peer Specialist)			$2,969	$2,969
Outreach Liaison #2				
Resource Specialist				
sub-total			**$10,069**	**$10,069**
TRAVEL				
Local Travel for Outreach			$3,250	$3,250
Travel to training and workshops				
sub-total			**$3,250**	**$3,250**
SUPPLIES/EQUIPMENT				
Consumer-related items			$1,530	$1,530
Office supplies			$1,000	$1,000
Cell Phone			$2,160	$2,160
sub-total			**$4,690**	**$4,690**
Other				
Staff training				
One-time rental assistance				
Security deposits				
Client transportation				
sub-total				
Total PATH Budget			**$45,000**	

NOT FINAL

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◯ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	

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

Source(s) of Match Dollars for State Funds:

Mercer County Behavioral Health Commission will receive a total of $29,907 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 23

Estimated Number of Persons to be Enrolled: 23

Estimated Number of Persons to be Contacted who are Literally Homeless: 20

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

MERCER COUNTY
BEHAVIORAL HEALTH COMMISSION
PATH INTENDED USE PLAN 2019-2020

Local Provider Description
The Mercer County Behavioral Health Commission, Inc. (MCBHC) is the provider organization receiving PATH funds within Mercer County. The MCBHC was originally incorporated by the Mercer County Board of Commissioners in 1979 to administer the county's substance abuse services, and later integrated to include mental health and intellectual disability services (1998). As the initial point of contact for the three programs, the MCBHC provides administrative oversight, centralized program intake functions, case management services, mental health emergency crisis services, peer support services, mobile psychiatric nursing services, early intervention services, and prevention education programs. For 38 years the MCBHC has outreached, engaged, intervened, and has been a partner in recovery with the targeted population. The MCBHC is a private, non-profit organization that administers the county's Mental Health, Developmental Services, and Substance Abuse services. The organization has long-standing experience and a positive track record of involvement with the targeted population. The MCBHC serves the entire Mercer County region of Pennsylvania.

The MCBHC serves as the Single County Authority (SCA) for drug and alcohol program funding through the PA Department of Drug and Alcohol Programs. As the SCA, the MCBHC is responsible for planning, administering, funding and evaluating the drug and alcohol service programs within Mercer County.

The MCBHC functions as the fiduciary for Mercer County and will receive a federal allocation of $56,180 and a state allocation of $18,727 totaling $74,907. MCBHC will provide $33,750 in federal funds and $11,250 in state funds to Community Counseling Center and the remaining $29,907 ($22,430 - federal and $7,477 state) will be used by MCBHC for provision of the PATH program. The attached line item budget reflects the detail funding for the MCBHC. One (1) MCBHC staff member, who coordinates PATH for other staff members at the MCBHC, is funded with PATH funds.

The mailing address for the MCBHC is:

Mercer County Behavioral Health Commission
8406 Sharon-Mercer Road
Mercer, Pennsylvania 16137

The MCBHC is identified in PDX as "PA-016: Mercer County MH/MR, Mercer Co. Behavioral Health Commission."

The MCBHC subcontracts with one in-county provider for PATH-funded services and supports. Community Counseling Center (CCC) will receive $33,750 in federal funds and $11,250 in state funds (totaling $45,000) to support PATH-funded services. This is reflected within the attached budget detail under the "*Contracts/Purchase Services*" line item.

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Community Counseling Center (CCC) is a non-profit agency that has been providing comprehensive community behavioral health services since 1957. CCC provides mental health and substance use disorder treatment, rehabilitation and support services through a wide range of services for children, adults, and families. There are service locations throughout Mercer County. A large area of focus for CCC is providing services to individuals with mental illness who are experiencing homelessness or to prevent homelessness. CCC assists individuals through Supported Housing, Community Residential Rehabilitation, Fairweather Lodges, and Enhanced Personal Care Boarding Homes. Please refer to CCC's Intended Use Plan for more comprehensive information.

The mailing address for CCC is:

Community Counseling Center
2201 East State Street
Hermitage, Pennsylvania, 16148

Community Counseling Center is identified in PDX as "PA-005 Mercer: Community Counseling."

Collaboration with HUD Continuum of Care (CoC) Program –
It is recognized that the Pennsylvania Continuum of Care (CoC) identified goal is to reduce homelessness by 50% by the 2022. The Housing Coordinator within the Mercer County Behavioral Health Commission has participated in the Western Region Continuum of Care meetings within the 2018-2019 fiscal year. This participation has provided the MCBHC an opportunity to be a resource of information for the staff within the MCBHC, as well as to the local Housing Coalition. The Housing Coordinator is also an active member of the local Housing Coalition.

Mercer County participates in the monthly Northern Regional Housing Advisory Board meetings. Mercer County participates in the Coordinated Entry Process, using the coordinated assessment, as of 6/30/17. The single point of entry allows for an easier flow of assisting homeless individuals within the county.

Additionally, the MCBHC Housing Coordinator participates regularly in the webinars provided by SAMHSA, which allows the MCBHC to maintain alignment with not only the state goals, but also with federal expectations.

Mercer County participates in the Western PA CoC, and its CoC number is: PA-601.

Collaboration with Local Community Organizations –
Local efforts for reducing homelessness within Mercer County are driven by the Mercer County Housing Coalition (MCHC). The MCHC meets monthly to discuss planning activities, program coordinator initiatives, updates within each participating organization, and other concerns. The current roster of participants at the MCHC meetings are representatives from: Mercer County Area Agency on Aging, Adult Probation and Parole, AWARE, Mercer County Behavioral

NOT FINAL

Health Commission, Community Action Partnership of Mercer County, Community Counseling Center, Mercer County Housing Authority, Primary Health Network, Prince of Peace Center, the Self Determination Housing of PA, Southwest Legal Services, and U.S. Department of Veterans Affairs.

One of the main functions that the Mercer County Behavioral Health Commission (MCBHC) provides is case management. It is imperative that the case management staff be aware of local community organizations and agencies which provide housing supports. The MCBHC Housing Coordinator is an additional resource for the case management staff when housing issues arise. Additionally, the MCBHC conducts a Utilization Review and authorization process for some housing related services. This allows greater oversight to providers who receive funding from the county for housing related services and ensures that the dollars received are being utilized effectively.

Master Lease and Bridge Housing

The Mercer County Behavioral Health Commission implemented Master Leasing and Bridge Subsidy programs in FY 2018-2019. The programs began July 10, 2018. Through the use of its Health Choices reinvestment funds, the Mercer County Behavioral Health Commission provides temporary tenant-based rental assistance to qualified individuals until they are able to receive a Section 8 Housing Choice Voucher or other type of rental subsidy or have obtained access to a subsidized unit. The target population served by the Bridge Subsidy program is adult, Medical Assistance eligible, residents over the age of eighteen (18) struggling with mental health, substance use, or co-occurring disorders who are in need of housing and supports at all stages of the recovery process. The primary purpose of the master Leasing and Bridge Subsidy programs is to provide permanent supportive housing for these priority consumers while creating a structured link to a more permanent subsidy.

The Mercer County Behavioral Health Commission works with a contracted **"**Housing Manager**"** from Community Action Partnership of Mercer County to develop and implement the Bridge Subsidy program. The program will be regularly assessed to ensure that it is effectively achieving identified goals. These goals include increasing the availability and access to housing options that are safe, integrated, affordable and accessible for the target population. Financial oversight is provided to the program internally through the Chief Financial Officer of the Mercer County Behavioral Health Commission, and externally through Southwest Behavioral Health Management, Inc.

The Master Leasing and Bridge Subsidy Programs have housed 16 applicants and their families thus far and has successfully transitioned one applicant (and family) to traditional tenancy.

Although participation in treatment is not required, applicants are encouraged to partake of Blended Case Management (BCM). The assistance BCM affords can aide in their stability and help transition the participants out of these programs and into traditional housing since these programs are time limited. Participant follow up on a quarterly basis has been implemented and

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is occurring in cooperation with active Blended Case Managers or the Housing Coordinator and Community Action Partnership Housing Specialist.

Additionally, Health Choices reinvestment funds have been targeted for use as Contingency Funds and have assisted 52 individuals and families obtain or maintain housing to date. The criteria for eligibility and goals for this program are the same as the Master Leasing and Bridge Subsidy Programs.

All of these programs are available to eligible PATH recipients.

Below are the key services provided by local community organizations throughout Mercer County with whom the MCBHC collaborates and coordinates with regularly:

Primary Health Providers
The Mercer County Assistance Office (through the PA Department of Human Services) 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 (PHN) 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 through the Mercer County Assistance Office helps to eliminate the barrier to treatment. Additionally, PHN has received special grant funding 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 PHN staff who determines eligibility for this grant program is also a Certified Health Care Navigator, and is an active member and participant at the Mercer County Housing Coalition meetings. Primary Health Network also provides transportation to medical appointments for PHN patients.

Mental Health Providers
The MCBHC provides Intake and Assessment, Blended Case Management, Certified Peer Specialist, Crisis Intervention, and Mobile Psychiatric Nursing services 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) located in Sharon, PA. The SRHS inpatient facility has both children and adult units. SRHS's Behavioral Health Services offer partial programs for children, adolescents, and adults. Outpatient mental health medication management is also provided by SRHS and serves as one of four licensed providers. The other three remaining licensed providers of outpatient mental health services are: Associates in Counseling and Child Guidance located in Sharon, PA, Community Counseling Center, with locations in Hermitage, PA, Greenville, PA and Grove City, PA, and Paoletta's Counseling

NOT FINAL

Service, located in Mercer, PA. 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

The MCBHC provides 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. Gaudenzia, located in Sharon, PA, and Community Counseling Center, a PATH funding recipient with locations in Hermitage, PA, Greenville, PA and Grove City, PA, both provide these levels of care for substance abuse treatment. Mercer County also has two licensed Methadone providers: Discover 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.

The MCBHC collaborates with all the agencies in the community that provide housing supports and services 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. Their services specific to housing include: supportive housing services, respite rooms, enhanced personal care boarding home, Fairweather Lodges, and full and partial Community Residential Rehabilitation programs. All programs are designed to meet the individual's needs and are intended to be structured and recovery-oriented. CCC is a recipient of PATH funding to support the housing programs that they offer. Please refer to CCC's Intended Use Plan for more specific details of the housing supports offered.

Other county organizations that offer housing services and supports, but are not subcontracted to provide PATH funded services and supports include: AWARE, City of Sharon Community Development Department, Community Action Partnership of Mercer County, Good Shepherd Center, Guardian's Nest, Joshua's Haven City Mission, Mental Health Association, Mercer County Housing Authority, Prince of Peace Center, Reaching Up and Out's Manna House, Salvation Army, Shenango Valley Urban League, VA Butler Healthcare Center, and Youth Advocate Program. All individuals served within these county organizations may be eligible for PATH funded assistance and programming as well.

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- **AWARE** provides emergency shelter for women, men and children fleeing from domestic violence situations. The organization partners with local school districts, allied health, medical and mental health, law enforcement and justice systems, and faith institutions as part of their larger mission to prevent domestic and 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 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 that enable them to move into stable and permanent housing.

- **The City of Sharon's Community Development Department** oversees the Community Development Block Grant (CDBG) funds. The City of Sharon offers a Housing Rehabilitation Program which provides a low interest installment loan of up to $10,000 for qualified individuals in the City of Sharon to improve the safety and sanitary conditions of their home.

- **Community Action Partnership of Mercer County (CAPMC**) offers a wide variety of housing supports and services. CAPMC Housing Counselors assist with housing counseling, senior housing, special needs housing, and single family rental housing. The agency owns and/or manages 275 units of senior housing at 10 locations. This program provides independent living housing units for income-qualified seniors aged 62 and older. Additionally, the agency owns and manages 22 units of special needs housing at five locations: Florence Street Apartments, Independence Park, and Permanent Supported Housing for Persons with Serious Mental Illness inclusive of eight units at two locations in which Community Counseling Center provides the supportive services. Additional 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 to offer decent, safe and affordable housing for five families. Rents are subsidized and based on household income. Further, CAPMC is a certified HUD Housing Counseling Agency and provides services under contract with the Mon Valley Initiative, PA Housing Finance Agency and City of Sharon.

- Additionally, CAPMC assists military veterans who are experiencing a housing crisis. CAPMC employs a veteran who does street outreach, assists veterans in navigating the Veteran's Administration (VA), and links veterans to additional supports offered by the VA.

- **The Good Shepherd Center** addresses the physical needs of the economically challenged in the greater Greenville area. Greenville is located in the Northern part of Mercer County. Services offered include: food pantry, thrift store, hot meals program, free medical clinic, and limited emergency housing/utility assistance. The medical clinic serves Greenville community members who have no Medical Assistance or other insurance, and who qualify within the income guidelines. If an individual goes to the

NOT FINAL

Good Shepherd Center and is in a housing crisis, Good Shepherd Center can pay for lodging for one night and works with other agencies to coordinate housing services.

- **Guardian's Nest** – The newest housing service for Veteran's is currently in the development stages. A Mercer County veteran recognized a need for housing options for homeless veterans and started a non-profit agency called Guardian's Nest. This endeavor will include a Veteran's Resource Center in order to connect veterans with available resources. The housing portion of the project will offer six transitional housing units. Four will be single male rooms, and two will be for couples or families.

- **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. A free medical clinic is also available to provide physicals and health screenings.

- **The Mental Health Association of Mercer County (MHA)** 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. MHA currently has two locations which provide a shared living situation where individuals have their own bedrooms and share the living areas, bathroom and kitchen. One location has three bedrooms and the other has five bedrooms. MHA offers four individual apartments, three of which are Section 8-approved. Additionally, they provide respite that MCBHC funds

- **The Mercer County Housing Authority (MCHA)** administers the Homeless Prevention and Rapid Re-Housing Program. MCHA also oversees the Section 8 Housing Choice Voucher program and public housing. To date there are 20 public housing properties available throughout Mercer County which are managed by the MCHA. In additional to providing housing, the MCHA offers a Resident Services Department which provides supportive services and programs to residents to promote self-sufficiency and housing stability. The MCHA offers a program which provides beds to children that move into a MCHA property with little or no furniture and without the means to obtain a bed. In addition, MCHA offers a Section 3 program which links individuals residing in MCHA properties to employment, training and contractual opportunities with projects and activities in their neighborhood.

- **The Prince of Peace Center** provides emergency services, Family Supportive Services (FSS), thrift store, and food services. Prince of Peace provides a program within the community entitled AWESOME (Assistance With Education, Shelter, Organization, Money management, and Employment). The program provides the participants with educational classes on a wide array of topics, including proper nutrition, financial planning, and informed decision making. When an individual successfully completes the class, they are awarded $125 to be put towards a utility bill or rent.

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- **Reaching Up Reaching Out**, a non-profit organization, recently opened the **Manna House** in 2018. It is a faith-based Life Recovery Program which offers transitional housing to women in recovery who have been recently released from incarceration. The Manna House offers case management services, supportive counseling, work assistance, transportation, housing assistance and referral services and can house up to six women.

- **The Salvation Army** operates a worship center and thrift store. It also provides housing assistance, emergency disaster services, emergency food assistance including hot meals to those in need, clothing assistance and home heating and utility assistance.

- **The Shenango Valley Urban League** exists to ensure equal access and opportunity to African Americans and others in need. The Shenango Valley Urban League provides comprehensive housing counseling services as they are a Certified HUD Counseling Agency. The Shenango Valley 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 assistance with one month's rent or security deposit.

- **VA Butler Healthcare Center** offers programs to Veterans through the U.S. Department of Veterans Affairs such as housing solutions, employment opportunities, health care, and justice- and reentry-related services. The VA also has a housing program for eligible veterans (HUD-VASH) which operates in collaboration with HUD in the form of rental assistance vouchers and supportive housing services to promote housing stability.

- **Youth Advocate Program (YAP)** offers two mental health housing support services: Mental Health Habilitation and Mental Health Chore and Homemaker Services. One of the identified needs for housing supports is a "hands on" approach in order to assist individuals in maintaining independent living. The MH Chore and Homemaker service helps adults with mental health challenges maintain their homes 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

<u>Employment Providers</u>
PA Career Link has an office in Sharon, PA, and 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. PA Career Link also houses the Office of Vocational Rehabilitation, Veterans Affairs, and Aging Division of Employment services at their Sharon, PA location.

Community Counseling Center (CCC), a recipient of PATH funding, is an employment provider for individuals with disabilities through their Employment Resource Specialists (ERS) program. After an individual completes an assessment through the Office of Vocational Rehabilitation,

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they can be referred to CCC for employment services. ERS is an employment placement service benefitting both the potential employee and the potential employer. ERS will assist with interviewing candidates, provide on the job training and educate potential employers about the benefits of hiring individuals with disabilities. CCC's vocational services assists individuals with disabilities to find and maintain gainful employment. The largest disability group served through this program is behavioral health consumers; however, other disability groups also served include: 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 agencies provide 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.

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Service Provision

A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients

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 provided they meet the PATH eligibility criteria. These individuals have been identified as having a serious mental illness in order to be eligible for case management services through the MCBHC. The Case Management department staff are aware of PATH funded services being available. The case managers meet with the PATH Coordinator and make applicable referrals for PATH assistance in order to provide support to the individual who may be at risk of homelessness, or who is homeless.

The PATH Coordinator at the MCBHC receives referrals for the PATH program through Blended Case Managers. PATH eligibility is determined through an individual being deemed as literally homeless or at imminent risk of homelessness, and the determination of a serious mental illness, age 18 or older and agreement to PATH services. The Case Managers have direct contact with the clients and work with them closely. The PATH Coordinator communicates directly with the Case Managers when a referral is made for PATH. Eligibility determination is done by the PATH Coordinator. Case notes done by the Case Managers for individual consumers reflect PATH related services. Housing services related to planning of housing, costs associated with matching eligible homeless persons with appropriate housing situations, technical assistance in applying for housing assistance, improving the coordination of housing services, re-establishment of utility services, and one-time only assistance with security deposits or first month's rent are PATH funded services provided to individuals who meet eligibility criteria. PATH funds are never paid directly to the PATH individual, but rather are paid directly to the vendor. Individual's information is entered into HMIS once the PATH application has been accepted.

Alignment with PATH goals
Street Outreach is not a service performed through the MCBHC. When a consumer receiving services through MCHBC is also experiencing a housing crisis, a referral to the PATH program is made. During the time of determining PATH eligibility, the PATH Coordinator meets with the staff person who is making the referral in order to discuss additional supports that the individual may benefit from. Examples of additional services includes educational classes on topics like budgeting, housekeeping, and credit counseling provided by a variety of community organizations or suggested linkages with other housing supports within Mercer County. The case manager assists the individual with applying for those classes or making referrals for additional housing supports.

Community Counseling Center (CCC) is able to support staff needed to do the outreach into the community to locate and assist those who have a mental health diagnosis and are homeless through the use of PATH funds. CCC staff meet individuals where they are in the community, and once completing the initial contact with the individual, determine their eligibility into the program and make needed referrals. The individual's information is entered into HMIS and the coordinated entry system to accurately collect data needed to complete the PATH application.

Maximizing of PATH funds
The Mercer County Behavioral Health Commission (MCHBC) maximizes the use of PATH funds for the individuals being served because they are also receiving services and supports of Mental Health Blended Case Management, Mental Health Certified Peer Specialist, Drug and Alcohol Case Coordination, and/or Drug and Alcohol Certified Recovery Specialist services. The funds that support these 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 MCHBC is also experiencing a housing crisis, a referral to the PATH program is made. During the time of determining PATH eligibility, the PATH Coordinator meets with the staff person who is making the referral in order to discuss additional supports that the individual may benefit from. Examples of additional services includes educational classes on topics like budgeting, housekeeping, and credit counseling provided by a variety of community organizations or suggested linkages with other housing supports within Mercer County. The case manager assists the individual with applying for those classes or making referrals for additional housing supports.

Gaps in current service system
Gaps existing within the current service system include emergency housing specific to: women, women with children, men with children, and entire family units. A sub-committee of the Mercer County Housing Coalition was formed to pursue funding to address these gaps. At this time, the committee continues to search for a suitable building and location for this project. Historically, one barrier for identifying a location is lack of local community support for a homeless shelter. Many community members publicly opposed a site that the committee had identified and acknowledged that while they are aware that the need exists for a homeless shelter, they do not want a shelter located in their neighborhood.

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A second identified gap is reaching the transitional age youth, which 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 upon reaching adulthood. As these transitional age youth attempt to survive independently without supportive services, many meet obstacles in achieving a self-sufficient, healthy and satisfying life. In regards to housing, this priority population begins to "couch surf" – living in households in which their name does not appear on the lease. Due to HUD changing the definition of homelessness, couch-surfing is no longer considered being homeless. Therefore, those individuals would not qualify for HUD homeless housing services. Mercer County Children and Youth Services (CYS) has the only Independent Living Program for transition age youth in the county. This program is only available to youth with an open case through Mercer County CYS and assists youth to remain in care and/or youth leaving care with obtaining and maintaining safe and affordable housing. The program can provide transitional housing and supportive services to eligible transition age youth.

Finally, there remains a problematic gap in securing housing for individuals with mental health diagnoses and having criminal histories (felony offenses and sex offenders).

Co-occurring services available
Services for individuals with co-occurring disorders of mental health and substance abuse are available through a variety of providers throughout Mercer County. Individuals experiencing a co-occurring mental illness and substance use disorder can access appropriate treatment through the Base Service Unit of the Mercer County Behavioral Health Commission (MCBHC), also known as the Central Intake Unit. MCBHC remains the gatekeeper and initial point of contact for persons in need of such services. The assessment process is conducted to ensure that individuals with co-occurring needs have access to services in a full continuum of care by identifying, referring, and authorizing appropriate levels of care. The Central Intake Unit provides intake, evaluation and referrals. As previously mentioned, MCBHC provides Certified Recovery Specialist services and Drug and Alcohol Case Coordination for drug and alcohol services in addition to the mental health services available. The staff are cross-trained in both substance abuse and mental health co-occurring disorders in order to be better prepared to address the specific needs of this population. The case management supervisors are also cross-trained and supervise both mental health and drug and alcohol staff. This cross-training allows the staff and supervisors the knowledge of resources available and knowledge of skills in working with the dually diagnosed populations. MCBHC works collaboratively with Community Counseling Center, which is the only local provider with a dual license for providing outpatient drug and alcohol services and mental health services. Additionally, the MCBHC contracts with multiple co-occurring residential treatment providers. All of those providers are outside of Mercer County.

The Housing Coordinator at MCBHC participates regularly in the webinars made available through the SAMHSA Homeless and Housing Resource Network in order to keep apprised of new services, issues and programs. Additional trainings that are offered by the Department of Drug and Alcohol Programs, as well as the Office of Mental Health and Substance Abuse Services are offered to MCBHC staff and providers throughout the year. Examples of trainings include areas such as: Dual Diagnosis, PTSD and Addiction, and Forensics and Addiction. Staff monitors the websites for upcoming relevant trainings and register for them as they become available.

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42 CFR Part 2 regulations
The MCBHC is 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 capture 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.

Justice-involved
The MCBHC coordinates with individuals being released from the county prison who meet the criteria for Vivitrol. A mobile Vivitrol van comes to the MCBHC monthly in order to provide the medical-assisted treatment and to link individuals with ongoing outpatient treatment within the community. Because the van is located at the MCBHC, the individuals are able to have immediate access to the Central Intake Unit, where additional referrals can be made to other community mental health, drug and alcohol, and community resources in order to have a continuity of care.

Mercer County recognizes that there are a large number of inmates incarcerated within the county jail who have mental health and/or drug and alcohol concerns. In working to address this, the President Judge requested an increase in supportive services to reduce the number of individuals in jail who have committed crimes because of unaddressed mental health and/or drug and alcohol conditions. Mercer County initiated a "Community Integration Project" in October 2016. The project is aimed at working more closely with identified individuals who are returning to the community from the county jail. Prior to discharge, the individuals meet with their Blended Case Manager, Certified Peer Specialist or Recovery Specialist, and Mobile Psychiatric Nurse. The case manager links the person with Medical Assistance and ensures that SSI/SSDI (if eligible) is re-activated soon after release. One of the identified barriers prior to this project was mental health and drug and alcohol consumers who were incarcerated were not linked with those important services soon enough and therefore were not receiving the needed medical care upon release.

Since June 1st, 2018 the project has served a total of 33 individuals being released from the Mercer County Jail. Seventeen of them were primarily identified as having mental health needs and 16 were identified as having substance abuse issues. At the present time there are 22 participants in the jail project; 13 have MH diagnoses and 9 have a D&A diagnosis. There have been 3 successful closures that were individuals with MH needs; one individual is employed and 2 have completed all legal obligations. There have been 2 successful closures of individuals with D&A needs; both are working and have completed all legal obligations.

The MCBHC provides co-occurring mental health and drug and alcohol intervention with the county jail. The Forensic Intervention Specialist conducts mental health and drug and alcohol evaluations per court orders, mental health psycho-educational groups, coordinates mental health hearings as needed at the jail for involuntary commitments, and is able to make referrals prior to release from the jail for outpatient services, case management, peer support, and other supportive

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services that are available. For fiscal year 2019 through 4-30-2018, a total of 311 inmates were assessed. The breakdown of assessment types provided is: 143 Drug and Alcohol, 54 Driving while Under the Influence, 38 Mental Health, and 76 Dual. In addition to the assessments, psycho-educational groups were provided. A total of ten drug and alcohol psycho-educational groups were provided. There were a total of 62 participants in those ten groups, for 91 total hours.

The MCBHC allocates a clerical staff's time for visiting the jail to assist all individuals with mental health or drug and alcohol issues in filling out their COMPASS applications. This eliminates any loss of benefit coverage for services and assures eligible patients utilize their full Medicaid benefits as soon as they need them. This not only provides them quick access to behavioral health services but, as a supplemental benefit, they are also immediately able to access any physical health services they may need.

Housing continues to be an obstacle for individuals with a criminal record. The Director of Probation and Parole is a current and active member, and chair, of the Mercer County Housing Coalition. One of the many barriers inmates face upon release from incarceration is lack of income. If an incarcerated individual has an identified mental health or co-occurring drug and alcohol diagnosis, and a doctor has determined the individual unable to work due to the disability, SSI/SSDI Outreach, Access and Recovery (SOAR) could be utilized within the prison system, prior to release, in order to establish SSI or SSDI, thereby reducing the barrier of financial burden relating to finding housing. SOAR is a very time burdensome service and is not reimbursable through Health Choices; therefore, it has not been utilized to its fullest capacity within Mercer County.

Forensic Certified Peer Specialists (CPS) have received specialized training in order to work more effectively with individuals involved with the justice system. At this time, Community Counseling Center (PATH provider) employees CPS' who have that specialized training.

Consumer stakeholder groups had identified the need for a Mental Health Court or a Drug Court. Having a mental health or drug court established could make effective use of limited criminal justice and mental health resources, to connect individuals to treatment and other social services in the community, to improve outcomes for offenders with mental illness in the criminal justice system, to respond to public safety concerns, and to address jail overcrowding and the disproportionate number of people with mental illness in the criminal justice system. Often times, inmates are released from prison after they have "maxed out" and there are no aftercare services, including housing supports, set up for them. Treatment Court served its first participant in January, 2019; has 7 active participants, and 5 pending participants.

Data

The MCBHC has been entering data into PA-HMIS since December 2011. CCC is also an established user of PA-HMIS. All PATH-eligible individuals are entered into the PA-HMIS system using ClientTrack. The Housing Coordinator at MCBHC has been trained on entering data into ClientTrack. As additional training for updates become available, the MCBHC Housing Coordinator participates in order to stay apprised of any new requirements or updates to

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the system. The PA-HMIS user manual is available for reference by the MCBHC Housing Coordinator.

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" with friends or family.

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 provided they meet the PATH eligibility criteria. These individuals have been identified as having a serious mental illness in order to be eligible for case management services through the MCBHC. The Case Management department staff are aware of PATH funded services being available. The case managers meet with the PATH Coordinator and make applicable referrals for PATH assistance in order to provide support to the individual who may be at risk of homelessness, or who is homeless. PATH eligibility includes age 18+, SMI, homeless or at imminent risk of homelessness, and agreement to receiving PATH services.

Alignment with State Comprehensive Mental Health Services Plan

Services provided within Mercer County related to housing are consistent with the State Comprehensive Mental Health Services Plan. The housing agencies available within the county coordinate services and promote targeting the resources available. Additionally, assessing the effectiveness of the current housing services is completed on a regular basis. The Mercer County Housing Coalition supports local efforts to end homelessness. The collaborative agencies are continually engaging in efforts to work towards ending homelessness to a functional zero. Additionally, all mental health and drug and alcohol housing services provided in Mercer County are recovery-oriented. Those recovery-oriented services are fostering empowerment of the individual to understand what recovery means and how stable housing promotes and builds their personal recovery.

The MCBHC staff plays a major part in coordinating, planning, and writing of the mental health services plan section within the Mercer County Human Services Plan. The Housing Coordinator assists with the housing section of the plan. Because of this, the narrative of the mental health section is all inclusive of housing supports provided in Mercer County including PATH funds. It is widely known that the Housing First approach is the most effective way to improve individual mental health recovery. As case managers meet with mental health consumers, housing is always at the forefront of service planning and coordination of services in order to ensure that individuals are receiving the housing supports needed.

The MCBHC provides multiple services and supports which are consistent with the state initiatives to prevent or reduce homelessness. The PATH Coordinator/Housing Coordinator and the case management department link homeless individuals, or individuals who are at imminent risk of homelessness, with supports and services that exist within the county. The support provided intends to encourage the individuals and families to break the cycle of entering back

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into situations that may lead to a housing crisis. Additional support provided by the MCBHC includes direct financial assistance for individuals who are facing eviction, or who are currently homeless. The financial assistance is never paid directly to the individual, but rather to the vendor. This financial assistance is most frequently used for first month's rent, rental assistance to prevent an eviction, or utility assistance.

The staff providing services through the MCBHC are providing case management services and are able to identify individuals that are homeless or at risk of homelessness throughout their daily work functions. When individuals are identified as possibly qualifying for PATH services, the MCBHC staff will meet with the PATH Coordinator in order to make that determination and referral.

Individuals and families are referred to other providers who may be offering educational classes on topics such as budgeting skills, tenant/landlord agreements, or how to find an apartment. The campaign of the United Way of Mercer County is "Lifting Families Out of Poverty." The organizations throughout Mercer County who receive funding from the United Way are encouraged to provide learning sessions. Those sessions are geared to promote financial stability and independence. By providing ongoing learning sessions and educational opportunities, people within the community – including those with mental health conditions – will be less likely to become homeless or face eviction. The MCBHC has been a long-standing member of the United Way and supports those efforts.

The MCBHC has an excellent collaborative and working relationship with the Mercer County Department of Public Safety and Program Director. The MCBHC has worked 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 over 70 identified 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. Local law enforcement personnel and other public safety staff would assist with identifying individuals who are at the highest risk of needing assistance, which would include those who are homeless, and would provide assistance to secure their safety. When needed, the Department of Public Safety would coordinate services and activities related to disaster response within the PA Disaster Mental Health and Human Services Coordinator.

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 called into situations within the county where behavioral health intervention may be needed. The Disaster Crisis Outreach and Response Team (DCORT) is a sub-group of CIRT. This state trained team is utilized for more specific disasters and would be utilized as part of the County Disaster plan, if needed. There are staff members at the MCBHC that are trained and actively serve on both CIRT and DCORT. Additionally, two employees at Community Counseling Center serves on both CIRT and DCORT.

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There are multiple individuals, groups, organizations and churches who participate and are trained for CIRT. There are currently 15 individuals trained in Mercer County in the basic National Organization for Victim Assistance (NOVA), 7 have the advanced NOVA training, 12 are DCORT trained, 11 are trained in Psychological First Aid, and 36 are trained in Grief and Bereavement. A total of 52 individuals serve on the CIRT Team.

Community Counseling Center provides regular emergency drills within their housing programs. This allows the residents within the variety of housing settings an opportunity to learn about emergency preparedness and to practice it. As those individuals move into the community and to less restrictive settings, they have experience with those educational and practice opportunities.

Other Designated Funds

Mercer County is not a Block Grant county and does not receive Block Grant funding.

The MCBHC maximizes the use of PATH funds for the individuals being served because these individuals are also receiving services and supports of Mental Health Blended Case Management, Certified Peer Specialist, Drug and Alcohol Case Coordination, and Certified Recovery Specialist services. The funds that support these other programs are provided by the Managed Care Organization and base funds from both the Mental Health and the Department of Drug and Alcohol Programs, but are not earmarked for PATH services specifically.

The MCBHC also receives federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars. Those funds are used for Case Coordination, Prevention and Intervention/Treatment of alcohol and drug use. Those funds are not earmarked for PATH services specifically.

Programmatic and Financial Oversight

Within the MCBHC, financial oversight is provided to the PATH program. Housing and PATH-related service expenditures are coded to a separate cost center to enable the financial information for the PATH program to be tracked and monitored. Additional oversight is provided by the Chief Financial Officer, who reviews and approves PATH dollars needed to support PATH referrals for services.

The MCBHC is familiar with the services Community Counseling Center (CCC) is providing to their supported living/housing program related to PATH individuals. Monthly invoices and their annual audit are reviewed. Please refer to CCC's IUP for additional information related to how CCC monitors the utilization of PATH dollars.

Additional programmatic and financial oversight is provided by the State PATH Coordinator. Regular monitoring is completed for all PATH recipient organizations in Mercer County.

SSI/SSDI Outreach, Access, Recovery (SOAR)

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There are currently five known individuals in Mercer County trained in SOAR. One staff member at the MCBHC, the previous PATH Coordinator, received the certification in 2014. To date, there are no PATH-funded consumers assisted using SOAR through the MCBHC because all of the PATH funded individuals receive SSI, SSDI and/or are employed.

SOAR can be very time consuming, and none of the case management staff currently employed at the MCBHC are able to take on additional responsibilities to successfully complete SOAR applications. The MCBHC Case Management department often assists their clients in accessing benefits through the Mercer County Assistance Office and/or the Social Security Office. The individuals that have been assisted with PATH funds through the MCBHC already have benefits in place due to the case management services they have been participating in, so there have been no individuals in need of SOAR to date.

Housing

The PATH staff through the MCBHC and CCC are kept apprised of the various housing services available within Mercer County. Staff are able to make appropriate referrals and linkages based on the information they are provided and knowledge of the local housing providers, which are listed in the "Collaboration with Local Community Organizations" section of the Intended Use Plan. Both the MCBHC and CCC actively attend and participate in the monthly Mercer County Housing Coalition Meetings as well as the Western PA CoC meetings, which allows everyone to be kept apprised of other housing agencies, projects and programs in the area and region.

The MCBHC PATH Coordinator is able to offer an individual who is facing eviction or is currently homeless and is eligible for PATH services direct financial assistance. The financial assistance is never paid directly to the individual, but rather to the vendor. This financial assistance is most frequently used for first month's rent, rental assistance to prevent an eviction, or utility assistance.

Community Counseling Center (CCC) is able to offer a person eligible for PATH services several different housing options. Please refer to CCC's IUP for additional information related to how CCC makes suitable housing available for PATH clients.

Coordinated Entry

Mercer County is part of the Northern Regional Housing Advisory Board. Mercer County began utilizing a Coordinated Entry Program as part of the Western CoC on 6/30/17. Four local agencies are able to enter homeless individuals into the Coordinated Entry system: Community Counseling Center, Community Action Partnership of Mercer County, AWARE and the Mercer County Housing Authority. The MCBHC PATH Coordinator attends monthly Mercer County Housing Coalition Meetings, where the Coordinated Entry Program is discussed. The MCBHC PATH Coordinator works with the CIS Administrator for CCC and CAP as the Coordinated Entry Point of Contact. No barriers have been identified as a result of the Coordinated Entry Program.

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Both the MCBHC and CCC utilize Pennsylvania 2-1-1 Southwest as often as possible. This United Way funded service provides individuals who call 2-1-1 resources available within the county related to the identified need. One of the most frequently requested services is related to housing needs.

Justice Involved

The Mercer County Criminal Justice Advisory Board (CJAB), Community's that Care (CTC), and the Mercer County Behavioral Health Commission collaborated to support the local police departments and other first responders to receive Crisis Intervention Team (CIT) trainings. In the fall of 2017, 15 police officers were trained in CIT. The training was very well received by those who participated at that time. In April 2018, 21 additional trainees completed the 40-hour training: 13 were police officers from across the county, three were from the county jail, three from a local provider, one Juvenile Probation Officer, and one adult Probation Officer. A third training was held in October 2018 and a fourth in April 2019 with 23 individuals participating and graduating from this class. The CIT trainings have provided an increase in collaboration between the police departments and the local mental health Drop-In Center, where the mental health consumers want to build a good relationship with the police officers.

Staff Information

Specific to the Mercer County Behavioral Health Commission (MCBHC), PATH is administered by one individual housed within the MCBHC. There is a total of 99 part-time and full-time staff employed by the MCBHC. 83% of the workforce is comprised of females and 17% males. Regarding race, 97% of the staff are Caucasian and 3% are unknown (refused). There are no PATH staff at MCBHC that are Certified Peer Specialists or Certified Recovery Specialists. Please reference CCC's Intended Use Plan for the respective staff demographics.

The PATH organizations provide their staff with regular trainings to keep up to date of the changing culture and to maintain cultural sensitivity. At least one Mercer County PATH staff is registered with the Think Cultural Health in order to stay apprised of upcoming trainings and to ensure that agency staff serving the targeted population is able to address any health disparities and maintain cultural competency.

Trainings are made available to staff through a variety of venues that include: on-site trainings, conferences, regional meetings, webinars, PATH technical center, etc. Training opportunities on effective outreach such as being person-centered, recovery oriented and highly informed on trauma, as well as gender, age, and cultural competency are highly valued within the MCBHC.

Client Information

The individuals served in the PATH program will have either a serious mental health or a co-occurring substance abuse and mental health disorder. The age range of PATH clients being served is 18 and over. Clients served by PATH funds are typically at imminent risk of homelessness. They are generally either "couch surfing," in a doubled-up living arrangement where their name is not on a lease, living in a condemned/substandard dwelling and have no

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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 a health care facility or criminal justice institution without a place to live. Others served are those considered "literally homeless." This refers to individuals who are staying in a temporary shelter, or those who are in transitional housing. It is estimated that the total number of individuals to be contacted, or to contact MCBHC and CCC will be 78. The individual organizational breakdown of the total number of individuals estimated to be contacted is MCBHC – 23; CCC – 55. It is estimated that the total number of individuals in Mercer County who will become enrolled in PATH services in the upcoming fiscal year will be around 73. Estimating that of those 73 clients, 87% will be literally homeless. The individual organizational breakdown of the total number is: MCBHC – 28 individuals; CCC – 45 individuals.

The unduplicated number of individuals (18 and older) enrolled in Blended Case Management, Peer Specialist, Drug and Alcohol Case Coordination, and Drug and Alcohol Recovery Specialist services within the 2017-2018 fiscal year (enrolled through 6/4/19) is 633. Of the individuals enrolled in the services identified above provided by the Mercer County Behavioral Health Commission, 20 individuals were enrolled in the PATH program. This equals 4% of individuals served at MCBHC received PATH funded services.

Demographics of PATH individuals (17 individuals) served through the MCBHC from 2017-2018 fiscal year (enrolled through 06/07/19):

Age:		**Race:**		**Ethnicity:**		**Gender:**	
18 – 45	41%	Black or African American	23%	Non-Hispanic/Non-Latino	71%	Male	1%
46-62	53%	White	65%	Refused	24%	Female	94%
63+	1%	Other	12%				

Consumer Involvement

The New Freedom Initiative (NFI) is Mercer County's Community Support Program. The local committee is comprised of 50% of individuals in recovery from mental health disorders and/or co-occurring disorders. NFI is partly responsible for developing the local Human Service Plan where housing is a component within the plan and is a well-known problem area for many of the individuals receiving services. Many of the individuals who participate in the monthly NFI meetings have had housing crisis experiences. These lived experiences can assist with providing that unique and specific perspective. NFI reports to the county Administrative Entity and to the Mercer County Behavioral Health Commission administrator any proposals, concerns, areas of need, etc. that would assist in the recovery of individuals with mental health and/or co-occurring disorders.

Additionally, local Mercer County mental health consumers attend the Western Regional Community Support Program (WRCSP) monthly. One of the committee's formed within the WRCSP is a group addressing homelessness and looking at ways to end homelessness. The

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ideas and suggestions shared at the WRCSP are shared at the local NFI committee. There is also representation at the WRCSP meetings by OMHSAS who are also able to hear what the mental health consumer's ideas and planning efforts and thoughts are.

Health Disparities Impact Statement
A subpopulation identified in HMIS data are LGBTQI individuals. The LGBTQI community within Mercer County has formed a support network for individuals. Some of this was an extension of a shooting incident in November 2016 involving a LGBTQI individual. This has offered greater support for individuals identifying as LGBTQI.

At a public hearing held as part of the planning process for the Human Services Plan, much discussion and thought was given on the needs of this population. This was one of the areas during the public hearing that attendees were asked to rate - the areas that Mercer County should focus and expand upon. Training needs was the highest rated area. Specifically, on understanding the population needs and awareness to the general population. The second area was for school support. Students who are struggling with their sexuality are having increased difficulties in the schools.

Efforts to support YYA Individuals
It is estimated that the unduplicated number of Transition-Age Youth (TAY) served using PATH funds in Mercer County is expected to be eleven. The breakdown is an estimated 8 individuals will be served through CCC and 3 individuals will be served through MCBHC. The PATH funded services for TAY are the same services provided to non-TAY: first month's rent, security deposit and utility assistance. Additional services are referrals to other agencies to provide assistance with obtaining and maintaining independent living. Supports offered through other agencies include supportive housing, housing counseling, outreach services, staff training, psychiatric rehabilitation, referrals to community mental health services, which may include case management, and additional housing supports. All services are used in order to prevent homelessness, or to establish housing and are never paid directly to the individual.

A sub-committee of NFI is the Transition-Age Workgroup (TAWG). TAWG was developed many years ago in an effort to identify and address the needs faced by the Transition-Age Youth population. This has proven to be very challenging for the committee and involved agencies. One major area of difficulty is getting individuals within the ages of 14-26 to participate and attend any meetings in order to share their specific needs. TAWG has proposed a number of options to address needs of this population. Some of the suggestions are: Big Brother/Big Sister program and Youth Peer Specialist.

TAWG developed a resource directory of services available within Mercer County for the TAY population. This resource directory was distributed in multiple places throughout the county, including, but not limited to: mental health providers, schools, churches, and libraries. It has also been posted on the MCBHC website. The use and availability of the resource directory is one effort completed by the TAWG workgroup.

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TAWG advocated for many years the need for a Transition Age Coordinator. The needs identified were for supporting individuals and family's transitioning from school age to adult services. Some areas identified for families and individuals were the need to learn where to go for supports, when and how to re-apply for benefits, access to employment and/or further educational services, educating schools on transition services and being a point of contact. This position was created within the 2017-2018 fiscal year and the Transition Age Coordinator has been actively involved in engaging schools, providers, learning of services and supports related to transitioning and making it known that she is a point of contact for the county.

Mercer County Children and Youth Services (MCCYS) has contracted with the Youth Advocate Program (YAP) to provide supportive services to youth ages 18- 21 who are leaving placement and do not have suitable or stable housing options. Once a youth has been identified to be an appropriate candidate for the program, MCCYS Independent Living (IL) Program refers the youth to YAP's housing assistance program. The YAP worker coordinates with the youth to see and secure safe, affordable housing. MCCYS covers the cost of the youth's rent for a period up to 12 months, by using a housing initiative grant, as well as IL grant money. Once the youth has moved into their own apartment, the YAP worker provides case management services to assist the youth in becoming more independent. All supportive housing participants are provided with the assistance necessary to access community resources, including, but not limited to, employment assistance, social security, Department of Public Welfare, and transportation services.

Due to the waiting list for subsidized housing, the youth is placed on the housing list upon entering the supportive housing program. This will be an option for the youth, if they do not anticipate taking over their supportive housing lease at the end of the 12-month period.

Housing continues to be a need in all categories, but especially with the TAY population. Even more alarming is that Mercer County is a pass through county for human trafficking and TAY are often targeted. Youth who are homeless are often targeted for human trafficking. Continued education to the community, families, and to youth themselves is needed to reduce the risk of being a victim of human trafficking.

NOT FINAL

Limited English Proficiency
At this time, Mercer County has not required the need for assistance in providing meaningful access to limited English proficient persons within the PATH program. All individuals served speak English as their first language or when it is not, are proficient in speaking and understanding English. If the need does develop, resources available include Mango, which is a free translating service, or Language-Line, which is a fee-for-service cost. Additionally, for individuals who may be in need of sign-language, Community Counseling Center (a PATH recipient) is able to provide American Sign Language interpreters.

Budget Narrative
The money received through the contract with the Mercer County Behavioral Health Commission will be used for salaries and benefits of the case workers who will be assisting the individuals referred for services. Within the Mercer County Behavioral Health Commission, a

portion of PATH funds are also utilized for one-time assistance to qualified individuals for rental payments, security deposits, or other special needs payments which would prevent eviction. The PATH coordinator at MCBHC will also ensure that referrals are being made to local agencies, as needed and accepted, for such areas as budgeting skills, independent living skills, mental health services, drug and alcohol services, etc. The overall budget consists of $56,180 – federal allocation and $18,727 – state match allocation. The budget does not include local match required for the state portion of the budget.

Personnel & Employee Benefits
This line item includes the cost of salary for one individual. The 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 individual listed under the salary line item. These are based on actual costs and are listed out in detail.

Travel
This line includes travel at .50 per mile, which is the current agency reimbursement rate for use of personal vehicles at the MCBHC. If an agency vehicle is used, the rate is .58 cents per mile, which is the 2019 government reimbursement rate. This line item includes attending meetings for the MCBHC PATH Coordinator.

Contracts/Purchase Services
MCBHC will be contracting with one local provider for PATH funded services for 2019-2020.

Community Counseling Center – Supportive Housing Services for this population are funded with PATH dollars. Community Counseling Center (CCC) is estimating contacting 55 individuals in the upcoming fiscal year. Of those individuals, CCC estimates that 45 individuals will become enrolled in PATH.

Supplies
Office Supplies – Basic supplies to run the program and to provide training material.

Other
One-Time Rental Assistance – 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.

Occupancy
This line item includes workspace for employees attributed to the PATH program.

NOT FINAL

Mercer County
Mercer County Behavioral Health Commission, Inc.
PATH Program
FY 2019-2020 Budget

*Please add additional rows as necessary

	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Position				
Housing Coordinator	42,835	.40 FTE	$17,134	$17,134
sub-total			**17,134**	**17,134**
Fringe Benefits				
FICA Tax			1,311	1,311
Health Insurance			2,114	2,114
Retirement			420	420
Life, Disability & Misc. Benefits			190	190
PA Unemployment			96	96
Workmen's Compensation			66	66
sub-total			**4,197**	**4,197**
Travel				
Travel to trainings and meetings			548	548
sub-total			**548**	**548**
Supplies				
Office Supplies			725	725
sub-total			**725**	**725**
Other				
One-time rental assistance			6,000	6,000
Occupancy			1,303	1,303
sub-total			**7,303**	**7,303**
Total PATH Budget				**$29,907**

NOT FINAL

Montgomery County - Access Services, Inc.
500 West Office Center Drive, Suite 100
Fort Washington, PA 19034
Contact: Kara Savastio

Provider Type: Social service agency
PDX ID: PA-077
State Provider ID: 4277
Contact Phone #: 215-540-2150

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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

NOT FINAL

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 79,998**	**$ 26,666**	**$ 106,664**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 79,998	$ 26,666	$ 106,664	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 79,998	$ 26,666	$ 106,664	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 79,998	$ 26,666	$ 106,664	

Source(s) of Match Dollars for State Funds:

Montgomery County will receive a total of $106,664 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 170

Estimated Number of Persons to be Enrolled: 132

Estimated Number of Persons to be Contacted who are Literally Homeless: 7

Number staff trained in SOAR in grant year ending in 2018: 4

Number of PATH-funded consumers assisted through SOAR: 4

NOT FINAL

Montgomery County
Access Services, Inc.
PATH IUP
FY 2019-2020
Local Provider Description

Access Services, Inc.
500 W. Office Center Drive
Suite 100
Fort Washington, PA 19034
Phone – 215-540-2150
Fax – 215-540-2165

The provider name listed in the PATH Data Exchange is Access Services, Inc. Access Services is a 501(c)(3) non-profit social services agency operating in eleven counties in Pennsylvania. This year, JRS received $106,664 total ($79,998 federal and $26,666 state match) in PATH funding.

In Montgomery County, Access Services offers the following programs:

- Montgomery County Mobile Crisis – Montgomery County's 24/7 mobile crisis response team providing crisis support services to the entire county. MCMC also provides support through the Teen Talk Line (anonymous talk and text line for teens in Montgomery County operated by trained peers) and the Peer Support Talk Line (warm line operated by Certified Peer Specialists)
- Starting Point – Mobile psychiatric rehabilitation program providing support in the community to adults with chronic mental illness.
- Justice Related Services – ***JRS is the county recipient of PATH funds.*** JRS provides blended case management services for adults with Serious Mental Illness who are involved with the criminal justice system. The program works to divert charges, shorten sentences, facilitate re-entry to the community, and reduce recidivism for people with a diagnosed SMI.
- Homeless Street Outreach- The Street Outreach Program seeks to provide whole-person intervention toward improving stability for persons identifying as homeless in Montgomery County. The Street Outreach Program partners with Your Way Home to confirm homelessness and qualify persons for housing support. The street Outreach Team provides screening and assessment, assistance in resolving immediate needs, referrals to providers, and ongoing caseload support until a homeless individual is sheltered
- In-Home Supports – IHS provides individualized in-home care and support for adults and children with developmental disabilities by setting personal goals and learning the basic skills of day-to-day living
- Lifesharing – The Lifesharing program supports individuals with developmental disabilities living with qualified, trained, host families. As host families welcome individuals into their lives, offering support and guidance, individuals with developmental disabilities become fully participating members of their communities and are empowered to reach for and achieve their goals and aspirations

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- Respite Services – Our respite program provides a temporary home with qualified providers for adults and children with behavioral health challenges to allow for their daily caregivers to strike a balance between time spent caring for others and time spent caring for themselves.
- Life Day Program – The Life Day Program helps adults with developmental disabilities develop functional skills and discover their talents through volunteer work and engaging social activities. Individuals in the Life Day Program learn social, community, personal, and vocational skills.

Collaboration with HUD Continuum of Care (CoC) Program
Currently, Your Way Home, PA504, is Montgomery County's unified homeless crisis response system, part of the HUD Continuum of Care. JRS connects with YWH, who fully embraces HUD policy of prioritizing rapid re-housing and permanent supportive housing, using a Housing First model. The entire JRS team has attended Service Prioritization Decision Assistance Tool (SPDAT) training so our coordinators are familiar with the prioritization tool used by YWH intake. The JRS team currently works hand-in-hand with the Homeless Street Outreach team in assessing and supporting homeless individuals within Montgomery County who have forensic involvement.

Collaboration with Local Community Organizations
Access Services has historically built positive relationships with community providers and county agencies in order to provide the most cohesive, beneficial, and efficient services to the people we serve. PATH-eligible clients served by JRS generally find supports through the following services:

- Outreach Teams – JRS is able to work closely with the agency's Mobile Crisis Program and Street Outreach Program for immediate mobile response to crisis situations and for assistance in outreach to clients who are street homeless. JRS has also received support from the Coordinated Homeless Outreach Center's outreach team with some of our street homeless clients during code blue situations. JRS attends Norristown HUB meetings to help with the identification of individuals who pose community risk and follows up on relevant referrals.
- Physical Health Providers – Access Services has been advancing our agency mission of integrated health across programs where we can utilize staff RNs for basic medical assessment and medical data collection. JRS' PATH-eligible participants are often susceptible to undiagnosed, undertreated, and untreated medical issues and oftentimes lack the coverage or advocacy skills to get access to the care that they need. Our program's Blended Case Management regulations require attempts at securing a physical/screening for all program participants and coordinators facilitate the scheduling of these appointments with community providers.
- Mental Health Providers – Access Services has developed strong relationships with the county's Community Behavioral Health Centers as well as Crisis Residential Programs, and Inpatient Behavioral Health Hospitals. Coordinators are trained in Mental Health First Aid and receive continual training on assessing for appropriate level of care in order

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to make appropriate and helpful referrals. The mission of JRS is to reduce incarceration for people with SMI through stabilization of symptoms and connection to community mental health service providers.

- Substance Abuse Treatment Providers – JRS frequently works with program participants who have a history of substance abuse to receive services to assess, treat, and house in supported sober-living environments when appropriate.
- Peer Support – JRS embeds forensic peer support with relevant training and lived experience to provide support, encouragement, and resources to program participants. Access Services also provides warm-line peer support through the Peer Support Talk Line which is a phone number provided to all JRS program participants.
- Employment - JRS frequently uses county employment and vocational training services for participants in need of income through employment.

Service Provision

The Justice Related Services program is a blended case management for adults with Serious Mental Illness who are involved in the criminal justice system. PATH funds are used by JRS for clients who are either street homeless or who are incarcerated and eligible for release pending housing. Many people remain incarcerated up until their maximum sentence date based solely on lack of a housing plan. Access to stable housing, either temporary or permanent, has proven to be a large system gap that disproportionately affects this population. For adults with SMI, length of time spent in jail is significantly longer than those without SMI. A recent study in Montgomery County found that the average length of stay in jail for people with SMI was 230 days versus general population without SMI, which averaged 72 days. Housing remains a critical area of support for these individuals who are mandated by probation to provide an address to avoid violating their probation terms and returning to jail. Currently the visibility of a person who is street homeless and suffering from an SMI makes it difficult to avoid interaction with law enforcement.

A gap also exists for individuals who return to the community with ongoing forensic involvement. At any moment, these individuals could be at risk of losing housing due to relapse of behaviors or violations of probation/parole. Due to this, all individuals served by JRS are being assessed for PATH eligibility continuously. Many times, individuals JRS serve can struggle to obtain and maintain employment due to their charges and the legal/treatment mandates posing a threat to income and ability to pay rent. JRS has, and would like more opportunity, to be able to fund financial assistance for individuals re-entering the community in the form of rental assistance. This can take the form of first/last month rent with security deposit in addition to admission, or equivalent, fees for residential treatment facilities such as recovery houses and other therapeutic living environments. Rental assistance will be monitored weekly to stay within the guideline of 20% of federal allocation of funding.

JRS' blended case managers work with the clients by utilizing the Your Way Home call center for rapid re-housing and also works with county supported housing resources when appropriate to find supervised residential settings for participants who need more structure for success in the community. JRS also creatively and actively partners with the Homeless Street Outreach team to assist clients in getting into emergency shelter programs a multidisciplinary support system while

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street homeless. In addition to physical housing, JRS case managers help facilitate benefits, employment, connection to mental health services, and community involvement to ensure stability and improvement in quality of life. For clients who have both SMI and a substance use disorder, case managers work on obtaining level of care assessment for the client to determine appropriate referral, then work to coordinate services as recommended, either through outpatient programming, recovery houses, or inpatient rehabilitation. JRS utilizes Montgomery County's two detox centers, D&A case management services through Gaudenzia, Creative Health Services, and RHD Center of Excellence, outpatient services at five different agencies, and access to over a dozen residential settings in surrounding counties, many of whom specialize in COD and are trauma-informed.

JRS staff are required to complete the University of Pittsburgh Case Management training. Staff are also encouraged to complete Mental Health First Aid training, Applied Suicide Intervention Skills Training, and SPDAT training as they are available. Two staff members are trained and have access to the HMIS system, Clarity in order to enroll and document all PATH client data. Individual coordinators maintain a spreadsheet with updates to demographics for PATH clients so that these changes can be tracked and monitored and adjusted in PATH as they occur. Case notes on PATH clients are sent to Clarity-trained staff daily to be entered into the HMIS system. PATH eligibility is determined through a questionnaire completed with an individual at time of intake. The questionnaire addresses level of housing status, or lack thereof, mental health diagnoses, history of substance use, income, and other potential benefit support. If a stable home plan is not verified, an individual may be determined to be literally homeless or at imminent risk allowing individual to be PATH eligible. PATH eligible individuals have ongoing assessment for appropriation of funding as well as individuals opened in services who are presenting potential need of allocation.

After a stable housing plan is identified and a JRS client is no longer PATH-eligible, services provided to a client is billed to Magellan or from county reinvestment dollars.
Access Services complies with all state and federal regulations governing the confidentiality of substance abuse and mental health records. JRS maintains confidentiality of individuals' records via a secured electronic health record system, Evolv and back up files are stored on a protected drive only accessible through special permissions granted by the IT department and confirmed by program supervisors. Physical charts and documents are kept in a locked area of the department and the entire office is only able to be entered with an assigned keycode. JRS has confidential releases signed by consumers for all relevant parties and is compliant with individual providers' unique release forms. As a covered program, we will meet the requirements of 42 CFR Part 2 defining the confidentiality regulations for substance abuse as it applies to client consent and disclosure of information in cases of medical information and other limited circumstances.

JRS continues to actively seek out relationships and trainings with local agencies who can assist with linking forensically involved clients to housing programs and job opportunities. JRS is actively involved on county efforts to reduce the number of people with SMI in jails. JRS currently co-chairs the county's Forensic Coalition which is committing to the national Stepping Up initiative in addition to chairing that coalitions Diversion subcommittee and sitting on the Reentry subcommittee. JRS also attends Women's Reentry Committee meetings and regularly

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attends county HUB meetings. JRS is actively involved in the county's Behavioral Health treatment court and completes assessments for all Behavioral Health Court applicants. In response to sometimes extended waits to see a psychiatrist or receive prescription refills in a timely manner, JRS also collaborates with the county's Mobile Crisis provider to utilize tele-psychiatry for necessary medication to help maintain stability in the community while waiting for a long-term service provider.

Data

JRS currently has two staff members trained in the county's HMIS system who are responsible for entering all PATH data. JRS is fully utilizing HMIS for PATH services and plans to train an additional two employees to ensure that we always have access to HMIS regardless of who is in the office. JRS maintains a separate spreadsheet to keep updates on changing demographics for PATH eligible clients.

Alignment with PATH goals

Program services provided using PATH funds will target those incarcerated in the county prison as well as street homeless individuals who have SMI and are part of an especially vulnerable adult population. Due to history of criminal charges as well as SMI that may be untreated, some of these adults are chronically homeless. JRS works to secure resources, teach skills, and provide advocacy for these individuals in order to help them succeed in permanent housing. Prison and street outreach includes working with the Street Outreach team, homeless shelters, missions, and other organizations potentially serving people who are eligible for JRS through PATH funds.

Alignment with State Comprehensive Mental Health Services Plan

Currently, as part of their Comprehensive Mental Health Services Plan, Pennsylvania is transitioning to a recovery-oriented mental health system which is outlined in the state publication A Call for Change. Montgomery County was an early adapter of this and Access' JRS engages all clients in a recovery-oriented and trauma-informed manner, providing case management services to help consumers reach the level of stability and functioning needed to avoid involvement in the criminal justice system and to maintain stable housing.

Alignment with State Plan to End Homelessness

Access Services works with Montgomery County Office of BH/DD to assure that all services provided using PATH funds are consistent with the State Plan to End Homelessness. This ensures that the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state.

The PATH program relies on agency protocol to provide an efficient, well-coordinated response to promote the safety and well-being of the people we serve. The agency has several locations across 11 counties and is able to relocate staff to continue necessary service provision without interruption. Emergency response updates are to be communicated through several channels

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including the agency website, e-mail, and phone. Agency servers are backed up on a daily basis so PATH consumers' information will be able to be restored within one week in case of an emergency. The agency also maintains a Disaster Planning Steering Committee to review and update procedures.

Other Designated Funds

Access Services JRS receives around $80,000 in a block grant from Montgomery County, to help support the administrative, overhead, and some operational costs of the PATH program.

Programmatic and Financial Oversight

Access Services JRS PATH funding is dispersed to the program through the Montgomery County Office of BH/DD. JRS submits the program budget and monthly billing to the county for review and approval.

JRS leadership assesses and evaluates current census in weekly supervision of case managers for PATH eligibility and appropriateness while also preforming monthly audits for allocation of PATH funds.

SSI/SSDI Outreach, Access, Recovery (SOAR)

Access Services JRS had a goal to have all coordinators and program supervisors complete the online SOAR training by June 30, 2017 in order to train coordinators in effective completion of benefit applications. To date, and with turn over, over half of staff are currently SOAR trained will continued efforts to make complete with all staff. Once coordinators are trained and using the SOAR model, outcomes will be tracked in the SOAR OAT system.

In fiscal year 2017-2018, four staff have provided assistance obtaining SSI/SSDI using the SOAR model with four individuals. All applications are currently pending in status.

Housing

Returning prisoners face many barriers in the private rental market. These include lack of affordability, having poor credit backgrounds, ineligibility due to criminal history, and delays in receiving benefits among other issues. JRS partners with providers to assist participants in overcoming these obstacles by locating and securing decent, affordable housing. The program is working on building relationships with landlords to facilitate better access to open units and to identify landlords willing to rent to individuals who may have criminal justice involvement. JRS also utilizes initiatives like Fair Housing Rights to identify affordable, non-subsidized housing. Additionally, JRS works with the Office of BH/DD in accessing any and all new housing initiatives developed for the mental health population through Medicaid reinvestment funds or other county resources.

Transitional housing provides an intensive, structured living environment for adults who need on-going assistance in developing and utilizing daily living skills in preparation for moving to

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independent housing. Justice-involved individuals may benefit from being directed to transitional housing options in the community while their legal issues are in the process of being resolved.

As a result of family conflict, there can be reluctance on the part of family members to welcome an offender back into their lives. In other cases, natural supports are non-existent. In these scenarios participants need immediate housing upon release as well as access to shelters on an emergency basis if their ongoing residential arrangements are disrupted. JRS assists individuals in connecting with resources that may be available relating to emergency/short-term housing. Homeless veterans continue to be actively sought out in outreach efforts as they are disproportionately represented in both the homeless and incarcerated populations. The program attempts to make full use of the extensive resources and support that the Veterans Administration has for veterans through community partners as well as services provided directly to veterans facing homelessness. The program is committed to informing any veteran who is homeless or at imminent risk of homelessness of the VA's "Make the Call – 877-424-3838" initiative that connects callers 24/7 to VA services to overcome or prevent homelessness for veterans. JRS staff are also available to assist eligible homeless veterans to apply for HUD-VASH vouchers which target vulnerable Veterans who have experienced multiple episodes of homelessness, have been homeless four or more times in the past three years, or who have been continuously homeless for one year or longer.

Coordinated Entry

The Montgomery County Housing and Community Development Department operates Your Way Home, which is the Coordinated Entry program for homeless individuals. JRS collaborates with the Your Way Home program on a regular basis to help homeless individuals secure housing through this program.

PATH funds help to provide intervention before an induvial reaches Category 1 homelessness status per HUD definition. To intervene before this status allows the opportunity to prevent the barrier of literal homelessness interfering with an individual's wellness, recovery, and stability.

Justice Involved

Currently Crisis Intervention Team training is not mandated in Montgomery County and currently one police department is recognized as having completed it. As an alternative, Montgomery County Emergency Services provides a three-day Crisis Intervention Specialist training to educate law enforcement around how to work with a person experiencing a mental health crisis. The curriculum focuses on:

- Introduction to Forensic Mental Health and Jail Diversion
- Overview of the Mental Health System in Pennsylvania (State and County)
- Mental Health Law and Treatment Options
- Crisis Intervention
- NAMI – In Our Own Voice: Living with Mental Illness
- Psychiatric Medication

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- Mental Illness
- Substance Abuse
- Suicide Awareness

The county is also currently in the process of joining the national Stepping Up initiative to reduce the amount of people with SMI incarcerated. This will include an evaluation of training provided to law enforcement officials in assessing the role of diversion as it relates to the mission of the initiative.

Staff Information

JRS currently has the capacity for 15 staff: one Program Director, one Associate Director, one Assistant Director, one Administrative Case Manager, nine Case Managers, and one Certified Peer Specialist. This number will be reviewed and revisited as the program expands. Current JRS staff consists of Caucasian, Biracial, and African American, and Hispanic female case managers. Staff are all trained in cultural competency as part of agency regulations and on-going trainings are available to ensure that the most relevant, sensitive, and appropriate services are being provided to JRS participants. Access Services abides by a person-centered, trauma-informed, and recovery-oriented model and coordinators are expected to be cognizant of, and responsive to, the needs of different populations in regard to age, gender, disability, sexual orientation, gender identity, race, religion, and any other areas of note. Reactivity to diverse populations related to demographics, criminal background, or diagnosis is assessed for in the coordinator interview process and the agency is committed to hiring individuals who are accepting and aware of differences of clients as well as knowledgeable around how to be responsive to their different needs. Coordinators are encouraged to attend relevant trainings on diversity and cultural competency as they are made available.

Client Information

Currently the broad demographic served by JRS is adults in Montgomery County who are involved in the criminal justice system and have SMI. Specifically, the demographics of all clients served since May 2018 break down as follows:

AGE –

18-24: 11
25-34: 46
35-44: 32
45-54: 23
55-64: 16
65 & Older: 4

GENDER –

Female: 42
Male: 90

NOT FINAL

RACE –

African American/Hispanic: 8
Asian: 1
Black or African American: 24
Black or African American/White: 3
Hispanic/Latino: 3
Indian/Middle Eastern: 1
Individual did not know: 0
No Answer: 28
White: 64

JRS currently serves about 170 individuals and has the capacity to grow to accommodate additional need. The majority of PATH individuals are incarcerated and at risk of imminent street homelessness, rather than literally homeless, and taken off PATH funding once housing is secured. In fiscal year 2018-2019, 132 individuals were enrolled PATH – a 67% increase over the previous fiscal year.

Consumer Involvement

A Certified Peer Specialist (CPS) is embedded into the JRS Program. JRS sought someone with lived experience in both the mental health and criminal justice systems to fill this role in order to offer peer support to program participants.

In addition, the county's department of BH/DD contracts with the Montgomery County Consumer Satisfaction team, which is a provider organization employing individuals in recovery, many of whom have experience with homelessness, to evaluate satisfaction of program participants.

The Women's Reentry Initiative utilizes input from women recently released from the county jail, some of whom were PATH eligible JRS participants, to help develop the most helpful and relevant strategies and resources related to reentry.

The county's Community Advocates program through Hopeworx provides forensic peer advocacy and meets with PATH-eligible individuals who are currently incarcerated to provide classes on success in the community upon reentry.

Health Disparities Impact Statement

A health disparity population is one that manifests a higher incidence of disease and overall poorer health status than the general population. PATH-eligible individuals are at risk of health disparities because of more limited access to and use of available health care services than the general community because of mental illness and other factors, which may leave them vulnerable to poorer health outcomes. JRS works to connect these consumers with appropriate physical health supports in the community and also employs 2 RNs in the agency who are available as needed to consumers.

NOT FINAL

Since program inception in January 2017, out of 111 PATH-eligible consumers, Access Services has served 19 Transitional Age Youth (TAY) aged 18-24 through PATH funding. While there is no focused outreach specifically targeting TAY at this time, JRS is a service made available to all Montgomery County residents over the age of 18 who meet criteria and forensic need. After a person is forensically stable, with their criminal charges having been resolved, JRS may seek to transition a TAY to the county's Transition-Age case management program, provided through Central Behavioral Health. Montgomery County also has a residential program for TAY with SMI to gain independent living skills. This program is called YALE (Young Adult Learning Environment) and JRS coordinators are available to make referrals as appropriate.

Limited English Proficiency

Access Services is able to comply with Executive Order 13166 by utilizing technology and local interpreters as needed to provide access to services for consumers with limited English proficiency. To date, only one referral to the program has had limited English proficiency and the program was able to arrange for an interpreter while connecting the consumer to long-term community supports. The program intends to be mindful of referral trends related to people with limited English proficiency and as the need arises, will assess staffing to reflect language needs of the population served.

NOT FINAL

Budget Narrative

The funds requested in the attached budget are primarily to pay for case manager salaries and benefits. There is 1.6 FTE case manager coverage and, weekly, two hours for the program director, two hours for program assistant director, and two hours for the administrative assistant. Benefits included in this budget are health care insurance, workers compensation insurance, unemployment insurance and retirement benefit costs. Employer taxes are based on set percentages of wages for social security and Medicare benefits. Personnel and benefit costs account for 78% of the total budget.

Staff development, communications, legal, accounting, and advertising costs comprise 4% of the total budget. These costs are based on a percentage of total costs or estimates of direct expenses for cell phone use, printing costs for advertising and training.

Administration expenses include overhead costs for utilities, insurance, communications, and housekeeping for office space based on a percentage of total costs. This accounts for 10% of the total budget.

In the travel section of the proposal we have budgeted a portion of agency owned vehicles to be utilized as well as staff using their own vehicles. The purpose of both is to aid in searching and obtaining housing for the consumers. Costs associated with client and staff travel account for the final 8% of the total budget costs.

NOT FINAL

MONTGOMERY COUNTY

ACCESS SERVICES

Justice Related Services Department
PATH Program
FY 2018-2019 Budget

BUDGET CATEGORY	Annual Salary	PATH-Funded FTE (hours/week)	PATH-funded Salary	TOTAL
STAFF/POSITIONS				
Director	$53,046.00	0.05	$2,652.00	$2,652.00
Assistant Director	$42,042.00	0.05	$2,102.00	$2,102.00
Caseworker	$36,046.00	1.60	$57,674.00	$57,674.00
Admin Assistant	$30,576.00	0.10	$3,058.00	$3,058.00
Sub-Total			**$65,486.00**	**$65,486.00**
FRINGE BENEFITS				
Employer Match Taxes			$4,954.00	$4,954.00
Insurance & Other Benefits			$12,442.00	$12,442.00
Retirement			$655.00	$655.00
Sub-Total			**$18,051.00**	**$18,051.00**
OTHER				
Staff Development			$1,200.00	$1,200.00
Advertising & Office Supplies			$600.00	$600.00
Communications (incl. cell phones)			$1,800.00	$1,800.00
Accounting & Legal			$480.00	$480.00
Sub-Total			**$4,080.00**	**$4,080.00**
TRAVEL				

NOT FINAL

Automobile Leased/Purchased			$1,620.00	$1,620.00
Automobile Insurance, Maint & Fuel			$1,000.00	$1,000.00
Staff/Client Travel			$5,760.00	$5,760.00
Sub-Total			**$8,380.00**	**$8,380.00**
Indirect Cost				
Administrative Costs			$10,667.00	$10,667.00
Sub-Total			**$10,667.00**	**$10,667.00**
Total PATH Buget			**$106,664.00**	**$106,664.00**

NOT FINAL

Philadelphia County
1101 Market Street, 7th Floor
Philadelphia, PA 19107
Contact: Marcella Mcguire

Provider Type: Social service agency
PDX ID: PA-021
State Provider ID: 4221
Contact Phone #: 2156854986

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 438,674**	**$ 194,221**	**$ 632,895**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 438,674	$ 194,221	$ 632,895	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 438,674	$ 194,221	$ 632,895	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 438,674	$ 194,221	$ 632,895	

Source(s) of Match Dollars for State Funds:

Philadelphia County will receive a total of $1,137,107 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 0

Estimated Number of Persons to be Enrolled: 0

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

Number staff trained in SOAR in grant year ending in 2018: 2

Number of PATH-funded consumers assisted through SOAR: 73

NOT FINAL

PHILADELPHIA COUNTY
1101 Market Street, 7th Floor
Philadelphia, PA 19109
Comprehensive FY 2019-2020 INTENDED USE PLAN

Local Provider Description
Philadelphia County will receive $289,639 State allocated PATH funds and $847,468 Federally allocated funds; totaling $1,137,107. The following are the funds broken down into each PATH funded provider:

Project	Federal Allocation	State Allocation	Total Allocation
Project Home - Outreach	$ 92,629	$ 30,877	$ 123,506
RHD - Kailo Haven	$ 289,370	$ 96,457	$ 385,827
RHD - La Casa	$ 253,601	$ 84,534	$ 338,135
RHD - Cedar Park	$ 211,868	$ 77,771	$ 289,639
Total	**$ 847,468**	**$ 289,639**	**$ 1,137,107**

PATH funded services are rendered via contractual agreements between the Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and two provider agencies. PATH funding is only a portion of the overall funding used to support homeless services. Currently, DBHIDS funds approximately $50 million dollars annually worth of services that serve exclusively homeless persons. The two provider agencies are as follows:

Resources for Human Development (RHD) – Supportive, Supervisory and Case Management 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 $50M for an array of homeless services through its contracted agencies including housing (transitional and permanent), residential support, case management, and outreach and evaluation. This service total includes federally PATH-funded services. PATH-funded services represent a small portion of the total services available to the people that are homeless with mental health challenges in Philadelphia. It is therefore difficult to discuss PATH-funded services in a discrete fashion.

NOT FINAL

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, the Philadelphia CoC, PA-500, or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinator have been involved with many aspects of the Coordinated Entry planning and present implementation. Persons who receive PATH-funded services are a high priority for CoC resources.

DBHIDS works very closely and intricately with the local Philadelphia CoC, PA-500. The collaboration is built upon a mutual respect and vision which is further deepened through multiple meetings between the CoC and DBHIDS, continual coordination regarding policies, as well as a seat held by DBHIDS Housing and Homeless Services Housing Director and Homeless Services Program Manager as an alternate 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 2018, 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. The Hub of Hope provides services included medical and psychiatric services as well as peer support and case management services, and this year has expanded to a daily model with showers, laundry and food services throughout the year. In the past the Hub of Hope was a winter initiative but is now offering services daily and year long. Participating agencies include Pathways to Housing PA, Horizon House and Bethesda Project. DBHIDS continually works towards the creation and coordination of policies with local organizations through the CoC Board and corresponding sub-committees.

RHD manages a significant portion of the Mental Health Residential system and has developed a newspaper targeted for and managed by homeless and formerly homeless persons, called "One Step Away." RHD operates two of the larger shelters in the city, one for single males and one for families, and operates services for persons experiencing homelessness in other counties. RHD also operates three drug and alcohol treatment programs that exclusively serve chronically homeless individuals (JOH New Start I, New Start II and Woman Space). RHD also operates a federally qualified health center, that offers low or no cost health care services for uninsured or underinsured individuals. Both agencies offer supportive employment programming that is available to PATH clients and as well as a range of Permanent Supportive Housing options. Additionally, both agencies are recipients of numerous McKinney/CoC grants.

With regards to Project Home's outreach efforts, all outreach teams are overseen by a County Coordinator of DBH Homeless Outreach Services who holds biweekly meetings to ensure lines of communication are open and coordination is smooth. In addition, all teams are responsible for adhering to shared policies and procedures. Meetings focus on hot spots, current issues and reviewing people on the streets and their needs.

NOT FINAL

Service Provision

Path eligibility for enrollment to the County PATH-funded programs, safe havens and outreach, include being homeless or at imminent risk of homelessness, 18 years of age or older, experiencing Serious Mental Illness and agrees to the PATH-funded service.

Philadelphia continues to use data to identify, target and prioritize the most vulnerable people on the street with the longest histories of homelessness to link to needed housing and service resources. This information is used to identify people who are eligible for Safe Havens and JOH emergency housing, and any other housing options so that these are the prioritized people targeted for housing resource. This year there will be continued collaboration around creating a prioritized By Name List of people from the city's OHS Coordinated Entry process in HMIS (CEA-BHRS). The collaboration between various City of Philadelphia departments as well as provider agencies enables ongoing dialogue and cooperation to ensure that each individual is receiving the level of care and services that are most appropriate for them. This includes situations where individuals are enrolled in PATH but it becomes apparent that they are eligible for other services and funding streams (i.e. Medicaid, Medicare). This transfer allows us to leverage the PATH funds allocated to serve the most individuals possible.

Alignment with PATH goals to target street outreach and case management

Street & Shelter Outreach

Seven street outreach teams are deployed city-wide in Philadelphia on a year round basis. These services have been expanded to provide 24 hour outreach. PATH-funded staff are included in these efforts and are deployed throughout the city, targeting the City as well as identified "hot spots". During periods of severe winter or summer weather, outreach hours are extended in order to prevent weather-related injuries or death. Individuals who are PATH eligible and are reached via Outreach efforts, are given access to Respite and Café-style overnight placements, Safe Havens, JOH or shelter placement, on a referral basis. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic homelessness. Outreach is also highly involved and focused on target hotspots in Philadelphia to work with people with Opioid Use Disorder to connect to services, treatment and housing when possible.

Project Home has also newly initiated a pilot project in downtown Philadelphia, coordinating outreach teams with the Philadelphia Police Department and the Center City District to help facilitate placements for people who are street homeless to connect to housing, treatment and medical care.

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.

NOT FINAL

Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with six social service agencies for the provision of 253 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. Two of these programs are specified for the Emerging Youth population, one for couples and 10 additional winter respite beds. 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 through CEA-BHRS and DBHIDS.

Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 90% during CY 2017, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process. DBHIDS also coordinates other housing projects with OHS to help link people to additional subsidies such as 811 vouchers, a shallow rent subsidy pilot, and housing options made available through the 100 day challenge. City departments and providers and stakeholders work closely together to help make these transitions possible with added services. DBHIDS also utilizes bridge subsidies for people in mental health residential slots using reinvestment funds.

The transitional housing programs serving homeless adults in Philadelphia remain full. Despite capacity expansion, there remains a substantial unmet need for permanent supported housing for homeless individuals who are graduating from these transitional programs. As is the case for persons who do not currently meet the federal definition of homelessness but have no current place to go, as well as persons incarcerated over 90 days but were homeless upon prison admission and will be homeless upon prison discharge.

Evaluation Services

Homeless persons who require emergency psychiatric assessment and stabilization services are afforded access to an eight bed crisis residence (Emergency Evaluation Center - EEC) or to five (5) Crisis Response Centers (CRCs). An assessment and treatment team, including psychiatrist time, has been funded to work closely with the Office of Supportive Housing (OSH) Intake sites, shelters.

Service Coordination: Access to the EEC and Crisis Response Center services is centrally coordinated by the DBHIDS Acute Services Unit. The CRCs accept walk-ins. DBHIDS has a Homeless Services Unit that is responsible for the coordination of homeless services.

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Coordination & Planning

The DBHIDS participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Commissioner of the Office of Homeless Services (OHS). These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan(Code Red), outreach planning and hotspots, working with the larger community and City stakeholders, 100 Day Challenge housing slots, Coordinated Entry (CEA-BHRS) and planning for people who are chronically homeless, not chronically homeless, and the emerging adult population. This also includes planning and evaluating continuing needs around housing assessment and the prioritized By Name List. All Safe Havens have been trained in HMIS and the VISPDAT and the TAY-VISPDAT to assess vulnerability and housing needs. Both OHS and DBHIDS work closely together and with Providers as well to ensure services are provided to those with mental and behavioral health needs.

Veterans

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.

Recovery Support

Outreach is designed to engage the most vulnerable persons living on our streets and assist them in moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), outreach can respond to most needs they are presented with. Project Home partners with the Mental Health Association of Southeastern PA (MHASP) to offer peer engagement services to persons living in Philadelphia's transportation hub of Suburban Station, Hub of Hope which has moved to a larger location in the station and now provides daily and increased services throughout the year. People transitioning to and living in housing have access to CPS services. Residents in Safe Havens work with peers in house or residents that take on leadership and peer roles, as well as Peer Advisory and Alumni groups.

Maximizing use of PATH funds

Agencies do leverage other available funds outside of PATH. US Veterans access VA services first and there are other county funds available for people including DBHIDS funded safe havens and DBHIDS and other funded outreach teams.

The City of Philadelphia is committed to aiding the State and bolstering supports following the lawsuit filed by the American Civil Liberties Union (ACLU). These actions include more definition attention and efforts around the movement of individuals from both the forensic and civil units at Norristown State Hospital (NSH). DBHIDS mental health services providers help coordinate with community based supports to assist the individual with linkages to employment,

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education, mental health treatment, healthcare, and other community based activities to help prevent recidivism. Additional efforts are put in place to assist individuals with building skills of independent living so that she/he may move on some day to her/his highest attainable level of independent living.

Gaps in current service systems

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 24th, 2018 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 834 persons were sleeping on the streets of Philadelphia. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly.

Increasing numbers may be due to lack of housing resources, increased persons with Opioid Use Disorder in the City of Philadelphia, and a small amount of affordable housing. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

Services for clients who have both SMI and a substance use disorder

All of the services described above are available for persons with co-occurring substance use disorders and all homeless services programs are expected to develop expertise to serve persons with co-occurring disorders. In addition, the DBHIDS has developed the Journeys of Hope (JOH) programs, which offer year-long substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

Safe Haven and Outreach staff have been trained in providing Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify more needed resources and treatment for people. In 2017 DBHIDS provided an Opioid Task Force to work with the community around needs. In 2018 additional respite beds have been planned for and implemented, and services have been increased for treatment, expanded Medical Assisted Treatment slots, and Housing First slots that target people with OUD.

At present there is a homeless encampment resolution pilot in 4 growing encampments in the Philadelphia neighborhood of Kensington, fueled by the growing opioid crisis in Philadelphia. The City is relying heavily on outreach and connection to treatment and services.

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.

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Justice-Involved
DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. If the trend remains constant, about 30% of the PATH clients served have a criminal history.

DBHIDS has also partnered this year with First Step Staffing to employ persons who are homeless or have a homeless history and people leaving the criminal justice system. This is a new partnership and First Step staffing is already working with people in PATH-funded Safe Havens to connect people to full-time employment.

Data
Outreach Staff have been upgraded to using tablets to do 'real time' data input into the outreach data system. With this system, weekly reports are generated for all outreach contacts and are shared with supervisors to use as a management tool. PATH Safe Haven and Outreach Providers have been trained in the HMIS system this year and submit data required by PATH. Safe Havens are now able to put in housing assessments and work with people to be part of the prioritized By Name List for Coordinated Entry. Project Home outreach is also using HMIS for their PATH data. DBHIDS and OHS continue to work on data needs between both Departments. Philadelphia is on its third HMIS product, ClientTrack. All PATH-funded programs entering data into HMIS have a written HMIS manual for reference and it is made available to new and current employees.

Alignment with PATH Goals
DBHIDS and the City continue to use street Outreach data to determine chronicity and people who are the most vulnerable and have spent the most times on the street to help inform eligibility for Housing First services, Safe Havens and any other housing options available through the OHS Clearinghouse/PHA or DBH reinvestment dollars. Data is and will be entered into HMIS to continue to create the HMIS Prioritized By Name list through contacts and the VISPDAT and housing assessments in the new CEA-BHRS system.

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

NOT FINAL

Medical Examiner's Office (MEO), the Prison System as well as many others. We utilize this process to ask ourselves what can we do better as a system to prevent homeless deaths.

The City, Outreach and it's various stakeholders have been working together around folks seeking housing that came from the 100 Day Challenge initiative to coordinate and collaborate around homelessness, looking to ways to decrease homelessness on the streets of Philadelphia. We continue to find ways to increase all collaborative efforts leading up to the system's Coordinated Entry process (CEA-BHRS) which includes utilizing HMIS to collect data, create a prioritized by name list, and using housing assessments and the VISPDAT. The homeless system is currently being trained in all these activities.

Safe Haven staff provide varying case management duties around connection to housing and work closely with residents and DBHIDS to provides these services.

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.

Alignment with State Plan to End Homelessness

$43M of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have been and are in the process of receiving Narcan training and K2 training which has been increasing in Philadelphia.

Project Home and DBHIDS have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services plans for disasters and emergencies in collaboration with the Philadelphia Office of Emergency Management, the Philadelphia Department of Public Health, and other City and community response stakeholders. Those plans include, but are not limited to evacuation, mass sheltering, points of dispensing for mass prophylaxis, and mass casualty events. Planning for Access and Functional Needs continues to be a priority in all of our planning efforts.

NOT FINAL

DBHIDS continues to work closely with homeless advocacy and service agencies during major events and incidents in Philadelphia in order to insure that homeless persons living on the street are contacted and surveyed prior to notice events, they receive timely information about events, and are offered services and supports during events based upon their identified preferences. In addition, particular attention is paid to planning for severe winter and severe heat periods, which results in additional resources and services being deployed in support of those on the street. Through our planning, outreach, and response efforts, resources continue to be identified and utilized by the homeless, resulting in some specific successes in providing housing to several long-term homeless individuals. Lessons learned in these major incidents continue to inform our planning. Additionally, Safe Haven and Outreach staff must complete Mental Health First Aid (MHFA) training which enables staff to intervene in the instance of a mental health crisis.

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. Last year, a seventh Outreach Team had been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City. This outreach team provides service to many people who are homeless and experiencing OUD for services, housing and treatment in the neighborhood of Kensington.

One RHD PATH-funded Safe Haven targets emerging adult males, and a second Emerging Adults Safe Haven has opened targeted females. We are seeing approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs and staff are working on training and supports for Outreach and Safe Havens to address needs of this population.

In the last year there access to Housing Choice Vouchers through PHA has virtually ended. This did slow down our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities. This year we have been working with the 811 program, started a Shallow Rent Subsidy pilot and received city funding for increased housing subsidies that came out of a need during the 100 day chronic team initiative.

Other Designated Funds

DBHIDS spends $50M 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.

NOT FINAL

Programmatic and Financial Oversight
The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitors the use of PATH funds through our fiscal and operations unit and has oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Cedar Park, La Casa and Kailo Haven, sends referrals in coordination with outreach, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical and daily support to all PATH-funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR)
Homeless Advocacy Project (HAP) had been providing SOAR to people in Safe havens and JOH as well as people who are homeless working with Outreach. HAP also works with people in OHS shelter and are connected to DHS for aging out youth. HAP has trained 2 staff members hired for this project (1 FT and 1 PT) and 7 HAP staff members have provided assistance with the DBH/SOAR project and there are additional staff provides representation in other SOAR projects. HAP has filed 73 DHB/HAP SOAR applications with 58 approvals and 0 denials, the rest are pending and the total average processing time is 58 days.

Access to Housing
Outreach participants have access to the DBH safe haven system that includes all three PATH-funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens have very limited access to these resources, these have been severely limited.

- OHS Clearinghouse opportunities, 50 811 subsidies targeted to people in JOH and Safe Haven if no other priorities presented, and Senior Housing

- Exclusive access to openings in the city's inventory of 705 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.

- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project

NOT FINAL

- Priority access to Mobile Psychiatric Rehabilitation Services (MPRS) including programs operated by RHD, Horizon House and Northwestern Human Services
- Additional slots created by the City after the 100 Day Challenge process including Housing First, Rapid Re-Housing and 1260 Housing Development Corporation
- 30 subsidies for Shallow Rent Pilot
- Bridge Vouchers utilizing DBHIDS reinvestment funds

Coordinated Entry
DBHIDS has worked closely with OHS and the COC, along with many providers (including Project Home and RHD) to help develop and implement the Coordinated Entry system in Philadelphia (CEA-BHRS). Safe Havens and PATH Outreach have been trained in HMIS and the VISPDAT and Safe Havens are now able to do housing assessments directly into HMIS. We are now preparing to implement a workgroup to do assessments as the system continues. Mobile assessors are also in process to help people on the street do housing assessments in partnership with Outreach.

There are some barriers to housing and treatment for PATH-eligible consumers in the safe haven programs as they are not awarded a point in the VISPDAT for street homelessness since they are now in safe havens for people who are considered chronic. Also some questions in the VISPDAT may not target their experiences or address their severity of behavioral and mental health needs. Lastly out outreach teams are still not able to utilize the system due to privacy and data concerns, but that is being worked through. Lastly we are working closely with the City, Providers and stakeholders to address these concerns.

Justice Involved
Crisis Intervention Training (CIT) is being used by the City of Philadelphia DBHIDS. The targeted goal was to train 35% of Philadelphia Police and we exceeded this number. The total number of all personnel trained to date is 2943. Per personal testimonies from the officers the training is extremely helpful. There has been recognition of officers who have saved lives by using the training.

Staff Information
All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies and health disparities. Trainings occur in the Summer and Winter of each year and cover a variety of important topics with regards to training. We do not collect demographic data on staff serving PATH clients.

NOT FINAL

Efforts continue to ensure that all providers are aware and trained in appropriate sensitivity measures (i.e. cultural, religious, LGBTQ, etc.). All of the DBHIDS Safe Havens work with transgender individuals and will accept a person based on their gender-identity, not on their demarcated gender at birth. In order to effectively engage with all participants, all staff are required to receive and respect all clients regardless of their cultural, religious, sexual, or gender differences.

Some of our PATH-funded program staff are CPS, but all programs have peers, persons with lived experience and CPS staff available that are not funded by PATH.

Client Information

The projected number of people to be contacted by the PATH-funded Project Home Outreach team and safe havens is approximately 3300 of which are unduplicated people. Out of the 3300 people, we expect approximately 800 are expected to become enrolled in outreach and safe havens. 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:

- 80.8 had both co-occurring substance abuse and behavioral health issues
- 5.6% veterans
- 58.5% black/African-American
- 33% white
- 71.5% male
- 28.5% female
- 15.2% between the ages of 18-29
- 22.1% between the ages of 30-39
- 22.9% between the ages of 40-49
- 26.5% between the ages of 50-59
- 13.3% aged 60+

NOT FINAL

Consumer Involvement

DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. Inclusivity efforts, with regard to planning and service initiatives, have increased in response to the DBHIDS' Recovery Transformation model that is implemented across the behavioral health care system. Numerous task forces have been organized to address programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia.

Safe Havens have access to Peer Specialists that come to the location and participate with residents in a variety of ways that are based on the interest and needs of the residents.
In an effort to engage families and help with a variety of needs and resources, DBHIDS also runs the Family Support Network; a place where families can stop-by to receive guidance they may need. Safe Havens are also part of the Safe Haven Learning Collaborative and participate fully in transforming the Safe Haven system to align with DBHIDS Practice Guidelines for a recovery oriented system. They also work with outreach to create a warmer hand off in alignment with these principles.

Finally, DBHIDS' Office of Mental Health prepares an Annual Plan for Mental Health Services. This plan is distributed on an annual basis to the public, the Community Support Program (CSP) and provider agencies. A forum is then offered to the community to provide comments, feedback, and suggest programs and services for inclusion in the plan. This public forum is open to consumers, family members, as well as the provider community.

Health Disparities Impact Statement
Mental Health and physical health are strongly linked. 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 80.8% male and 58.5% 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. There are outreach workers who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH-funded staff are included in this data system.

15.2% of the street population are between the ages of 18-29, which shows a slight decrease from last year, and RHD La Casa Safe Haven was transitioned to serve the Youth and Young Adult population to better meet the needs of males within this age group and to create a bridge to Permanent Supported Housing. Outreach expects to enroll approximately 115 YYA and PATH expects to enroll approximately 20 YYA into the 3 PATH-funded safe havens. LaCasa expects to enroll 10 YYA males and approximately 10% of Cedar Park and Kailo Haven also engage YYA, so overall PATH-funded safe havens expect to enroll 20 people. All PATH-funded

NOT FINAL

programs expect to enroll 135 YYA. DBHIDS works closely with Youth and Young Adult outreach and shelter Providers and utilize the TAY VISPDAT in HMIS.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

Limited English Proficiency
PATH-funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative
The PATH Funds received are allocated for the wages and salaries of the Outreach Workers and Safe Haven Staff. This includes the cost of salaries for 35 staff in three residential programs and 5 outreach staff. All of the staff listed on the PATH 2019-2020 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

NOT FINAL

Phila Comprehensive Budget

Project Home Outreach	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Case Manager 100%	$30,388	100%	$30,388	$30,388
Case Aide	$24,165	35%	$8,458	$8,458
Response Worker	$32,588	100%	$32,588	$32,588
Response Worker	$27,080	100%	$27,080	$27,080
Response Worker	$24,992	100%	$24,992	$24,992
Subtotal	**$139,213**			**$123,506**

RHD - Kailo Haven	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Clinical Manager	$60,000	100%	$60,000	$60,000
Program Mgr	$40,000	100%	$40,000	$40,000
Supervisor	$32,000	100%	$32,000	$32,000
Supervisor	$28,497	100%	$28,497	$28,497
Peer Specialist	$11,025	100%	$11,025	$11,025
Case Mgr	$39,585	100%	$39,585	$39,585
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Resident Advisor	$21,840	100%	$21,840	$21,840
Subtotal	**$385,827**			**$385,827**

RHD - Cedar Park	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Program Manager	$67,000	100%	$67,000	$67,000
Case Mgr	$39,599	100%	$39,599	$39,585
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880

NOT FINAL

Resident Advisor	$22,880	100%	$22,880	$22,880
Resident Advisor	$22,880	100%	$22,880	$22,880
Subtotal	**$289,639**			**$289,639**

RHD - La Casa	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Program Manager	$60,000	100%	$60,000	$60,000
Case Manager	$45,000	100%	$45,000	$45,000
Residential Advisor	$26,109	99.95%	$26,095	$26,095
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Residential Advisor	$25,880	100%	$25,880	$25,880
Subtotal	**$338,135**			**$338,135**

Grand Total				**$1,137,107**

NOT FINAL

Philadelphia County - Project HOME
1515 Fairmont Ave.
Philadelphia, PA 19130
Contact: Carol Thomas

Provider Type: Social service agency
PDX ID: PA-042
State Provider ID: 4242
Contact Phone #: 2152327272

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	n/a
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

Project Home will receive a total of $123,506 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 3,000

Estimated Number of Persons to be Enrolled: 870

Estimated Number of Persons to be Contacted who are Literally Homeless: 3,000

Number staff trained in SOAR in grant year ending in 2018: 4

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Project HOME: Street Outreach
1515 Fairmount Avenue
Philadelphia, PA 19130
2017-2018 PATH Intended Use Plan
Philadelphia County

Local Provider Description

The mission of the Project HOME (PA-042 Philadelphia: Project HOME) community is to empower persons to break the cycle of homelessness and poverty, to address structural causes of poverty, and to enable all of us to attain our fullest potential as individuals and as members of the broader society. Project Home achieves this through the provision of a continuum of care comprised of street outreach; supportive housing; and comprehensive services including health care, education, and employment. They also address the root causes of homelessness through neighborhood revitalization programs, including affordable housing development; employment training and opportunities; adult and youth education; health care; and environmental enhancement. Project HOME strives to create a stable and secure environment where we support each other in our struggles for self-esteem, recovery and the confidence to move toward self-actualization. The work of Project Home is rooted in our strong spiritual conviction of the dignity of each person.

More detailed information regarding Project HOME can be found at their Web site, www.projecthome.org. Project Home recently received national recognition from the National Alliance to End Homelessness (NAEH) for non-profit sector achievement. Project Home, founded in 1988, has been a local and national leader in outreach to street homeless individuals through their Outreach Coordination Center (OCC). Project Home is a non-profit social service agency that contracts with the Philadelphia County Department of Behavioral Health for residential and homeless services. Project HOME coordinates all city supported outreach

Project HOME will receive $123,506 from PATH Funding; all of which is federally allocated. Project Home, as indicated below, actively involves consumers and families in all of its activities, including staff hiring and volunteer opportunities. Further, outreach works to engage the person where they are, offer choices, and where appropriate, refer to mental health or substance abuse treatment programs as part of the behavioral health care continuum.

Project	Federal Allocation	State Allocation	Total Allocation
Project Home - Outreach	$ 92,629	$ 30,877	$ 123,506
Total	**$ 92,629**	**$ 30,877**	**$ 123,506**

Collaboration with the HUD Continuum of Care (CoC) Program

NOT FINAL

Project HOME is a primary recipient of local CoC funds, as well as the lead Outreach and Homeless Advocacy Organization in the city.

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 attends the Philadelphia Continuum of Care CoC Board (PA-500 Philadelphia CoC) meetings and sub committees and contributes to the vision, development and management of the CoC. The PATH Coordinator sits on the local CoC board. Philadelphia's CoC meets every 2-months. Persons who receive PATH-funded services are a high priority for CoC resources.

Coordination 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 2018, 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. The Hub of Hope provides services included medical and psychiatric services as well as peer support and case management services, and this year has expanded to a daily model with showers, laundry and food services throughout the year. In the past the Hub of Hope was a winter initiative but is now offering services daily and year long. 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.

With regards to Project Home's outreach efforts, all outreach teams are overseen by a County Coordinator of DBH Homeless Outreach Services who holds biweekly meetings to ensure lines of communication are open and coordination is smooth. In addition, all teams are responsible for adhering to shared policies and procedures. Meetings focus on hot spots, current issues and reviewing people on the streets and their needs.

Service Provision

PATH eligibility

PATH eligibility for enrollment to the County PATH-funded programs, safe havens and outreach, include being literally homeless, 18 years of age or older, experiencing Serious Mental Illness and agreement to the PATH-funded services.

Alignment with PATH goals to target street outreach and case management

Philadelphia continues to use data to identify, target and prioritize the most vulnerable people on the street with the longest histories of homelessness to link to needed housing and service resources. This information is used to identify people who are eligible for Safe Havens and JOH emergency housing, and any other housing options so that these are the prioritized people targeted for housing resource. This year there will be continued collaboration around creating a

NOT FINAL

prioritized By Name List of people from the city's OHS Coordinated Entry process in HMIS (CEA-BHRS). The collaboration between various City of Philadelphia departments as well as provider agencies enables ongoing dialogue and cooperation to ensure that each individual is receiving the level of care and services that are most appropriate for them. This includes situations where individuals are enrolled in PATH but it becomes apparent that they are eligible for other services and funding streams (i.e. Medicaid, Medicare). This transfer allows us to leverage the PATH funds allocated to serve the most individuals possible.

Street & Shelter Outreach

Seven street outreach teams are deployed city-wide in Philadelphia on a year round basis. These services have been expanded to provide 24 hour outreach. PATH-funded staff are included in these efforts and are deployed throughout the city, targeting the City as well as identified "hot spots". During periods of severe winter or summer weather, outreach hours are extended in order to prevent weather-related injuries or death. Individuals who are PATH-eligible and are reached via Outreach efforts, are given access to Respite and Café-style overnight placements, Safe Havens, JOH or shelter placement, on a referral basis. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic homelessness. Outreach is also highly involved and focused on target hotspots in Philadelphia to work with people with Opioid Use Disorder to connect to services, treatment and housing when possible.

Project Home has also newly initiated a pilot project in downtown Philadelphia, coordinating outreach teams with the Philadelphia Police Department and the Center City District to help facilitate placements for people who are street homeless to connect to housing, treatment and medical care.

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.

Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with six social service agencies for the provision of 253 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. Two of these programs are specified for the Emerging Youth population, one for couples and 10 additional winter respite beds. 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 through CEA-BHRS and DBHIDS.

Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 90% during CY

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2017, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process. DBHIDS also coordinates other housing projects with OHS to help link people to additional subsidies such as 811 vouchers, a shallow rent subsidy pilot, and housing options made available through the 100 day challenge. City departments and providers and stakeholders work closely together to help make these transitions possible with added services. DBHIDS also utilizes bridge subsidies for people in mental health residential slots using reinvestment funds.

The transitional housing programs serving homeless adults in Philadelphia remain full. Despite capacity expansion, there remains a substantial unmet need for permanent supported housing for homeless individuals who are graduating from these transitional programs. As is the case for persons who do not currently meet the federal definition of homelessness but have no current place to go, as well as persons incarcerated over 90 days but were homeless upon prison admission and will be homeless upon prison discharge.

Evaluation Services

Homeless persons who require emergency psychiatric assessment and stabilization services are afforded access to an eight bed crisis residence (Emergency Evaluation Center - EEC) or to five (5) Crisis Response Centers (CRCs). An assessment and treatment team, including psychiatrist time, has been funded to work closely with the Office of Supportive Housing (OSH) Intake sites, shelters.

Service Coordination: Access to the EEC and Crisis Response Center services is centrally coordinated by the DBHIDS Acute Services Unit. The CRCs accept walk-ins. DBHIDS has a Homeless Services Unit that is responsible for the coordination of homeless services.

Coordination & Planning

The DBHIDS participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Commissioner of the Office of Homeless Services (OHS). These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan(Code Red), outreach planning and hotspots, working with the larger community and City stakeholders, 100 Day Challenge housing slots, Coordinated Entry (CEA-BHRS) and planning for people who are chronically homeless, not chronically homeless, and the emerging adult population. This also includes planning and evaluating continuing needs around housing assessment and the prioritized By Name List. All Safe Havens have been trained in HMIS and the VISPDAT and the TAY-VISPDAT to assess vulnerability and housing needs. Both OHS and DBHIDS work closely together and with Providers as well to ensure services are provided to those with mental and behavioral health needs.

Veterans

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.

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Recovery Support

Outreach is designed to engage the most vulnerable persons living on our streets and assist them in moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), outreach can respond to most needs they are presented with. Project Home partners with the Mental Health Association of Southeastern PA (MHASP) to offer peer engagement services to persons living in Philadelphia's transportation hub of Suburban Station, Hub of Hope which has moved to a larger location in the station and now provides daily and increased services throughout the year. People transitioning to and living in housing have access to CPS services. Residents in Safe Havens work with peers in house or residents that take on leadership and peer roles, as well as Peer Advisory and Alumni groups.

Maximizing use of PATH funds

Agencies do leverage other available funds outside of PATH. US Veterans access VA services first and there are other county funds available for people including DBHIDS funded safe havens and DBHIDS and other funded outreach teams.

The City of Philadelphia is committed to aiding the State and bolstering supports following the lawsuit filed by the American Civil Liberties Union (ACLU). These actions include more definition attention and efforts around the movement of individuals from both the forensic and civil units at Norristown State Hospital (NSH). DBHIDS mental health services providers help coordinate with community based supports to assist the individual with linkages to employment, education, mental health treatment, healthcare, and other community based activities to help prevent recidivism. Additional efforts are put in place to assist individuals with building skills of independent living so that she/he may move on some day to his/her highest attainable level of independent living.

Gaps in current service systems

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 24th, 2018 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 834 persons were sleeping on the streets of Philadelphia. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly. Increasing numbers may be due to lack of housing resources, increased persons with Opioid Use Disorder in the City of Philadelphia, and a small amount of affordable housing. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

Services for clients who have both SMI and a substance use disorder

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

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(JOH) programs, which offer yearlong substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

Safe Haven and Outreach staff have been trained in providing Narcan; an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify more needed resources and treatment for people. In 2017 DBHIDS provided an Opioid Task Force to work with the community around needs. In 2018 additional respite beds have been planned for and implemented, and services have been increased for treatment, expanded Medical Assisted Treatment slots, and Housing First slots that target people with OUD.

At present, there is a homeless encampment resolution pilot in 4 growing encampments in the Philadelphia neighborhood of Kensington, fueled by the growing opioid crisis in Philadelphia. The City is relying heavily on outreach and connection to treatment and services.

42 CFR Part 2
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.

Justice-Involved
DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. If the trend remains constant, about 30% of the PATH clients served have a criminal history.

DBHIDS has also partnered this year with First Step Staffing to employ persons who are homeless or have a homeless history and people leaving the criminal justice system. This is a new partnership and First Step staffing is already working with people in PATH-funded Safe Havens to connect people to full-time employment.

Data
Outreach Staff have been upgraded to using Tablets to do ‘real time’ data input into the outreach data system. With this system, weekly reports are generated for all outreach contacts and are shared with supervisors to use as a management tool. PATH Safe Haven and Outreach Providers have been trained in the HMIS system this year and submit data required by PATH. Safe Havens

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are now able to put in housing assessments and work with people to be part of the prioritized By Name List for Coordinated Entry. Project Home outreach is also using HMIS for their Path data. DBHIDS and OHS continue to work on data needs between both Departments. There is a goal for Project Home and all of outreach to share data with HMIS and do Housing Assessments and VISPDAT, and/or work with Mobile Assessors and Access Points who are able to provide. Philadelphia is on its third HMIS product, ClientTrack. All PATH-funded programs entering data into HMIS have a written HMIS manual for reference and it is made available to new and current employees.

Alignment with PATH goals

DBHIDS and the City continue to use street Outreach data to determine chronicity and people who are the most vulnerable and have spent the most times on the street to help inform eligibility for Housing First services, Safe Havens and any other housing options available through the OHS Clearinghouse/PHA or DBH reinvestment dollars. Data will also will be entered into HMIS to continue to create the HMIS Prioritized By Name list through contacts and the VISPDAT and housing assessments in the new CEA-BHRS system.

Alignment with State Mental Health Services Plan

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 we can do better as a system to prevent homeless deaths.

The City, Outreach and its various stakeholders have been working together around the 100 Day Challenge model to coordinate and collaborate around homelessness, again looking to ways to decrease homelessness on the streets of Philadelphia. With a new administration in the City and several Departments, we continue to find ways to increase all collaborative efforts. These efforts have led to the By Name List, Coordinated Entry and utilizing the VISPDAT as an assessment tool.

Alignment with State Plan to End Homelessness

$43M of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have been and

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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.

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services plans for disasters and emergencies in collaboration with the Philadelphia Office of Emergency Management, the Philadelphia Department of Public Health, and other City and community response stakeholders. Those plans include, but are not limited to evacuation, mass sheltering, points of dispensing for mass prophylaxis, and mass casualty events. Planning for Access and Functional Needs continues to be a priority in all of our planning efforts.

DBHIDS continues to work closely with homeless advocacy and service agencies during major events and incidents in Philadelphia in order to ensure that homeless persons living on the street are contacted and surveyed prior to notice events, they receive timely information about events, and are offered services and supports during events based upon their identified preferences. In addition, particular attention is paid to planning for severe winter and severe heat periods, which results in additional resources and services being deployed in support of those on the street. Through our planning, outreach, and response efforts, resources continue to be identified and utilized by the homeless, resulting in some specific successes in providing housing to several long-term homeless individuals. Lessons learned in these major incidents continue to inform our planning. Additionally, Safe Haven and Outreach staff must complete Mental Health First Aid (MHFA) training which enables staff to intervene in the instance of a mental health crisis.

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. Last year, a seventh Outreach Team had been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City. Hotspots with multiple people who are homeless and experiencing OUD are also being targeted for services, housing and treatment.

One RHD PATH-funded Safe Haven targets emerging adult males, and a second Emerging Adults Safe Haven has opened targeted females. We are seeing approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs and staff are working on training and supports for Outreach and Safe Havens to address needs of this population.

In the last several years access to Housing Choice Vouchers through PHA has virtually ended. This did slow down our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities. This year we have been

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working with the 811 program, started a Shallow Rent Subsidy pilot and received city funding for increased housing subsidies that came out of a need during the 100 day chronic team

Other Designated Funds
DBHIDS spends $50M annually for persons experiencing homelessness; this includes funding from Medicaid, the Mental Health Block Grant and the Substance Abuse Block Grant. Different funding streams are work in collaboration to fund our efforts with the Journey of Hope Programs, Housing First Services and Safe Havens. It should be noted that these funds are not specifically designated to only serve people who are experiencing homelessness and have a serious mental illness (SMI), as some of the funds are designated for addiction services. Additionally, none of the designated funds are earmarked specifically for PATH services.

Programmatic and Financial Oversight
The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Cedar Park, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS provides daily support to all PATH-funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR)
Homeless Advocacy Project (HAP) had been providing SOAR to people in Safe havens and JOH as well as people who are homeless working with Outreach. HAP also works with people in OHS shelter and are connected to DHS for aging out youth. HAP has trained 2 staff members hired for this project (1 FT and 1 PT) and 7 HAP staff members have provided assistance w/the DBH/SOAR project and there are additional staff provides representation in other SOAR projects. HAP has filed 73 DHB/HAP SOAR applications with 58 approvals and 0 denials, the rest are pending and the total average processing time is 58 days.

Access to Housing
Outreach participants have access to the DBH safe haven system that includes all three PATH-funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens have very limited access to these resources, these have been severely limited.

- OHS Clearinghouse opportunities, 50 811 subsidies targeted to people in JOH and Safe Haven if no other priorities presented, and Senior Housing

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- Exclusive access to openings in the city's inventory of 705 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.

- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project. .

- Priority access to Mobile Psychiatric Rehabilitation Services (MPRS) including programs operated by RHD, Horizon House and Northwestern Human Services.

- Additional slots created by the City after the 100 Day Challenge process including Housing First, Rapid Re-Housing and 1260 Housing Development Corporation

- 30 subsidies for Shallow Rent Pilot

- Bridge Vouchers utilizing DBHIDS reinvestment funds.

Coordinated Entry
DBHIDS has worked closely with OHS and the COC, along with many Providers including Project Home and RHD to help develop and implement the Coordinated Entry system in Philadelphia (CEA-BHRS). Safe Havens and PATH Outreach have been trained in HMIS and the VISPDAT and Safe havens are now able to do housing assessments directly into HMIS. We are now preparing to implement a workgroup to do assessments as the system continues. Mobile assessors are also in process to help people on the street do housing assessments in partnership with Outreach.

There are some barriers to housing and treatment for PATH-eligible consumers in the safe haven programs as they are not awarded a point in the VISPDAT for street homelessness since they are now in safe havens for people who are considered chronic. Also some questions in the VISPDAT may not target their experiences or address their severity of behavioral and mental health needs. Lastly out outreach teams are still not able to utilize the system due to privacy and data concerns, but that is being worked through. Lastly we are working closely with the City, Providers and stakeholders to address these concerns.

Justice Involved
Crisis Intervention Training (CIT) is being used by the City of Philadelphia DBHIDS. The targeted goal was to train 35% of Philadelphia Police and we exceeded this number. The total number of all personnel trained to date is 2943. Per personal testimonies from the officers the training is extremely helpful. There has been recognition of officers who have saved lives by using the training.

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Staff Information
All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies and health disparities. We do not collect demographic information on staff serving PATH clients.

Efforts continue to ensure that all providers are aware and trained in appropriate sensitivity measures (i.e. cultural, religious, LGBTQ, etc.). All of the DBHIDS Homeless Outreach work with transgender individuals and will accept a person based on their gender-identity, not on their demarcated gender at birth. In order to effectively engage with all participants, all staff are required to receive and respect all clients regardless of their cultural, religious, sexual, or gender differences.

Some of our PATH-funded program staff are CPS, but all programs, including Project Home, have peers, persons with lived experience and CPS staff available that are not funded by PATH.

Client Information
The projected number of people to be contacted by the PATH-funded Project Home Outreach team and safe havens is approximately 3300 of which are unduplicated people. Out of the 3300 people we expect approximately 800 are expected to become enrolled in outreach and safe havens. 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). Project Home expects to enroll 700 people. The following are the demographics of those who received Outreach contacts:

- 80.8% had both co-occurring substance abuse and behavioral health issues
- 5.6% veterans
- 58.5% black/African-American
- 33% white
- 71.5% male
- 28.5% female
- 15.2% between the ages of 18-29
- 22.1% between the ages of 30-39
- 22.9% between the ages of 40-49
- 26.5% between the ages of 50-59
- 13.3% 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

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task forces have been organized to address programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia.

CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. All DBHIDS services operated by Project HOME participate in the CST process. Safe Havens have access to Peer Specialists that come to the location and participate with residents in a variety of ways that are based on the interest and needs of the residents. Project Home has advisory boards that residents can attend and join. DBHIDS also runs the Family Support Network in an effort to engage families and help with a variety of needs and resources.
Project HOME Street outreach engages homeless individuals and families living on the streets of Philadelphia. Outreach represents building a reliable relationship that can allow individuals to consider coming inside and accepting services. The approach to services is person first, strength-based and trauma informed and Project Home recognizes that individuals with behavioral health challenges and other barriers such as deep poverty and lack of resources need assistance and care in order to increase their resources and make informed choices about their array of options.

Project HOME offers and connects people to emergency shelter placement, Safe Haven placements, and Drug and Alcohol referrals to either assessment centers at the CRCs, Journey of Hope or outpatient options. People without insurance to pay for care are referred to BHSI. The team operates within the Outreach Coordination Center (OCC) to answer to response calls for homeless individuals and families through the City's outreach homeless hotline.

In the case of families on the street the goal is to link the family to Office of Supportive Housing (OHS) emergency services for their immediate housing needs. Outreach will transport them to the after-hour services and shelter as well as, advocate for their immediate needs and if requested by the family will assist with other services including information about permanent housing as applicable. If families refuse services and have vulnerable children we inform them that we are mandatory reporters and that we must make decisions based on the safety of the child or children. Finally, the overall approach of Project HOME outreach is to assist persons in identifying their needs, wants and desires as they recover their lives within the framework of our mission which is listed below:

Health Disparities Impact Statement
Behavioral 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. 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

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teams target underserved populations who are more likely to experience behavioral health disparities.

Philadelphia's street homeless population has been found to be 80.8% male and 58.5% 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. Outreach has staff that are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH-funded staff are included in this data system.

15.2% of the street population are between the ages of 18-29, which shows a slight decrease from last year, and RHD La Casa Safe Haven was transitioned to serve the Youth and Young Adult population to better meet the needs of males within this age group and to create a bridge to Permanent Supported Housing. Outreach expects to enroll approximately 115 YYA and PATH expects to enroll approximately 20 YYA into the 3 PATH-funded safe havens. Lacasa expects to enroll 10 YYA males and approximately 10% of Cedar Park and Kailo Haven also engage YYA, so overall PATH-funded safe havens expect to enroll 20 people. All PATH-funded programs expect to enroll 135 YYA. DBHIDS works closely with Youth and Young Adult outreach and shelter Providers and utilize the TAY VISPDAT in HMIS. Project Home estimates that $1235 will be used for YYA.

Project Home works with both safe havens and provides the warm hand-off for youth on the street. Project Home collaborates with the Synergy Project, a youth outreach provider.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

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Limited English Proficiency PATH-funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative

The PATH funds received are allocated to cover the salaries and benefits for 5 outreach staff. All of the staff listed on the PATH 2019-2020 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
PATH – Phila Co
Project Home 2019.2020

Project Home Outreach	**Annual Salary**	**PATH-funded FTE**	**PATH-funded salary**	**TOTAL**
Case Manager 100%	$30,388	100%	$30,388	$30,388
Case Aide	$24,165	35%	$8,458	$8,458
Response Worker	$32,588	100%	$32,588	$32,588
Response Worker	$27,080	100%	$27,080	$27,080
Response Worker	$24,992	100%	$24,992	$24,992
Total	**$139,213**			**$123,506**

Grand Total				**$123,506**

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Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

RHD-Cedar Park will receive a total of $289,639 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 55

Estimated Number of Persons to be Enrolled: 50

Estimated Number of Persons to be Contacted who are Literally Homeless: 55

Number staff trained in SOAR in grant year ending in 2018: 4

Number of PATH-funded consumers assisted through SOAR: 1

NOT FINAL

Resources for Human Development: Cedar Park
4700 Wissahickon Avenue
Philadelphia, PA 19144
2019-2020 PATH Intended Use Plan
Philadelphia County

Local Provider Description

Resources for Human Development (RHD) is a non-profit community behavioral health services organization center that provides a full continuum of mental health, substance abuse and physical health services. The Philadelphia County Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) contracts with RHD to provide mental health services, including PATH funded resources. Cedar Park (PA-043 Philadelphia: Resources for Human Development – Cedar Park) is a Safe Haven located 4926 Baltimore Avenue, Philadelphia, PA 19143. The PATH funds received cover part of the cost of the supportive staff at this location.

Cedar Park serves women with serious and persistent mental illness, and persons with co-occurring substance abuse issues who are considered chronically street homeless. This program is centrally gatekept by Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS) and is contained within the County's residential care continuum.

Cedar Park will receive $289,639 from PATH funding; all of which is allocated from the state.

Project	Federal Allocation	State Allocation	Total Allocation
RHD - Cedar Park	$ 211,868	$ 77,771	$ 289,639
Total	**$ 211,868**	**$ 77,771**	**$ 289,639**

Coordination with the HUD Continuum of Care (CoC) Program

Cedar Park, represented by RHD, is a key participant in the Philadelphia Continuum of Care (CoC), Board, PA-500, and is the recipient of a variety of CoC grants to provide permanent supportive housing (PSH) to persons with serious mental illness.

In addition, RHD and Cedar Park work very closely with Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS). The Department of Behavioral Health and Intellectual disAbilities (DBHIDS) allocates $50M for an array of homeless services through its contracted agencies including housing (transitional and permanent), residential support, case management, and outreach and evaluation.

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The DBHIDS PATH coordinator as well as RHD, sits on the local Continuum of Care (CoC) Board or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinator have been involved with last year's 100 Day Challenge in Philadelphia, including the housing initiative that came out of that process, and part of the Coordinated Entry planning, discussions, training and implementation. 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 multiple meetings between the Office of Homeless Services (OHS), RHD, and DBHIDS, and continual coordination regarding people in Safe Havens, including Cedar Park, to identify housing, housing needs and challenges that may arise.

Collaboration with Local Community Organizations

The designated PATH providers and 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 management by homeless and formerly homeless persons, called "One Step Away." RHD also operates three drug and alcohol treatment programs (JOH) that serve exclusively chronically homeless individuals, New Start I, New Start II and Womanspace. They also run a federally qualified health center that offers low or no cost health care services for the uninsured or underinsured. The agency offers supportive employment programming that is available to PATH clients and has an inventory of Permanent Supportive Housing and is the recipient of numerous McKinney/COC grants. RHD also works with Horizon House to identify people with the highest need for housing services through their programs (Housing First).

RHD and Cedar Park works closely with outreach teams who are targeting the most vulnerable people on the streets to make the warm handoff and connection into the Safe Haven. They attend joint trainings with outreach teams, as well as monthly Safe Haven Director's meetings where outreach information is updated and vice versa.

Service Provision

PATH eligibility determination

PATH eligibility for enrollment to the County PATH-funded programs, safe havens and outreach, includes being literally or imminently at risk of homeless, 18 years of age or older, experiencing Serious Mental Illness and agrees to the PATH-funded service.

Alignment with PATH goals to target street outreach and case management

Street & Shelter Outreach

Seven street outreach teams are deployed city-wide in Philadelphia on a year round basis. These services have been expanded to provide 24 hour outreach. PATH-funded staff are included in these efforts and are deployed throughout the city, targeting the City as well as identified "hot spots". During periods of severe winter or summer weather, outreach

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hours are extended in order to prevent weather-related injuries or death. Individuals who are PATH eligible and are reached via Outreach efforts, are given access to Respite and Café-style overnight placements, Safe Havens, JOH or shelter placement, on a referral basis. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic homelessness. Outreach is also highly involved and focused on target hotspots in Philadelphia to work with people with Opioid Use Disorder to connect to services, treatment and housing when possible.

Project Home has also newly initiated a pilot project in downtown Philadelphia, coordinating outreach teams with the Philadelphia Police Department and the Center City District to help facilitate placements for people who are street homeless to connect to housing, treatment and medical care.

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.

Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with six social service agencies for the provision of 253 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. Two of these programs are specified for the Emerging Youth population, one for couples and 10 additional winter respite beds. 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 through CEA-BHRS and DBHIDS.

Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 90% during CY 2017, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process. DBHIDS also coordinates other housing projects with OHS to help link people to additional subsidies such as 811 vouchers, a shallow rent subsidy pilot, and housing options made available through the 100 day challenge. City departments and providers and stakeholders work closely together to help make these transitions possible with added services. DBHIDS also utilizes bridge subsidies for people in mental health residential slots using reinvestment funds.

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The transitional housing programs serving homeless adults in Philadelphia remain full. Despite capacity expansion, there remains a substantial unmet need for permanent supported housing for homeless individuals who are graduating from these transitional programs. As is the case for persons who do not currently meet the federal definition of homelessness but have no current place to go, as well as persons incarcerated over 90 days but were homeless upon prison admission and will be homeless upon prison discharge.

Evaluation Services
Homeless persons who require emergency psychiatric assessment and stabilization services are afforded access to an eight bed crisis residence (Emergency Evaluation Center - EEC) or to five (5) Crisis Response Centers (CRCs). An assessment and treatment team, including psychiatrist time, has been funded to work closely with the Office of Supportive Housing (OSH) Intake sites, shelters.

> *Service Coordination:* Access to the EEC and Crisis Response Center services is centrally coordinated by the DBHIDS Acute Services Unit. The CRCs accept walk-ins. DBHIDS has a Homeless Services Unit that is responsible for the coordination of homeless services.

Coordination & Planning
The DBHIDS participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Commissioner of the Office of Homeless Services (OHS). These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan(Code Red), outreach planning and hotspots, working with the larger community and City stakeholders, 100 Day Challenge housing slots, Coordinated Entry (CEA-BHRS) and planning for people who are chronically homeless, not chronically homeless, and the emerging adult population. This also includes planning and evaluating continuing needs around housing assessment and the prioritized By Name List. All Safe Havens have been trained in HMIS and the VISPDAT and the TAY-VISPDAT to assess vulnerability and housing needs. Both OHS and DBHIDS work closely together and with Providers as well to ensure services are provided to those with mental and behavioral health needs.

Veterans
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.

Recovery Support
Outreach is designed to engage the most vulnerable persons living on our streets and assist them in moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive

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housing that is both project based and scattered site), outreach can respond to most needs they are presented with. Project Home partners with the Mental Health Association of Southeastern PA (MHASP) to offer peer engagement services to persons living in Philadelphia's transportation hub of Suburban Station, Hub of Hope which has moved to a larger location in the station and now provides daily and increased services throughout the year. People transitioning to and living in housing have access to CPS services. Residents in Safe Havens work with peers in house or residents that take on leadership and peer roles, as well as Peer Advisory and Alumni groups.

RHD Safe Havens also work with PHA, OHS, DBHIDS and Housing First Providers to secure Permanent Supported Housing for all eligible residents. RHD continues to work with OHS and DBHIDS around the annual winter plan (Code Blue and Winter Initiative beds) and the summer heat emergency plan (Code Red) and participated in the planning of the City's new Coordinated Entry and Planning for people who are chronically and not chronically homeless, as well as the emerging adult population.

Maximizing use of PATH funds
Agencies do leverage other available funds outside of PATH. US Veterans access VA services first and there are other county funds available for people including DBHIDS funded safe havens and DBHIDS and other funded outreach teams.

The City of Philadelphia is committed aiding the State and bolstering supports following the lawsuit filed by the American Civil Liberties Union (ACLU). These actions include more definition attention and efforts around the movement of individuals from both the forensic and civil units at Norristown State Hospital (NSH). DBHIDS mental health services providers help coordinate with community based supports to assist the individual with linkages to employment, education, mental health treatment, healthcare, and other community based activities to help prevent recidivism. Additional efforts are put in place to assist individuals with building skills of independent living so that she/he may move on some day to his/her highest attainable level of independent living.

Gaps in current service systems
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 24th, 2018 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 834 persons were sleeping on the streets of Philadelphia. There are a variety of reasons for seeing an increase in numbers including lack of housing resources, an increasing amount of people with Opioid Use Disorder on the streets, and minimal affordable housing. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

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Services for clients who have both SMI and a substance use disorder
All of the services described above are available for persons with co-occurring substance use disorders and all homeless services programs are expected to develop expertise to serve persons with co-occurring disorders. In addition, the DBHIDS has developed the Journeys of Hope (JOH) programs, which offer yearlong substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

Cedar Park staff have been trained in using Narcan, an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify more needed resources and treatment for people. In 2017 DBHIDS and the City of Philadelphia and stakeholders, started an Opioid Task Force to work with the community around needs. In 2018 additional respite beds have been planned for and implemented, and services have increased for treatment, expanded Medical Assisted Treatment slots, and Housing First slots that are for people with OUD.

At present there is a homeless encampment resolution pilot in 4 growing encampments in the Philadelphia neighborhood of Kensington, fueled by the growing opioid crisis in Philadelphia. The City is relying heavily on outreach and connection to treatment and services. Some of the people living in the encampments will be admitted to safe havens including Cedar Park.

DBHIDS is not responsible for following 42 CFR Part 2 regulations, as we do not provide licensed drug and alcohol outreach programs.

Justice-Involved
DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. Based on these trends, we believe that 30% of PATH clients served have a criminal history.

DBHIDS has also partnered this year with First Step Staffing to employ persons who are homeless or have a homeless history and people leaving the criminal justice system. This is a new partnership and First Step staffing is already working with people in PATH-funded Safe Havens to connect people to full-time employment.

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Data
RHD Cedar Park had been trained in HMIS in the spring of 2017 and is submitting PATH data elements to HMIS. In 2018 Cedar Park staff were trained to do Housing Assessments and the VISPDAT for the CEA-BHRS process to help residents of Cedar Park get connected to housing. Once people are submitted to HMIS and CEA-BRHS they will be part of the prioritized By Name List for housing. All PATH-funded programs entering data into HMIS have a written HMIS manual for reference and it is made available to new and current employees.

Alignment with PATH Goals
Philadelphia continues to use data to identify, target and prioritize the most vulnerable people with the longest histories of street homelessness to link to needed housing and service resources. This information is used to identify people who are eligible for Safe Havens and JOH emergency housing, and any other housing options. This year Cedar Park has begun to do Housing Assessments and the VISPDAT in accordance with the City's new Coordinated Entry system (CEA-BHRS) to create a prioritized By Name List of people in conjunction with City Departments (Office of Homeless Services) and other stakeholders, including Project Home and RHD. Cedar Park admits chronically homeless women to their program. The collaboration between various City of Philadelphia departments as well as provider agencies enables ongoing dialogue and cooperation to ensure that each individual is receiving the level of care and services that are most appropriate for them. This includes situations where individuals are enrolled in PATH but it becomes apparent that they are eligible for other services and funding streams (i.e. Medicaid, Medicare). This transfer allows us to leverage the PATH funds allocated to serve the most individuals possible.

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.

Alignment with State Plan to End Homelessness
$43M of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have received Narcan training and K2 training which has been increasing in Philadelphia.

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DBHIDS and RHD have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services plans for disasters and emergencies in collaboration with the Philadelphia Office of Emergency Management, the Philadelphia Department of Public Health, and other City and community response stakeholders. Those plans include, but are not limited to evacuation, mass sheltering, points of dispensing for mass prophylaxis, and mass casualty events. Planning for Access and Functional Needs continues to be a priority in all of our planning efforts.

DBHIDS continues to work closely with homeless advocacy and service agencies during major events and incidents in Philadelphia in order to ensure that homeless persons living on the street are contacted and surveyed prior to notice events, they receive timely information about events, and are offered services and supports during events based upon their identified preferences. In addition, particular attention is paid to planning for severe winter and severe heat periods, which results in additional resources and services being deployed in support of those on the street. Through our planning, outreach, and response efforts, resources continue to be identified and utilized by the homeless, resulting in some specific successes in providing housing to several long-term homeless individuals. Lessons learned in these major incidents continue to inform our planning. Additionally, Safe Haven and Outreach staff must complete Mental Health First Aid (MHFA) training which enables staff to intervene in the instance of a mental health crisis.

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. A seventh Outreach Team has been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City, ie the Kensington neighborhood in Philadelphia.

In the last few years access to Housing Choice Vouchers through PHA has virtually ended. This did slow down our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars, but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities. This year we have been working with the 811 program, started a Shallow Rent Subsidy pilot and received city funding for increased housing subsidies that came out of a need during the 100 day chronic team initiative and Cedar Park residents are eligible for these resources.

Other Designated Funds

DBHIDS spends $50M 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

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specifically designated to only serve people who are experiencing homelessness and have a serious mental illness (SMI), as some of the funds are designated for addiction services. Additionally, none of the designated funds are earmarked specifically for PATH services.

Programmatic and Financial Oversight

The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Cedar Park, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical support to Cedar Park. DBHIDS provides daily support to all PATH-funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR)

Homeless Advocacy Project (HAP) had been providing SOAR to people in Safe havens and JOH as well as people who are homeless working with Outreach. HAP also works with people in OHS shelter and are connected to DHS for aging out youth. HAP has trained 2 staff members hired for this project (1 FT and 1 PT) and 7 HAP staff members have provided assistance w/the DBH/SOAR project and there are additional staff provides representation in other SOAR projects. HAP has filed 73 DHB/HAP SOAR applications with 58 approvals and 0 denials, the rest are pending and the total average processing time is 58 days.

Access to Housing

Outreach participants have access to the DBH safe haven system that includes all three PATH-funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens have very limited access to these resources, these have been severely limited.

- OHS Clearinghouse opportunities, this year an additional 50 811 subsidies targeted to people in JOH and Safe Haven if no other priorities presented, and Senior Housing

- Exclusive access to openings in the city's inventory of 705 Housing First options, operated by Horizon House and PATHways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by PATHways to Housing.

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- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project.

- Priority access to Mobile Psychiatric Rehabilitation Services (MPRS) including programs operated by RHD, Horizon House and Northwestern Human Services.

- Additional slots created by the City after the 100 Day Challenge process including Housing First, Rapid Re-Housing and 1260 Housing Development Corporation

- 30 subsidies for Shallow Rent Pilot

- Bridge Vouchers utilizing DBHIDS reinvestment funds

Coordinated Entry
DBHIDS has worked closely with OHS and the COC, along with many Providers including Project Home and RHD to help develop and implement the Coordinated Entry system in Philadelphia (CEA-BHRS). Safe Havens and PATH Outreach have been trained in HMIS and the VISPDAT and Safe havens are now able to do housing assessments directly into HMIS. We are now preparing to implement a workgroup to do assessments as the system continues. Mobile assessors are also in process to help people on the street do housing assessments in partnership with Outreach.

There are some barriers to housing and treatment for PATH-eligible consumers in the safe haven programs as they are not awarded a point in the VISPDAT for street homelessness since they are now in safe havens for people who are considered chronic. Also some questions in the VISPDAT may not target their experiences or address their severity of behavioral and mental health needs. Lastly out outreach teams are still not able to utilize the system due to privacy and data concerns, but that is being worked through. Lastly we are working closely with the City, Providers and stakeholders to address these concerns.

Justice Involved
Crisis Intervention Training (CIT) is being used by the City of Philadelphia DBHIDS. The targeted goal was to train 35% of Philadelphia Police and we exceeded this number. The total number of all personnel trained to date is 2943. Per personal testimonies from the officers the training is extremely helpful. There has been recognition of officers who have saved lives by using the training.

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

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trainings on cultural competencies and health disparities. We do not collect demographic information on staff serving PATH clients.

Efforts continue to ensure that all providers are aware and trained in appropriate sensitivity measures (i.e. cultural, religious, LGBTQ, etc.). All of the DBHIDS Safe Havens work with transgender individuals and will accept a person based on their gender-identity, not on their demarcated gender at birth. In order to effectively engage with all participants, all staff are required to receive and respect all clients regardless of their cultural, religious, sexual, or gender differences.

Some of our PATH-funded program staff are CPS, but all programs have peers, persons with lived experience and CPS staff available that are not funded by PATH.

Client Information

The projected number of people to be contacted by the PATH-funded Project Home Outreach team and safe havens is approximately 3300 of which are unduplicated people. Out of the 3300 people we expect approximately 800 are expected to become enrolled in outreach and safe havens. 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:

Cedar Park specifically expects to contact approximately 45 people and enroll 40 people. Most people are contacted and enrolled the same day due to safe haven eligibility criteria being met before referrals are made to the safe havens. 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:

- 80.8% had both co-occurring substance abuse and behavioral health issues
- 5.6% veterans
- 58.5% black/African-American
- 33% white
- 71.5% male
- 28.5% female
- 15.2% between the ages of 18-29
- 21.1% between the ages of 30-39
- 22.9% between the ages of 40-49
- 26.5% between the ages of 50-59
- 13.3% aged 60+

Consumer Involvement

DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. All programs funded by DBHIDS follow the Practice Guidelines and RHD has worked closely with the Safe Haven Learning Collaborative to create the Safe Haven Practice Guidelines. In addition, DBHIDS regularly

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meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia.

Safe Havens have access to Peer Specialists that come to the location and participate with residents in a variety of ways that are based on the interest and needs of the residents.
In an effort to engage families and help with a variety of needs and resources, DBHIDS also runs the Family Support Network; a place where families can stop-by to receive guidance they may need. Safe Havens are also part of the Safe Haven Learning Collaborative and participate fully in transforming the Safe Haven system to align with DBHIDS Practice Guidelines for a recovery oriented system. They also work with outreach to create a warmer hand off in alignment with these principles. Cedar Park requests that every resident list a family member or someone they consider to be family to program events and DBHIDS concurrent reviews.

Finally, DBHIDS' Office of Mental Health prepares an Annual Plan for Mental Health Services. This plan is distributed on an annual basis to the public, the Community Support Program (CSP) and provider agencies. A forum is then offered to the community to provide comments, feedback, and suggest programs and services for inclusion in the plan. This public forum is open to consumers, family members, as well as the provider community.

Health Disparities Impact Statement

Behavioral Health and physical health are strongly linked. Evidence shows that behavioral health disorders are associated with increased risk, occurrence, progression and outcomes of serious chronic diseases and health conditions. The cycle can decrease someone's ability to be a part of treatment and recovery from both. PATH funds are used to hire outreach workers, and those teams target underserved populations who are more likely to experience behavioral health disparities.

Philadelphia's street homeless population has been found to be 71.5% male and 58.5% 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. There people on the street that only speak Spanicsh, and there are outreach staff who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender-Male to Female and Transgender-Female to Male. PATH-funded staff are included in this data system.

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15.2% of the street population are between the ages of 18-29, which shows a slight decrease from last year, and RHD La Casa Safe Haven was transitioned to serve the Youth and Young Adult population to better meet the needs of males within this age group and to create a bridge to Permanent Supported Housing. Outreach expects to enroll approximately 115 YYA and PATH expects to enroll approximately 20 YYA into the 3 PATH-funded safe havens. LaCasa expects to enroll 10 YYA males and approximately 10% of Cedar Park and Kailo Haven also engage YYA, so overall PATH-funded safe havens expect to enroll 20 people. All PATH-funded programs expect to enroll 135 YYA. DBHIDS works closely with Youth and Young Adult outreach and shelter Providers and utilize the TAY VISPDAT in HMIS.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

Limited English Proficiency

PATH-funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative

The PATH Funds received are allocated for the salaries and benefits for 10 direct care staff at Cedar Park specifically. All of the staff listed on the PATH 2019-2020 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.

<u>Travel, Supplies, Indirect, and Other</u> costs will be funded by Philadelphia County.

PATH Allocation…………………………………………………… Total: $289,639

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RHD Cedar Park PATH
2019-2020 Comprehensive Budget

RHD - Cedar Park	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Program Manager	$67,000	100%	$67,000	$67,000
Case Mgr	$27,040	100%	$27,040	$27,040
Ld Resident Advisor	$26,000	100%	$26,000	$26,000
Resident Advisor	$24,900	100%	$24,900	$24,900
Resident Advisor	$24,900	100%	$24,900	$24,900
Resident Advisor	$24,900	100%	$24,900	$24,900
Resident Advisor	$24,900	100%	$24,900	$24,900
Resident Advisor	$24,900	90%	$19,968	$23,333
Resident Advisor	$24,900	90%	$19,968	$23,333
Resident Advisor	$24,900	90%	$19,968	$23,333
Subtotal	**$294,340**			**$289,639**

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Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

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Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

RHD-Kailo Haven will receive a total of $385,827 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 73

Estimated Number of Persons to be Enrolled: 58

Estimated Number of Persons to be Contacted who are Literally Homeless: 73

Number staff trained in SOAR in grant year ending in 2018: 4

Number of PATH-funded consumers assisted through SOAR: 2

NOT FINAL

Resources for Human Development: Kailo Haven
4700 Wissahickon Avenue
Philadelphia, PA 19144
2019-2020 PATH Intended Use Plan
Philadelphia County

Local Provider Description

Resources for Human Development (RHD) is a non-profit community behavioral health services organization center that provides a full continuum of mental health, substance abuse and physical health services. The Philadelphia County Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) contracts with RHD to provide mental health services, including PATH funded resources. Kailo Haven (PA-061 Philadelphia: Resourced for Human Development – Kailo Haven) is a Safe Haven located at 2107 Tioga Street, Philadelphia, PA 19134. The PATH funds received cover part of the cost of the supportive staff at this location.

Kailo Haven serves persons with serious and persistent mental illness, and persons with co-occurring substance abuse issues who are chronically street homeless. This program is centrally gatekept by Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS) and is contained within the County's residential care continuum.

Kailo Haven will receive $385,827 from PATH funding; all of which is federal allocated.

Project	Federal Allocation	State Allocation	Total Allocation
RHD - Kailo Haven	$ 289,370	$96,457	$ 385,827
Total	**$ 289,370**	**$96,457**	**$ 385,827**

Coordination with the HUD Continuum of Care (COC) Program

Kailo Haven, represented by RHD, is a key participant in the Philadelphia Continuum of Care (CoC) Board, PA-500, and is the recipient of a variety of CoC grants to provide permanent supportive housing (PSH) to persons with serious mental illness.

In addition, RHD and Kailo Haven work very closely with Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS). DBHIDS allocates $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.

The DBHIDS PATH coordinator as well as RHD sits on the local Continuum of Care (CoC) Board or sub committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinator have been involved with the housing of people into housing projects that came out of the 100 Day Challenge in Philadelphia

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and Kailo Haven has been part of the Coordinated Entry implementation and housing assessment process. 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 monthly meetings between the Office of Homeless Services (OHS), RHD, and DBHIDS, and continual coordination regarding people in Safe Havens, including Kailo Haven, to identify housing, housing needs and challenges that may arise.

Collaboration with the Local Community Organizations

The designated PATH providers and Kailo Haven are well connected in the network of community providers working to end homelessness. RHD operates the central intake for single men for the city. RHD manages a significant portion of the Mental Health Residential system and has a newspaper developed for and management by homeless and formerly homeless persons, called "One Step Away". RHD also operates three drug and alcohol treatment programs (JOH) that serve exclusively chronically homeless individuals, New Start I, New Start II and Womanspace. RHD also operates a federally qualified health center that offers low or no cost health care services for the uninsured or underinsured. The agency offers supportive employment programming that is available to PATH clients and has an inventory of Permanent Supportive Housing and is recipients of numerous McKinney/COC grants. RHD also works with Horizon House to identify people with the highest need for housing services through their programs (Housing First).

Service Provision

PATH eligibility for enrollment to the County PATH-funded programs, safe havens and outreach, include being literally homeless, 18 years of age or older, experiencing Serious Mental Illness and agrees to the PATH-funded service. Agencies do leverage other available funds outside of PATH. US Veterans access VA services first and there are other county funds available for people including DBHIDS funded safe havens and DBHIDS and other funded outreach teams.

Alignment with PATH goals to target street outreach and case management

Street & Shelter Outreach

Seven street outreach teams are deployed city-wide in Philadelphia on a year round basis. These services have been expanded to provide 24 hour outreach. PATH-funded staff are included in these efforts and are deployed throughout the city, targeting the City as well as identified "hot spots". During periods of severe winter or summer weather, outreach hours are extended in order to prevent weather-related injuries or death. Individuals who are PATH-eligible and are reached via Outreach efforts, are given access to Respite and Café-style overnight placements, Safe Havens, JOH or shelter placement, on a referral basis. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic homelessness. Outreach is also highly involved and focused on target hotspots in Philadelphia to work

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with people with Opioid Use Disorder to connect to services, treatment and housing when possible.

Project Home has also newly initiated a pilot project in downtown Philadelphia, coordinating outreach teams with the Philadelphia Police Department and the Center City District to help facilitate placements for people who are street homeless to connect to housing, treatment and medical care.

> 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.

Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with six social service agencies for the provision of 253 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. Two of these programs are specified for the Emerging Youth population, one for couples and 10 additional winter respite beds. 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 through CEA-BHRS and DBHIDS.

> Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 90% during CY 2017, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process. DBHIDS also coordinates other housing projects with OHS to help link people to additional subsidies such as 811 vouchers, a shallow rent subsidy pilot, and housing options made available through the 100 day challenge. City departments and providers and stakeholders work closely together to help make these transitions possible with added services. DBHIDS also utilizes bridge subsidies for people in mental health residential slots using reinvestment funds.

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.

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Evaluation Services

Homeless persons who require emergency psychiatric assessment and stabilization services are afforded access to an eight bed crisis residence (Emergency Evaluation Center - EEC) or to five (5) Crisis Response Centers (CRCs). An assessment and treatment team, including psychiatrist time, has been funded to work closely with the Office of Supportive Housing (OSH) Intake sites, shelters.

> Service Coordination: Access to the EEC and Crisis Response Center services is centrally coordinated by the DBHIDS Acute Services Unit. The CRCs accept walk-ins. DBHIDS has a Homeless Services Unit that is responsible for the coordination of homeless services.

Coordination & Planning

The DBHIDS participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Commissioner of the Office of Homeless Services (OHS). These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan(Code Red), outreach planning and hotspots, working with the larger community and City stakeholders, 100 Day Challenge housing slots, Coordinated Entry (CEA-BHRS) and planning for people who are chronically homeless, not chronically homeless, and the emerging adult population. This also includes planning and evaluating continuing needs around housing assessment and the prioritized By Name List. All Safe Havens have been trained in HMIS and the VISPDAT and the TAY-VISPDAT to assess vulnerability and housing needs. Both OHS and DBHIDS work closely together and with Providers as well to ensure services are provided to those with mental and behavioral health needs.

Veterans

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.

Recovery Support

Outreach is designed to engage the most vulnerable persons living on our streets and assist them in moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), outreach can respond to most needs they are presented with. Project Home partners with the Mental Health Association of Southeastern PA (MHASP) to offer peer engagement services to persons living in Philadelphia's transportation hub of Suburban Station, Hub of Hope which has moved to a larger location in the station and now provides daily and increased services throughout the year. People transitioning to and living in housing have access to CPS services.

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Residents in Safe Havens work with peers in house or residents that take on leadership and peer roles, as well as Peer Advisory and Alumni groups.

Maximizing use of PATH funds
The City of Philadelphia is committed aiding the State and bolstering supports following the lawsuit filed by the American Civil Liberties Union (ACLU). These actions include more definition attention and efforts around the movement of individuals from both the forensic and civil units at Norristown State Hospital (NSH). DBHIDS mental health services providers help coordinate with community based supports to assist the individual with linkages to employment, education, mental health treatment, healthcare, and other community based activities to help prevent recidivism. Additional efforts are put in place to assist individuals with building skills of independent living so that she/he may move on some day to her/his highest attainable level of independent living.

Gaps in current service systems
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 24th, 2018, as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 834 persons were sleeping on the streets of Philadelphia.

There are a variety of reasons for seeing an increase in numbers including lack of housing resources, an increasing amount of people with Opioid Use Disorder on the streets, and minimal affordable housing. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

Services for clients who have both SMI and a substance use disorder
All of the services described above are available for persons with co-occurring substance use disorders and all homeless services programs are expected to develop expertise to serve persons with co-occurring disorders. In addition, the DBHIDS has developed the Journeys of Hope (JOH) programs, which offer yearlong substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

Kailo Haven staff have been trained in using Narcan, an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify more needed resources and treatment for people. In 2017 DBHIDS provided an Opioid Task Force to work with the community around needs. In 2018 additional respite beds have been

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planned for and implemented, and services have increased for treatment, expanded Medical Assisted Treatment slots, and Housing First slots that are for people with OUD.

At present there is a homeless encampment resolution pilot in 4 growing encampments in the Philadelphia neighborhood of Kensington, fueled by the growing opioid crisis in Philadelphia. The City is relying heavily on outreach and connection to treatment and services. Some of the people living in the encampments will be admitted to safe havens including Kailo Haven.

DBHIDS is not responsible for following 42 CFR Part 2 regulations, as we do not provide licensed drug and alcohol outreach programs.

Justice-Involved
DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. Based on these trends, we believe that 30% of PATH clients served have a criminal history.

DBHIDS has also partnered this year with First Step Staffing to employ persons who are homeless or have a homeless history and people leaving the criminal justice system. This is a new partnership and First Step staffing is already working with people in PATH-funded Safe Havens to connect people to full-time employment.

Data
RHD Kailo Haven staff had been trained in HMIS in the spring of 2017 and are currently submitting PATH data elements to HMIS. In 2018, Cedar Park has been trained to do Housing Assessments and the VISPDAT for the CEA-BHRS process to help residents of Cedar Park get connected to housing. Once people are submitted to HMIS and CEA-BRHS they will be part of the prioritized By Name List for housing. Philadelphia is on its third HMIS product, ClientTrack. All PATH-funded programs entering data into HMIS have a written HMIS manual for reference and it is made available to new and current employees.

Alignment with PATH goals to target street outreach and case management
Philadelphia continues to use data to identify, target and prioritize the most vulnerable people with the longest histories of street homelessness to link them to needed housing and service resources. This information is used to identify people who are eligible for Safe Havens and JOH emergency housing, and any other housing options. This year Kailo Haven has begun to do Housing Assessments and the VISPDAT in accordance with the City's new Coordinated Entry

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system (CEA-BHRS) to create a prioritized By Name List of people in conjunction with City Departments (Office of Homeless Services) and other stakeholders, including Project Home and RHD. Kailo Haven admits chronically homeless men to their program, which includes additional resources during winter initiative in Philadelphia. The collaboration between various City of Philadelphia departments as well as provider agencies enables ongoing dialogue and cooperation, to ensure that each individual is receiving the level of care and services that are most appropriate for them. This includes situations where individuals are enrolled in PATH but it becomes apparent that they are eligible for other services and funding streams (i.e. Medicaid, Medicare). This transfer allows us to leverage the PATH funds allocated to serve the most individuals possible.

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.

Alignment with State Plan to End Homelessness

$43M of DBHIDS' reinvestment funds are earmarked for our housing programs which includes tenant based rental assistance for person experiencing homelessness. This also includes former inmates or persons with a history in the criminal justice system. We collaborate closely with the prisons, courts, criminal justice partners, providers, and probation staff through the Behavioral Health Justice Related Services Unit.

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have been and are in the process of receiving Narcan training and K2 training which has been increasing in Philadelphia.

Project Home and DBHIDS have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services plans for disasters and emergencies in collaboration with the Philadelphia Office of Emergency Management, the Philadelphia Department of Public Health, and other City and community response stakeholders. Those plans include, but are not limited to evacuation, mass sheltering, points of dispensing for mass prophylaxis, and mass casualty events. Planning for Access and Functional Needs continues to be a priority in all of our planning efforts.

DBHIDS continues to work closely with homeless advocacy and service agencies during major events and incidents in Philadelphia in order to ensure that homeless persons living on the street are contacted and surveyed prior to notice events, they receive timely information about events,

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and are offered services and supports during events based upon their identified preferences. In addition, particular attention is paid to planning for severe winter and severe heat periods, which results in additional resources and services being deployed in support of those on the street. Through our planning, outreach, and response efforts, resources continue to be identified and utilized by the homeless, resulting in some specific successes in providing housing to several long-term homeless individuals. Lessons learned in these major incidents continue to inform our planning. Additionally, Safe Haven and Outreach staff must complete Mental Health First Aid (MHFA) training which enables staff to intervene in the instance of a mental health crisis.

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. A sevent Outreach Team has been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City. Hotspots with multiple people who are homeless and experiencing OUD are also being targeted for services, housing and treatment, with additional outreach services in the Philadelphia neighborhood of Kensington where the City has seen an increased use of OUD.

One RHD PATH-funded Safe Haven targets emerging adult males, and a there is a second Emerging Adults Safe Haven for women. We are seeing approximately 80% of young adults entering the TAY Safe Haven having LGBTQ needs and staff are working on training and supports for Outreach and Safe Havens to address needs of this population.

Access to Housing Choice Vouchers through PHA has virtually ended over the last few years. This did slow down our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities. This year we have been working with the 811 program, started a Shallow Rent Subsidy pilot and received city funding for increased housing subsidies that came out of a need during the 100 day chronic team initiative.

Other Designated Funds

DBHIDS spends $50M 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.

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Programmatic and Financial Oversight
The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD Cedar Park, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical support to Cedar Park. DBHIDS provides daily support to all PATH-funded programs.

SSI/SSDI Outreach, Access, Recovery (SOAR)
Homeless Advocacy Project (HAP) had been providing SOAR to people in Safe havens and JOH as well as people who are homeless working with Outreach. HAP also works with people in OHS shelter and are connected to DHS for aging out youth. HAP has trained 2 staff members hired for this project (1 FT and 1 PT) and 7 HAP staff members have provided assistance w/the DBH/SOAR project and there are additional staff provides representation in other SOAR projects. . HAP has filed 73 DHB/HAP SOAR applications with 58 approvals and 0 denials, the rest are pending and the total average processing time is 58 days.

Access to Housing
Outreach participants have access to the DBH safe haven system that includes all three PATH-funded residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens have very limited access to these resources, these have been severely limited.

- OHS Clearinghouse opportunities, 50 811 subsidies targeted to people in JOH and Safe Haven if no other priorities presented, and Senior Housing

- Exclusive access to openings in the city's inventory of 705 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.

- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project. .

- Priority access to Mobile Psychiatric Rehabilitation Services (MPRS) including programs operated by RHD, Horizon House and Northwestern Human Services.

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- Additional slots created by the City after the 100 Day Challenge process including Housing First, Rapid Re-Housing and 1260 Housing Development Corporation
- 30 subsidies for Shallow Rent Pilot
- Bridge Vouchers utilizing DBHIDS reinvestment funds

Coordinated Entry
DBHIDS has worked closely with OHS and the COC, along with many Providers including Project Home and RHD to help develop and implement the Coordinated Entry system in Philadelphia (CEA-BHRS). Safe Havens and PATH Outreach have been trained in HMIS and the VISPDAT and Safe havens are now able to do housing assessments directly into HMIS. We are now preparing to implement a workgroup to do assessments as the system continues. Mobile assessors are also in process to help people on the street do housing assessments in partnership with Outreach.

There are some barriers to housing and treatment for PATH-eligible consumers in the safe haven programs as they are not awarded a point in the VISPDAT for street homelessness since they are now in safe havens for people who are considered chronic. Also some questions in the VISPDAT may not target their experiences or address their severity of behavioral and mental health needs. Our outreach teams are still not able to utilize the system due to privacy and data concerns, but that is being worked through. Lastly, we are working closely with the City, Providers and stakeholders to address these concerns.

Justice Involved
Crisis Intervention Training (CIT) is being used by the City of Philadelphia DBHIDS. The targeted goal was to train 35% of Philadelphia Police and we exceeded this number. The total number of all personnel trained to date is 2943. Per personal testimonies from the officers the training is extremely helpful. There has been recognition of officers who have saved lives by using the training.

Staff Information
All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies and health disparities. We do not collect demographic information on staff serving PATH clients.

Efforts continue to ensure that all providers are aware and trained in appropriate sensitivity measures (i.e. cultural, religious, LGBTQ, etc.). All of the DBHIDS Safe Havens work with transgender individuals and will accept a person based on their gender-identity, not on their demarcated gender at birth. In order to effectively engage with all participants, all staff are

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required to receive and respect all clients regardless of their cultural, religious, sexual, or gender differences.

Some of our PATH-funded program staff are CPS, but all programs have peers, persons with lived experience and CPS staff available that are not funded by PATH.

Client Information

The projected number of people to be contacted by the PATH-funded Project Home Outreach team and safe havens is approximately 3300 unduplicated people. Out of the 3300 people, we expect approximately 800 are expected to become enrolled in outreach and safe havens. 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:

Kailo Haven specifically expects to contact approximately 65 people and enroll 58 people. Most residents are contacted and enrolled on the same day since there is an eligibility criteria for safe haven admission but sometimes people do not stay. 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:

- 80.8% had both co-occurring substance abuse and behavioral health issues
- 5.6% veterans
- 58.5% black/African-American
- 33% white
- 71.5% male
- 28.5% female
- 15.2% between the ages of 18-29
- 22.1% between the ages of 30-39
- 22.9% between the ages of 40-49
- 26.5% between the ages of 50-59
- 13.3% aged 60+

Consumer Involvement

DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. Numerous task forces have been organized to address programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia. At Kailo Haven, cards and stamps are provided to residents who want to contact family members and this

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helps in repairing possibly damaged relationships. Family of choosing are invited to events or to visit, or join for meals. Kailo Haven also holds cook outs and holiday meals for residents and their family or friend and supports.

Safe Havens have access to Peer Specialists that come to the location and participate with residents in a variety of ways that are based on the interest and needs of the residents and Kailo Haven has a PATH-funded CPS on site. In an effort to engage families and help with a variety of needs and resources, DBHIDS also runs the Family Support Network; a place where families can stop-by to receive guidance they may need. Safe Havens are also part of the Safe Haven Learning Collaborative and participate fully in transforming the Safe Haven system to align with DBHIDS Practice Guidelines for a recovery oriented system. They also work with outreach to create a warmer hand off in alignment with these principles.

Kailo Haven has an advisory committee run by the residents and the leadership go to all staff meetings. They give and receive input concerning any issues or policies and are part of all decision making procedures. Residents also form their own recovery and goal plans.

Finally, DBHIDS' Office of Mental Health prepares an Annual Plan for Mental Health Services. This plan is distributed on an annual basis to the public, the Community Support Program (CSP) and provider agencies. A forum is then offered to the community to provide comments, feedback, and suggest programs and services for inclusion in the plan. This public forum is open to consumers, family members, as well as the provider community.

Health Disparities Impact Statement

Behavioral 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. 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 80.8% male and 58.5% 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. There are also outreach staff who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH-funded staff are included in this data system.

15.2% of the street population are between the ages of 18-29, which shows a slight decrease from last year, and RHD La Casa Safe Haven was transitioned to serve the Youth and Young Adult population to better meet the needs of males within this age group and to create a bridge to

NOT FINAL

Permanent Supported Housing. Outreach expects to enroll approximately 115 YYA and PATH expects to enroll approximately 20 YYA into the 3 PATH-funded safe havens. LaCasa expects to enroll 10 YYA males and approximately 10% of Cedar Park and Kailo Haven also engage YYA, so overall PATH-funded safe havens expect to enroll 20 people. All PATH-funded programs expect to enroll 135 YYA. DBHIDS works closely with Youth and Young Adult outreach and shelter Providers and utilize the TAY VI-SPDAT in HMIS. YYA are also able to access any appropriate adult PATH services in the county as well.

DBHIDS and providers hope to reduce disparities by working closely with providers who have made serving these communities a priority and therefore to reduce disparities and increase positive outcomes, including leaving homelessness. Training is provided on a regular basis to outreach and safe haven staff regarding behavioral health disparities and effective strategies for overcoming these disparities.

Limited English Proficiency

PATH-funded Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

Budget Narrative

The PATH Funds received are allocated for the salaries and benefits for 19 direct care staff at Kailo Haven specifically. All of the staff listed on the PATH 2019-2020 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

NOT FINAL

Kailo Haven Budget Table

Clinical Manager	$0	100%	$0	$0
Program Dir	$40,000	100%	$40,000	$62,000
Supervisor	$32,000	100%	$32,000	$32,000
Supervisor	$32,000	100%	$28,497	$32,000
Peer Specialist	$0	100%	$0	$0
Case Mgr	$39,585	100%	$39,585	$39,585
Resident Advisor	$27,040	100%	$27,040	$27,040
Resident Advisor	$27,040	100%	$27,040	$27,040
Resident Advisor	$27,040	100%	$27,040	$27,040
Resident Advisor	$24,980	100%	$24,980	$24,980
Resident Advisor	$24,980	100%	$24,980	$24,980
Resident Advisor	$24,980	50%	$24,980	$12,490
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
Resident Advisor	$24,980	40%	$24,980	$9,984
D.S. Personnel	$27,040	62%	$27,040	$16,768
Subtotal	**$385,827**			**$385,827**

NOT FINAL

Philadelphia County - RHD (La Casa)
504 Washington Ave
Philadelphia, PA 19147
Contact: Howard McNeill

Provider Type: Community mental health center
PDX ID: PA-059
State Provider ID: 4259
Contact Phone #: 2154625041

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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

NOT FINAL

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
h. Construction (non-allowable)				
i. Other	**$ 0**	**$ 0**	**$ 0**	
No Data Available				
j. Total Direct Charges (Sum of a-i)	$ 0	$ 0	$ 0	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 0	$ 0	$ 0	

Source(s) of Match Dollars for State Funds:

RHD-La Casa will receive $338,135 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 21

Estimated Number of Persons to be Enrolled: 18

Estimated Number of Persons to be Contacted who are Literally Homeless: 21

Number staff trained in SOAR in grant year ending in 2018: 4

Number of PATH-funded consumers assisted through SOAR: 4

NOT FINAL

Resources for Human Development: La Casa
4700 Wissahickon Avenue
Philadelphia, PA 19144
2018-2019 PATH Intended Use Plan
Philadelphia County

Local Provider Description
Resources for Human Development (RHD) is a non-profit community behavioral health services organization center that provides a full continuum of mental health, substance abuse and physical health services. The Philadelphia County Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) contracts with RHD to provide mental health services, including PATH funded resources. La Casa (PA – 059 Philadelphia: Resources for Human Development – La Casa) is a Safe Haven located at 504 Washington Avenue, Philadelphia, PA 19147. The PATH funds received cover part of the cost of the supportive staff at this location.

La Casa serves homeless Youth and Young Adult 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 federally allocated.

Project	Federal Allocation	State Allocation	Total Allocation
RHD - La Casa	$ 253,601	$ 84,534	$ 338,135
Total	**$ 253,601**	**$ 84,534**	**$ 338,135**

Coordination with the HUD Continuum of Care (CoC) Program
La Casa, represented by RHD, is a key participant in the Philadelphia Continuum of Care (CoC) Board, PA-500 and is the recipient of a variety of CoC grants to provide permanent supportive housing (PSH) to persons with serious mental illness.

In addition, RHD and La Casa work very closely with Philadelphia's Department of Behavioral Health and Intellectual disAbilities (DBHIDS). DBHIDS allocates $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.

The DBHIDS PATH coordinator as well as RHD sits on the local Continuum of Care (CoC) Board or sub-committees and contributes to the vision, development and management of the CoC. The local CoC lead and the DBHIDS PATH coordinator have been involved with the housing opportunities that came from the 100 Day Challenge in Philadelphia, and have been part of the Coordinated Entry implementation. Persons who receive PATH-eligible services are a high priority for CoC resources.

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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 multiple meetings between the Office of Homeless Services (OHS), RHD, and DBHIDS, and continual coordination regarding people in Safe Havens, including La Casa, to identify housing, housing needs and challenges that may arise.

Collaboration with Local Community Organizations

The designated PATH providers and La Casa are well connected in the network of community providers working to end homelessness. RHD operates the central intake for single men for the city. RHD manages a significant portion of the Mental Health Residential system and has a newspaper developed for and management by homeless and formerly homeless persons, called "One Step Away".

RHD also operates three drug and alcohol treatment programs that serve exclusively chronically homeless individuals, New Start I, New Start II and Womanspace. RHD also operates a federally qualified health center that offers low or no cost health care services for the uninsured or underinsured. The agency offers supportive employment programming that is available to PATH clients and has an inventory of Permanent Supportive Housing and is recipients of numerous McKinney/COC grants. RHD also works with Horizon House to identify people with the highest need for housing services through their programs (Housing First).

RHD and La Casa work closely with outreach teams, including Youth Outreach and Youth Providers and shelters, who are targeting the most vulnerable people on the streets, and young adults, to make the warm handoff and connection into the Safe Haven and help support their housing and case management needs. They attend joint trainings with outreach teams, as well as monthly Safe Haven Director's meetings where outreach information is updated and vice versa.

Service Provision

PATH eligibility for enrollment to the County PATH-eligible programs, safe havens and outreach, include being literally homeless, 18 years of age or older, experiencing Serious Mental Illness and agrees to the PATH-eligible service.

Alignment with PATH goals to target street outreach and case management

Street & Shelter Outreach

Seven 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-eligible staff are included in these efforts and are deployed throughout the city, targeting the City as well as identified "hot spots". During periods of severe winter or summer weather, outreach hours are extended in order to prevent weather-related injuries or death. Individuals who are PATH-eligible and are reached via Outreach efforts, are given access to Respite and Café-style overnight placements, Safe Havens, JOH or shelter placement, on a referral basis. Safe havens are designed to accommodate rapid admissions and to address the needs of persons with mental illness who have experienced chronic

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homelessness. Outreach is also highly involved and focused on target hotspots in Philadelphia to work with people with Opioid Use Disorder to connect to services, treatment and housing when possible.

Project Home has also newly initiated a pilot project in downtown Philadelphia, coordinating outreach teams with the Philadelphia Police Department and the Center City District to help facilitate placements for people who are street homeless to connect to housing, treatment and medical care.

> 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.

Current Housing/Shelter Services & Supports

DBHIDS currently has contracts with six social service agencies for the provision of 253 entry-level beds designated specifically for homeless persons with mental illness or co-occurring disorders. Two of these programs are specified for the Emerging Youth population, one for couples and 10 additional winter respite beds. 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 through CEA-BHRS and DBHIDS.

> Service Coordination: DBHIDS' Office of Mental Health continues to centrally gatekeep virtually all of the current mental health residential slots. This includes the 253existing entry level beds as well as a large number of transitional and permanent housing resources that serve to prevent persons with mental health disabilities from becoming homeless. The larger residential system and continuum of resources have maintained an occupancy level of 90% during CY 2017, but 95% occupancy rate if dedicated beds are accounted for, meaning active and viable referrals were in the admission process. DBHIDS also coordinates other housing projects with OHS to help link people to additional subsidies such as 811 vouchers, a shallow rent subsidy pilot, and housing options made available through the 100 day challenge. City departments and providers and stakeholders work closely together to help make these transitions possible with added services. DBHIDS also utilizes bridge subsidies for people in mental health residential slots using reinvestment funds.

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

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days but were homeless upon prison admission and will be homeless upon prison discharge.

Evaluation Services
Homeless persons who require emergency psychiatric assessment and stabilization services are afforded access to an eight bed crisis residence (Emergency Evaluation Center - EEC) or to five (5) Crisis Response Centers (CRCs). An assessment and treatment team, including psychiatrist time, has been funded to work closely with the Office of Supportive Housing (OSH) Intake sites, shelters.

> Service Coordination: Access to the EEC and Crisis Response Center services is centrally coordinated by the DBHIDS Acute Services Unit. The CRCs accept walk-ins. DBHIDS has a Homeless Services Unit that is responsible for the coordination of homeless services.

Coordination & Planning
The DBHIDS participates in ongoing planning and coordination of homeless service initiatives, under the direction of the Commissioner of the Office of Homeless Services (OHS). These initiatives have included the annual winter plan (Code Blue), and summer heat emergency plan(Code Red), outreach planning and hotspots, working with the larger community and City stakeholders, 100 Day Challenge housing slots, Coordinated Entry (CEA-BHRS) and planning for people who are chronically homeless, not chronically homeless, and the emerging adult population. This also includes planning and evaluating continuing needs around housing assessment and the prioritized By Name List. All Safe Havens have been trained in HMIS and the VISPDAT and the TAY-VISPDAT to assess vulnerability and housing needs. Both OHS and DBHIDS work closely together and with Providers as well to ensure services are provided to those with mental and behavioral health needs.

Veterans
All PATH-eligible services in Philadelphia, are available to homeless veterans. Weekly PATH-eligible 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.

Recovery Support
Outreach is designed to engage the most vulnerable persons living on our streets and assist them in moving forward in their recovery. With an array of recovery options (including specialized homeless treatment, housing first programs, permanent supportive housing that is both project based and scattered site), outreach can respond to most needs they are presented with. Project Home partners with the Mental Health Association of Southeastern PA (MHASP) to offer peer engagement services to persons living in Philadelphia's transportation hub of Suburban Station, Hub of Hope which has moved to a larger location in the station and now provides daily and increased services throughout

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the year. People transitioning to and living in housing have access to CPS services. Residents in Safe Havens work with peers in house or residents that take on leadership and peer roles, as well as Peer Advisory and Alumni groups.

Maximizing use of PATH funds
Agencies do leverage other available funds outside of PATH. US Veterans access VA services first and there are other county funds available for people including DBHIDS funded safe havens and DBHIDS and other funded outreach teams.

The City of Philadelphia is committed aiding the State and bolstering supports following the lawsuit filed by the American Civil Liberties Union (ACLU). These actions include more definition attention and efforts around the movement of individuals from both the forensic and civil units at Norristown State Hospital (NSH). DBHIDS mental health services providers help coordinate with community based supports to assist the individual with linkages to employment, education, mental health treatment, healthcare, and other community based activities to help prevent recidivism. Additional efforts are put in place to assist individuals with building skills of independent living so that she/he may move on some day to his/her highest attainable level of independent living.

Gaps in current service systems
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 24th, 2018 as part of the national homeless count sponsored by the Department of Housing and Urban Development. At that time, 834 persons were sleeping on the streets of Philadelphia. There are a variety of reasons for seeing an increase in numbers including the lack of housing resources, an increasing amount of people with Opioid Use Disorder on the streets, and minimal affordable housing. There has been a partnership with the Philadelphia Housing Authority to address the gap in capacity, but the housing opportunities have decreased significantly. It is also possible that the numbers have increased since Outreach teams are covering more areas of the City and count now includes people sleeping in hospital Emergency Rooms. There is also a severe gap in affordable housing in Philadelphia County. SSI payments are not enough for Fair Market Rent. We continue to need more affordable housing options for people receiving SSI or less than SSI.

Services for clients who have both SMI and a substance use disorder
All of the services described above are available for persons with co-occurring substance use disorders and all homeless services programs are expected to develop expertise to serve persons with co-occurring disorders. In addition, the DBHIDS has developed the Journeys of Hope (JOH) programs, which offer yearlong substance abuse treatment that will result in obtaining permanent supportive housing for all persons who complete the programs. These are licensed addiction treatment services with capacity to serve persons with co-occurring mental health disorders.

La Casa staff have been trained in using Narcan, an effective treatment for people who are unresponsive at risk of death due to opioid drug overdose. DBHIDS is also working closely with Prevention Point who is doing Outreach with this population, and we are working to identify

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more needed resources and treatment for people. In 2017 DBHIDS provided an Opioid Task Force to work with the community around needs. In 2018 additional respite beds have been planned for and implemented, and services have increased for treatment, expanded Medical Assisted Treatment slots, and Housing First slots that are for people with OUD.

At present there is a homeless encampment resolution pilot in 4 growing encampments in the Philadelphia neighborhood of Kensington, fueled by the growing opioid crisis in Philadelphia. The City is relying heavily on outreach and connection to treatment and services. Some of the people living in the encampments will be admitted to safe havens, including PATH-eligible safe havens.

DBHIDS is not responsible for following 42 CFR Part 2 regulations, as we do not provide licensed drug and alcohol outreach programs.

Justice-Involved
DBHIDS Homeless Services partners with the Behavioral Health Justice Related Services (BHJRS) to coordinate care for people that have been incarcerated and offers Permanent Supported Housing for those discharged from the prison system. We collaborate closely with BHJRS to create unofficial jail diversion opportunities to ensure that when PATH clients are incarcerated they are treated appropriately and swiftly with regards to treatment and discharge. When people are not eligible for subsidies from the Philadelphia Housing Authority they are offered Bridge Subsides from DBHIDS reinvestment dollars. During this time, we are continually working on creating an efficient flow of institutionalized and incarcerated individuals into the appropriate level of care. Of note, we have experienced a 30% increase in the Safe Havens of clients with a criminal justice history. Based on these trends, we believe that 30% of PATH clients served have a criminal history.

DBHIDS has also partnered this year with First Step Staffing to employ persons who are homeless or have a homeless history and people leaving the criminal justice system. This is a new partnership and First Step staffing is already working with people in PATH-eligible Safe Havens to connect people to full-time employment. La Casa also partners with Horizon House's employment services and they work in collaboration to help residents obtain employment or educational goals.

Data
RHD La Casa staff had been trained in HMIS in the spring of 2017 and are submitting PATH data elements into HMIS. In 2018, La Casa staff has been trained to do Housing Assessments and the TAY-VISPDAT for the CEA-BHRS process to help residents of La Casa get connected to housing. Once people are submitted to HMIS and CEA-BRHS they will be part of the prioritized By Name List for housing. Philadelphia is on its third HMIS product, ClientTrack. All PATH-eligible programs entering data into HMIS have a written HMIS manual for reference and it is made available to new and current employees.

Alignment with PATH Goals

NOT FINAL

Philadelphia continues to use data to identify, target and prioritize the most vulnerable people with the longest histories of street homelessness to link to needed housing and service resources. This information is used to identify people who are eligible for Safe Havens and JOH emergency housing, and any other housing options. This year La Casa is doing Housing Assessments and the TAY-VISPDAT in HMIS, which is in accordance with the City's new Coordinated Entry system (CEA-BHRS), to create a prioritized By Name List of people in conjunction with City Departments (Office of Homeless Services) and other stakeholders, including Project Home and RHD. La Casa admits homeless Youth and Young men to their program and have been trained in LGBTQ needs and supports. The collaboration between various City of Philadelphia departments as well as provider agencies enables ongoing dialogue and cooperation to ensure that each individual is receiving the level of care and services that are most appropriate for them. This includes situations where individuals are enrolled in PATH but it becomes apparent that they are eligible for other services and funding streams (i.e. Medicaid, Medicare). This transfer allows us to leverage the PATH funds allocated to serve the most individuals possible.

The City uses Outreach data to determine chronicity and people who are the most vulnerable and have spent the most times on the street to help inform eligibility for Housing First services, Safe Havens and any other housing options available through PHA or DBH reinvestment dollars. This data is also being used to help inform the OHS By Name List which is being built to target people with the most need and chronicity to access valuable resources for housing and to end homelessness through CEA-BHRS and HMIS.

DBHIDS works with a variety of City Departments and stakeholders at quarterly Homeless Death Reviews to identify circumstances that may have led to someone's death on the streets or in emergency housing, and ways to collaborate to identify issues and prevention of homeless deaths. This includes the Department of Behavioral Health and Intellectual disAbilities (DBHIDS), OHS, the Medical Examiner's Office (MEO), the Prison System as well as many others. We utilize this process to ask ourselves what we can do better as a system to prevent homeless deaths.

La Casa staff provide varying case management duties around connection to housing and work closely with residents and DBHIDS to provides these services.

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.

Alignment with State Plan to End Homelessness

$43M 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.

NOT FINAL

Persons experiencing mental health and/or substance abuse have services and treatment available and have access to a variety of housing options including: OHS Clearinghouse Permanent Supported Housing options, some of which are Project Home, McKinney and HUD funded PSH, Housing First services, and RHD JOH programs. Outreach and Safe Haven staff have received Narcan training and K2 training which has been increasing in Philadelphia.

DBHIDS and RHD have worked in collaboration with the VA and VA stakeholders at a variety of meetings, including going over individual names and a Boot Camp style of meetings bringing everyone to the table to collaborate and end Veteran's Homelessness.

The Philadelphia Department of Behavioral Health and Intellectual disAbility Services plans for disasters and emergencies in collaboration with the Philadelphia Office of Emergency Management, the Philadelphia Department of Public Health, and other City and community response stakeholders. Those plans include, but are not limited to evacuation, mass sheltering, points of dispensing for mass prophylaxis, and mass casualty events. Planning for Access and Functional Needs continues to be a priority in all of our planning efforts.

DBHIDS continues to work closely with homeless advocacy and service agencies during major events and incidents in Philadelphia in order to ensure that homeless persons living on the street are contacted and surveyed prior to notice events, they receive timely information about events, and are offered services and supports during events based upon their identified preferences. In addition, particular attention is paid to planning for severe winter and severe heat periods, which results in additional resources and services being deployed in support of those on the street. Through our planning, outreach, and response efforts, resources continue to be identified and utilized by the homeless, resulting in some specific successes in providing housing to several long-term homeless individuals. Lessons learned in these major incidents continue to inform our planning. Additionally, Safe Haven and Outreach staff must complete Mental Health First Aid (MHFA) training which enables staff to intervene in the instance of a mental health crisis.

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. A seventh Outreach Team has been provided more support to people who need it and are not in typically seen locations of Center City as we continue to identify new hot spots in the City.

In the last few years access to Housing Choice Vouchers through PHA has virtually ended. This did slow down our ability to discharge people to PSH from Safe Havens and JOH who had been prioritized for 200 of these vouchers annually. We have identified some alternate programs through McKinney slots and DBHIDS reinvestment dollars but there is a need for this number of vouchers again in the future. OHS and DBHIDS are working together to identifying new resources, subsidies and landlords to provide housing opportunities. This year we have been working with the 811 program, started a Shallow Rent Subsidy pilot and received city funding for increased housing subsidies that came out of a need during the 100 day chronic team initiative and La Casa residents are eligible for these resources.

NOT FINAL

Other Designated Funds
DBHIDS spends $50M annually for persons experiencing homelessness, this includes funding from Medicaid, the Mental Health Block Grant and the Substance Abuse Block Grant. Different funding streams are work in collaboration to fund our efforts with the Journey of Hope Programs, Housing First Services and Safe Havens. It should be noted that these funds are not specifically designated to only serve people who are experiencing homelessness and have a serious mental illness (SMI), as some of the funds are designated for addiction services. Additionally, none of the designated funds are earmarked specifically for PATH services.

Programmatic and Financial Oversight
The City of Philadelphia's Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) monitor the use of PATH funds through our fiscal and operations unit and oversight of all the programs. The Coordinator for Homeless Services works and oversees the Outreach Coordination Center (OCC) and monitors, provides trainings and is in daily contact with Project Home's Outreach program. The DBHIDS Homeless Services Unit monitors RHD La Casa, sends referrals, oversees discharges, and the Concurrent Review process that links people to housing. DBHIDS also provides technical support to La Casa. DBHIDS provides daily support to all PATH-eligible programs.

SSI/SSDI Outreach, Access, Recovery (SOAR)
Homeless Advocacy Project (HAP) had been providing SOAR to people in Safe havens and JOH as well as people who are homeless working with Outreach. HAP also works with people in OHS shelter and are connected to DHS for aging out youth. HAP has trained 2 staff members hired for this project (1 FT and 1 PT) and 7 HAP staff members have provided assistance w/the DBH/SOAR project and there are additional staff provides representation in other SOAR projects. HAP has filed 73 DHB/HAP SOAR applications with 58 approvals and 0 denials, the rest are pending and the total average processing time is 58 days.

Access to Housing
Outreach participants have access to the DBH safe haven system that includes all three PATH-eligible residential programs. Outreach participants and safe haven residents have priority access to a variety of housing initiatives including:

- The City and Philadelphia Housing Authorities Blueprint Initiative, which had allocated 200 Housing Choice Vouchers a year to address issues of homelessness in the community has limited these vouchers to work with alternative PHA priorities. Safe Havens have very limited access to these resources, these have been severely limited.

- OHS Clearinghouse opportunities, 50 811 subsidies targeted to people in JOH and Safe Haven if no other priorities presented, and Senior Housing

NOT FINAL

- Exclusive access to openings in the city's inventory of 705 Housing First options, operated by Horizon House and Pathways to Housing PA, this includes a new team focused on people with Opioid Use Disorder. Housing First slots are being increased and funded for FY 18 by Pathways to Housing.

- Various McKinney permanent supportive housing programs including McKinney programs with Project Home, 1260 Housing Development Corporation, Horizon House and Bethesda Project.

- Priority access to Mobile Psychiatric Rehabilitation Services (MPRS) including programs operated by RHD, Horizon House and Northwestern Human Services.

- Additional slots created by the City after the 100 Day Challenge process including Housing First, Rapid Re-Housing and 1260 Housing Development Corporation

- 30 subsidies for Shallow Rent Pilot

- Bridge Vouchers utilizing DBHIDS reinvestment funds.

Coordinated Entry
DBHIDS has worked closely with OHS and the CoC, along with many Providers including Project Home and RHD to help develop and implement the Coordinated Entry system in Philadelphia (CEA-BHRS). Safe Havens and PATH Outreach have been trained in HMIS and the VISPDAT and Safe havens are now able to do housing assessments directly into HMIS. We are now preparing to implement a workgroup to do assessments as the system continues. Mobile assessors are also in process to help people on the street do housing assessments in partnership with Outreach.

There are some barriers to housing and treatment for PATH-eligible consumers in the safe haven programs as they are not awarded a point in the VISPDAT for street homelessness since they are now in safe havens for people who are considered chronic. Also some questions in the VISPDAT may not target their experiences or address their severity of behavioral and mental health needs. Lastly out outreach teams are still not able to utilize the system due to privacy and data concerns, but that is being worked through. Lastly we are working closely with the City, Providers and stakeholders to address these concerns.

Justice Involved
Crisis Intervention Training (CIT) is being used by the City of Philadelphia DBHIDS. The targeted goal was to train 35% of Philadelphia Police and we exceeded this number. The total number of all personnel trained to date is 2943. Per personal testimonies from the officers the training is extremely helpful. There has been recognition of officers who have saved lives by using the training.

NOT FINAL

Staff Information
All programs are expected to document efforts to recruit and retain staff at all levels that are culturally appropriate to the population served. This documentation must include goals, efforts made toward those goals, and outcomes. Additionally, all staff are required to receive annual trainings on cultural competencies and health disparities. We do not collect demographic information on staff serving PATH clients.

Efforts continue to ensure that all providers are aware and trained in appropriate sensitivity measures (i.e. cultural, religious, LGBTQ, etc.). All of the DBHIDS Safe Havens work with transgender individuals and will accept a person based on their gender-identity, not on their demarcated gender at birth. In order to effectively engage with all participants, all staff are required to receive and respect all clients regardless of their cultural, religious, sexual, or gender differences.

Some of our PATH-funded program staff are CPS, but all programs have peers, persons with lived experience and CPS staff available that are not funded by PATH.

Client Information
The projected number of people to be contacted by the PATH-eligible Project Home Outreach team and safe havens is approximately 3300 unduplicated people. Out of the 3300 people, we expect approximately 800 are expected to become enrolled in outreach and safe havens. 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:

La Casa specifically expects to contact approximately 15 people and enroll 10. Often residents are contacted and enrolled on the same day due to safe haven eligibility criteria. 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:

- 80.8% had both co-occurring substance abuse and behavioral health issues
- 5.6% veterans
- 58.5% black/African-American
- 33% white
- 71.5% male
- 28.5% female
- 15.2% between the ages of 18-29
- 22.1% between the ages of 30-39
- 22.9% between the ages of 40-49
- 26.5% between the ages of 50-59
- 13.3% aged 60+

NOT FINAL

Consumer Involvement
DBHIDS continually involves consumer, provider and family groups in the development of programs, policies and procedures that affect them directly. Numerous task forces have been organized to address programmatic issues which include provider, consumer and family representatives. In addition, DBHIDS regularly meets with The Consumer Satisfaction Team (CST), an organization of consumers and family members that monitor service quality and advocate for the needs of individual consumers and their families. CST addresses the needs of consumers served in all parts of the behavioral health system. This involves assessing the satisfaction of consumers in drug and alcohol, adult and children's mental health and dual diagnosis programs. The information provided by CST is used by DBHIDS and provider agencies to continually improve the quality of mental health services in Philadelphia.

La Casa employs a Peer Specialists at their location who participates and works with residents in a variety of ways that are based on the interest and needs of the residents.
In an effort to engage families and help with a variety of needs and resources, DBHIDS also runs the Family Support Network; a place where families can stop-by to receive guidance they may need. Safe Havens are also part of the Safe Haven Learning Collaborative and participate fully in transforming the Safe Haven system to align with DBHIDS Practice Guidelines for a recovery oriented system. They also work with outreach to create a warmer hand off in alignment with these principles.

La Casa utilizes a person-centered approach to support individuals to increase quality of life and overall wellness. This is also to help obtain and sustain housing in the community of their choosing. Staff at La Casa provides trauma-informed care. Residents are encouraged to have family members and significant others of their choosing be associated as they prefer on their recovery journey. There are visiting hours and internet access for communications, as well as several measures implemented that foster family involvement.

Finally, DBHIDS' Office of Mental Health prepares an Annual Plan for Mental Health Services. This plan is distributed on an annual basis to the public, the Community Support Program (CSP) and provider agencies. A forum is then offered to the community to provide comments, feedback, and suggest programs and services for inclusion in the plan. This public forum is open to consumers, family members, as well as the provider community.

NOT FINAL

Health Disparities Impact Statement
Behavioral and physical health are strongly linked. Evidence shows that behavioral health disorders are associated with increased risk, occurrence, progression and outcomes of serious chronic diseases and health conditions. 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 80.8% male and 58.5% 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. There are

people who are street homeless only speak Spanish and we have outreach staff who are fluent in Spanish. When persons are referred to behavioral health services, their ethnic and cultural backgrounds are considered in the referral process, as required by the DBHIDS Practice Guidelines. Referring staff are looking for agencies and services that reflect the community from which the person they are serving hails from. Data is collected to track the following key factors in Behavioral Health Disparities: language barriers, cultural and ethnic barriers to services, barriers related to LGBTQ status. DBHIDS outreach services include 2 categories to the gender variable, Transgender- Male to Female and Transgender-Female to Male. PATH-eligible staff are included in this data system. La Casa has been trained around various LGBTQ needs to serve this population of emerging youth.

15.2% of the street population are between the ages of 18-29, which shows a slight decrease from last year, and RHD La Casa Safe Haven was transitioned to serve the Youth and Young Adult population to better meet the needs of males within this age group and to create a bridge to Permanent Supported Housing. Outreach expects to enroll approximately 115 YYA and PATH expects to enroll approximately 20 YYA into the 3 PATH-eligible safe havens. La Casa expects to enroll 10 YYA males and approximately 10% of Cedar Park and Kailo Haven also engage YYA, so overall PATH-funded safe havens expect to enroll 20 people. All PATH-eligible programs expect to enroll 135 YYA. DBHIDS works closely with Youth and Young Adult outreach and shelter Providers and utilize the TAY VI-SPDAT in HMIS.

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. YYA clients are also able to utilize any other PATH services as appropriate.

Limited English Proficiency

PATH-eligible Safe Havens and Outreach have been given information for free interpretation through Proprio language services. This information is made available for people who receive these services.

NOT FINAL

Budget Narrative

The PATH Funds received are allocated for the salaries and benefits for 13 direct care staff at La Casa. All of the staff listed on the PATH 2019-2020 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

NOT FINAL

La Casa 2019.2020 PATH Budget

RHD - La Casa	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Director	$61,325	100%	$61,325	$61,325
case manager	$45,000	100%	$45,000	$45,000
dir serv prof	$27,040	100%	$27,040	$27,040
dir serv prof	$26,000	100%	$26,000	$26,000
dir serv prof	$26,000	100%	$26,000	$26,000
dir serv prof	$26,000	100%	$26,000	$26,000
dir serv prof	$26,000	100%	$26,000	$26,000
dir serv prof	$26,000	60%	$15,600	$15,600
dir serv prof	$26,000	60%	$15,600	$15,600
dir serv prof	$26,000	60%	$15,600	$15,600
dir serv prof	$26,000	60%	$15,600	$15,600
cps	$29,120	100%	$29,120	$29,120
ops manager	$37,000	25%	$9,250	$9,250
Subtotal	**$399,485**			**$338,135**

Schuylkill County - Service Access and Management, Inc.
590 Terry Reiley Way
Pottsville, PA 17901
Contact: Gerald Achenbach

Provider Type: Social service agency
PDX ID: PA-064
State Provider ID: 4264
Contact Phone #: 5706212700

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.
Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◉ No ○

NOT FINAL

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 34,816**	**$ 11,605**	**$ 46,421**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 34,816	$ 11,605	$ 46,421	Detailed budgets and narratives are included in individual provider IUPs.

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 34,816	$ 11,605	$ 46,421	
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 34,816	$ 11,605	$ 46,421	

Source(s) of Match Dollars for State Funds:

Schuylkill County will receive a total of $46,421 in federal and state PATH funds.
Detailed budgets and narratives are included in individual provider IUPs.

Estimated Number of Persons to be Contacted: 310

Estimated Number of Persons to be Enrolled: 84

Estimated Number of Persons to be Contacted who are Literally Homeless: 186

Number staff trained in SOAR in grant year ending in 2018: 0

Number of PATH-funded consumers assisted through SOAR: 0

NOT FINAL

Service Access and Management, Inc.
590 Terry Reiley Way
Pottsville, PA 17901
Schuylkill County, Pennsylvania

PATH Intended Use Plan FY 2018-2019

Local Provider Description

Full name and mailing address of provider organization(s) in the IUP
The sole provider for PATH (Projects for Assistance in Transition from Homelessness) services in Schuylkill County for the 2018-2019 fiscal year will be:

Service Access and Management, Inc.
590 Terry Reiley Way
Pottsville, PA 17901

Type of organization (e.g., community mental health center, county or local government entity, health care provider, private non-profit organization)
Service Access and Management, Inc. is a non-profit 501(c)(3) that focuses on providing mental health case management services and all supplemental services related to case management such as housing 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

NOT FINAL

- Supported Living Program (on-site housing assistance)
- Transitional Living Program (on-site housing assistance)
- Vocational Services

Indicate geographic area(s) to be served by provider(s)
This Intended Use Plan will serve consumers in Schuylkill County, Pennsylvania. Even though Service Access and Management, Inc. operates in forty-eight (48) Pennsylvania counties and six (6) counties in New Jersey, this particular Intended Use Plan is only for Schuylkill County, Pennsylvania.

Amount of PATH funds the organization will receive with federal and state amounts spelled out for each provider
Schuylkill County is scheduled to receive a total of $46,421 in PATH funding for the 2018 – 2019 fiscal year. Of this amount, $34,816 is the Federal Allocation and $11,605 is the State Allocation. The local contribution toward the case management position and outreach services is $25,894.

List the provider number and name as it appears in PDX
Our provider number and name as it appears in PDX is:

PA-064 Schuylkill: Service Access and Management, Inc.

Collaboration with HUD Continuum of Care (CoC) Program
Schuylkill County's membership in the HUD Continuum of Care Program is with the PA-509 Eastern Pennsylvania Continuum of Care. More specifically, we are included on the Central Valley Regional Homeless Advisory Board (RHAB).

The Service Access and Management, Inc. Housing Coordinator, who supervises the county PATH program, is an active participant on the Central Valley Regional Homeless Advisory Board and recently completed a 3-year term as the Co-Chair of the Central Valley Regional Homeless Advisory Board. That term ended on June 30, 2017. The SAM Housing Coordinator continues to participate in monthly Central Valley RHAB meetings and bi-annual Eastern Continuum of Care meetings. Service Access and Management, Inc.'s participation in the Continuum of Care began in October 2009 and will continue.

Service Access and Management, Inc. is fully participating in the regional Coordinated Entry program, which was implemented by the Continuum of Care in January 2018. Service Access and Management, Inc.'s Housing Coordinator and PATH Master Case Manager both received Coordinated Entry System training from the Continuum of Care in order to provide consumers with the best care possible. The Service Access and Management, Inc. PATH Master Case Manager has her consumers utilize the 2-1-1 system that connects the consumer to the Coordinated Entry System. While using 2-1-1, the consumer is provided a universal assessment that allows them to access all services available to them, including the PATH program.

NOT FINAL

Two organizations within our county are HUD Continuum of Care (CoC) recipients. Those recipients are Schuylkill Women in Crisis and Resources for Human Development. The Service Access and Management, Inc. PATH program collaborates regularly with Schuylkill Women in Crisis and Resources for Human Development.

Whenever the Service Access and Management, Inc. PATH program enrolls a female who has experienced any form of domestic violence or was involved in thought-to-be domestic violence, we ask that consumer to immediately sign release of information forms and we then contact Schuylkill Women in Crisis for their assistance.

Resources for Human Development has developed and opened twelve apartments with the assistance of HUD Continuum of Care (CoC) funds. Our PATH Master Case Manager works closely with the Resources for Human Development case manager. Together, they have placed a number of PATH consumers into Resources for Human Development apartments.

Service Access and Management, Inc. is a member of the PA-509 Eastern Pennsylvania Continuum of Care.

Collaboration with Local Community Organizations
Partnerships and activities with local community organizations that provide key services to PATH-eligible clients are often facilitated through 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. Other Service Access and Management, Inc. staff who serve on the LHOT are the Housing Coordinator and PATH Master Case Manager. The LHOT meets regularly; however, LHOT may meet more often when the need arises. The LHOT met often during November 2017, December 2017 and January 2018 to plan for the January 2018 Point-in-Time Count.

Other local planning activities, along with coordination of programs, have provided PATH-eligible clients the opportunity to reside in one of five permanent supportive housing apartment buildings that have been developed through program coordination with Block Grant funds. Admission into these five apartment buildings is initiated by submitting an application to Service Access and Management, Inc. Permanent supportive housing opportunities that are available to assist PATH-eligible clients include:

a. Barefield Plaza, located in Pottsville, is the site of 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 Merakey Mt. Hope apartment building, located in Pottsville, includes a total of ten (10) beds; however, 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.

NOT FINAL

c. Two apartments, located at 719 North Second Street, Pottsville, are also on the county's permanent supportive housing inventory. Three beds are available at 719 North Second Street for consumers affected by a mental health illness, including PATH consumers.

d. Two additional permanent supportive housing units are located at 610 West Market Street in Pottsville. There are three bedrooms available at this location for consumers affected by a mental health illness, including PATH consumers.

e. Three permanent supportive housing units are available for PATH-eligible clients at 21 South Centre Street in Pottsville. There are three one bedroom apartments available at this location.

f. Currently, construction is taking place at 217 North Second Street in Pottsville on a three unit apartment building that will be added to the permanent supportive housing program. Two of the units will be one bedroom apartments and one unit will be a two bedroom apartment. PATH consumers will be targeted for tenancy in that building.

g. A full-time Housing Coordinator assists in many housing matters. The duties of the Housing Coordinator complement PATH services. The Housing Coordinator supervises the PATH Master Case Manager.

NOT FINAL

Service Provision

A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients

When the Service Access and Management, Inc. PATH Master Case Manager meets with a consumer, the consumer's status is discussed including housing, finances, medical and any other matters related to housing. If the consumer has not yet utilized the 2-1-1 Coordinated Entry System, the consumer is helped to utilize it.

The PATH Master Case Manager, through a thorough intake interview, determines the PATH-eligibility of the consumer using the PATH guidelines. If the consumer is willing, an enrollment may be completed the same day, or scheduled for another day depending on the availability of the consumer and PATH Master Case Manager.

At the time of the enrollment, written documentation of a mental health illness is not required; however, the consumer is informed that a written diagnosis is needed within the timeline provided by the PATH program. During enrollment, eligibility is documented in the PA Homeless Management Information System (PA HMIS). The consumer's intake information is also added to CPR-Web, which is Service Access and Management, Inc.'s comprehensive and secure database.

Alignment with PATH goals

Since beginning its administration of PATH in July 2010, Service Access and Management, Inc. has employed one full-time case manager dedicated solely to the PATH Program. We will continue to employ one full-time, dedicated case manager in the PATH Program. By using this

model, Service Access and Management, Inc. is able to align the PATH Master Case Manager's job description to the PATH goals. Our focus will be case management.

Street outreach in Schuylkill County has been discussed on numerous occasions with a variety of professionals in human service agencies and other programs. Although there are certain instances where active street outreach outside of the office is beneficial, we have found that we are able to provide more effective and efficient assistance to the PATH population by focusing on case management and serving the many individuals who walk into our office. A strong network of local human service professionals recommends, on a regular basis, Service Access and Management, Inc. to those in need of housing assistance. So, outreach also occurs as those who are literally homeless seek out Service Access and Management, Inc. instead of Service Access and Management, Inc. searching for the homeless.

Our PATH Master Case Manager uses two different strategies to actively seek out individuals who may be in need of housing. The PATH Master Case Manager conducts routine visits to Safe Haven. Individuals with a mental health diagnosis who are in a controlled state of crisis are eligible to reside overnight at the Safe Haven program for a limited amount of time. In addition to Safe Haven visits, the PATH Master Case Manager conducts full day outreach visits one day each week at My Father's House. My Father's House is the county's only general population day program for individuals who are homeless.

Aggressive, daily outreach that is conducted literally "on the street" is not a necessity in Schuylkill County because, oftentimes, a person who is homeless, or a family member of a person who is homeless, will seek out our PATH Master Case Manager by name. Monica Kissinger's (PATH Master Case Manager) name is becoming synonymous with homelessness throughout Schuylkill County based on her successful reputation for assisting those who are homeless. We have learned that through our PATH Master Case Manager's networking and reputation, persons who are literally homeless have found us. During this current fiscal year, from July 1, 2017, through June 30, 2018, we anticipate that approximately three hundred (300) potential PATH-eligible consumers will either walk into the Service Access and Management, Inc. office or call the PATH Master Case Manager to seek assistance.

Even though the PATH Master Case Manager will not need to be "on the street" conducting daily outreach, the PATH Master Case Manager will engage in other forms of outreach. The outreach may include: (a) observing and engaging an individual on the street who appears to be homeless, (b) locating a person who has been observed on the street or in a site unfit for human habitation 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.
One full-time PATH Master Case Manager will continue to work hand-in-hand with PATH-eligible consumers in assisting them with locating housing and securing other services. The PATH Master Case Manager will do this, directly, through written goals with the PATH consumers.

NOT FINAL

Maximizing PATH funds
The leveraging of other available funds for PATH client services is a real strength of our PATH program.

One constant source of leverage is though our County Mental Health Office. The County Mental Health Office, in collaboration with the Block Grant Board, provides leveraged funds in the following ways: (a) permanent supported housing apartments for PATH consumers are created in partnership with real estate developers, (b) furniture is provided for PATH consumers who are tenants in the permanent supported housing apartments, (c) matching funds are available for the PATH grant which assist with meeting the total costs of the PATH Master Case Manager, and (d) ancillary funds for PATH consumers are available for emergency motel and rooming house vouchers, rental subsidy monies and critical household supplies.

PATH consumers also benefit from the Transition Age Youth Program that provides rental subsidies, security deposits, moving costs, payments of arrears, 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 operates a day program for the homeless and an overnight shelter for men and women. These supports are available for PATH-eligible consumers.

Gaps that exist in the current service systems
Schuylkill County has solved some of its most significant housing gaps.

For example, Schuylkill County never had a general population homeless shelter. In 2015, a day shelter for men and women was opened. In 2016, an overnight shelter was added for males. In 2017, after some modifications to the overnight shelter, beds for women were added to the overnight shelter.

We were also limited in how we assisted transition age youth. A grant that was awarded to Service Access and Management, Inc. in 2015 significantly enhanced our housing services and financial supports to transition age youth who were identified as having a mental health illness. Unfortunately, that funding was exhausted in March 2018. However, as those funds were expiring, we learned that we had received a PHARE grant from the Pennsylvania Housing Finance Agency that would allow us to continue our transition age youth housing project.

Even though we are able to provide professional support services and rental assistance to transition age youth, we do lack a residential housing program targeted specifically for transition age youth.

The availability of Housing Choice (Section 8) Vouchers has been improving; however, there is still a gap in the immediate availability of Housing Choice (Section 8) Vouchers. There are two

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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 also 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:

- Limited housing options for persons who are homeless
- Limitations for successful prisoner re-entry
- Some limitations to public transportation
- Difficulty in locating apartments that can pass Housing Choice (Section 8) Voucher inspections

Co-occurring services
Both mental health and drug and alcohol outpatient providers take into consideration the presence of a co-occurring diagnosis. Drug and alcohol non-hospital detoxification and drug and alcohol rehabilitation services are available within the county. Non-hospital and hospital based treatment services are 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 rental subsidies to individuals with drug and alcohol issues. Oftentimes, these individuals are also identified with a serious mental health illness.

42 CFR Part 2 regulations
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, Inc.'s PATH program, along with all other programs at Service Access and Management, Inc., the consumer is provided documents to notify them of their rights to privacy. Consumers learn 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 provided a copy of Service Access and Management, Inc. Grievance Procedures in the event that they feel that any of their rights have been violated during their time with Service Access and Management, Inc.

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Service Access and Management, Inc. also cooperates with requests from drug and alcohol facilities when those facilities have separate, more specific forms. For example, Pyramid Health Care and Roxbury will request that their forms are also included when partnering on cases.

To ensure that all PATH consumers' information is protected, our PATH Master Case Manager uses HMIS and CPR-Web, which are both secure databases. Service Access and Management, Inc. also has a "release" process for any consumer information that is shared with another agency. The consumer must consent to this release of information by signing a release form. Consumers may withdraw the release at any time if they choose.

Criminal 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 Master Case Manager works with consumers at all points in the criminal justice system process. Often, our PATH Master Case Manager will attend hearings with consumers who have been charged with crimes or who are facing eviction. The PATH Master Case Manager can work with individuals in prison as well as those who are about to be released. The PATH Master Case Manager is able to help consumers access resources and act as a point-of-contact for probation and parole officials.

Consumers who are in need of health services and enrolled in Service Access and Management, Inc.'s PATH program can work with the PATH Master Case Manager to seek out health services for which they are eligible. Often, health needs are identified during enrollment, and the PATH Master Case Manager may refer or empower the consumer to refer themselves for health services.

While in the community, consumers with a criminal history often have trouble accessing public housing and other affordable housing due to their previous criminal charges. Service Access and Management, Inc.'s PATH Master Case Manager has established a close relationship with our two public housing authorities and is very well versed on what information is needed to assist consumers with "exceptions" and to address previous charges. This would include a letter of rehabilitation from treatment facilities, letters of completion from probation and parole officials, confirmations of diagnosis and other information that makes their applications more likely to be approved. If the application is denied, the PATH Master Case Manager can help the consumer file an appeal and, again, help the consumer secure documents needed to improve their chances of prevailing at their appeal hearing.

Consumers with a criminal history often have barriers to finding employment. Service Access and Management, Inc.'s PATH Master Case Manager works closely with the local CareerLink office, which is located less than a half-mile from the Service Access and Management, Inc. office. CareerLink is a no-cost service available to PATH consumers that helps them access job opportunities in businesses that employ individuals with criminal backgrounds.

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

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applicants who 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.

Data

Currently, Service Access and Management, Inc. fully utilizes PA HMIS and enters all PATH data into the system. Schuylkill County uses the ClientTrack product.

When new consumers are opened into the PATH program, all data is entered into the HMIS system. This allows our PATH program to run reports in the HMIS system and to utilize that information to complete the yearly PATH report.

Service Access and Management, Inc.'s PATH Master Case Manager and Housing Coordinator will continue to participate in new PATH trainings and other valuable PATH Webinars and Conference calls when they become available. All Service Access and Management, Inc. Housing staff are on the HMIS mailing list and receive all notifications of new HMIS required trainings and optional training opportunities. Service Access and Management, Inc.'s PATH Master Case Manager and Housing Coordinator participate in new HMIS trainings and have access to previously conducted trainings that are archived on the PA HMIS website.

In the event that Service Access and Management, Inc. would need to train new staff to use HMIS, there is a library of trainings available within the HMIS (Client Track). Trainings are available by PDF documents and are also in recorded webinar form located at http://www.pennsylvaniacoc.org/pahmis/. New staff would be required to complete all trainings relating to PATH and HMIS. Support from HMIS is also offered to help with the training of new staff.

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.

In respect to case management, even though our PATH funding is limited, we do employ a fulltime PATH Master Case Manager, dedicated solely to PATH. Because Federal and State PATH funds fall short in completely funding the position, the County contributes Block Grant monies to support this position. The PATH Master Case Manager benefits not only from state level PATH technical assistance, but the PATH Master Case Manager also benefits from all other technical assistance and training provided to all Service Access and Management, Inc.'s

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case managers. Because we have employed a PATH Case Manager since July 2010, we fully understand the role of our PATH Master Case Manager.

During fiscal year 2015-2016, our PATH Master Case Manager attended the PATH two day technical assistance conference in State College on April 20 – 21, 2016. Our PATH Master Case Manager also attended the statewide PATH conference that occurred from June 13 – 15, 2017. At this time, there is not a PATH conference scheduled for 2018.

In addition to the history of the position, along with daily support of the positon by Service Access and Management, Inc., our current PATH Master Case Manager also completed the Service Access and Management, Inc. Master Case Manager program.

PATH consumers are well supported with strong and comprehensive 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, 2017, through June 30, 2018, we project that more than three hundred (300) potential PATH-eligible consumers will either walk into the Service Access and Management, Inc. office or call the PATH Master Case Manager to seek assistance.

Since the opening of the Servants to All day program facility for homeless in Schuylkill County (entitled My Father's House) on November 4, 2015, all individuals who are homeless, or at imminent risk of homelessness, oftentimes first visit My Father's House. Because there is a close relationship between the PATH program and My Father's House, individuals who arrive at My Father's House, and who declare a mental health illness or demonstrate symptoms, are referred to the PATH Master Case Manager.

Street outreach in Schuylkill County has been discussed on numerous occasions with a variety of professionals in human service agencies and other programs. Although there are certain instances where active street outreach outside of the office is beneficial, we have found that we are able to provide more effective and efficient assistance to the PATH population by focusing on case management and serving the many individuals who walk into our office. A strong network of local human service professionals recommends, on a regular basis, the Service Access and Management, Inc. PATH Master Case Manager to those in need of housing assistance. Outreach occurs as individuals who are homeless seek out the PATH Master Case Manager instead of the PATH Master Case Manager searching for the homeless.

Although, our PATH Master Case Manager actually uses two different strategies to actively seek out individuals who may be in need of housing. The PATH Master Case Manager conducts routine visits to Safe Haven, a mental health short-term crisis residential facility. Individuals with a mental health diagnosis who are in a controlled state of crisis are eligible to reside overnight at the Safe Haven program for a limited amount of time. In addition to Safe Haven

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visits, the PATH Master Case Manager conducts full day outreach visits one day a week at My Father's House. My Father's House is the county's only general population day program for individuals who are homeless.

Aggressive, daily outreach that is conducted literally "on the street" is not a necessity in Schuylkill County because, oftentimes, a person who is homeless, or a family member of a person who is homeless, will seek out our PATH Master Case Manager by name. Monica Kissinger's (PATH Master Case Manager) name 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 Master Case Manager's networking and reputation, persons who are literally homeless make drop-in visits to the Service Access and Management, Inc. office. During this current fiscal year, from July 1, 2017, through June 30, 2018, we anticipate that approximately three hundred (300) potential PATH-eligible consumers will either walk into the Service Access and Management, Inc. office or call the PATH Master Case Manager to seek assistance.

In summary, the PATH Master Case Manager engages in various forms of outreach. The outreach may include: (a) observing and engaging an individual on the street who appears to be homeless, (b) receiving reports of individuals who may be homeless and locating those individuals who have been observed on the street or in a site unfit for human habitation and are 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.

Alignment with State Comprehensive Mental Health Services Plan

The State Comprehensive Mental Health Services Plan states:

> "OMHSAS has implemented an OMHSAS Permanent Supportive Housing Initiative utilizing local, state and federal resources to expand affordable, supportive housing and residential programs for adults."

Schuylkill County has taken a very aggressive approach in the development of permanent supportive housing. Our first units were opened in 2012. We now have twenty-one (21) permanent supportive housing beds. The development of four (4) additional beds is in progress. PATH consumers are often selected for tenancy in permanent supportive housing.

The State Comprehensive Mental Health Services Plan also states:

> "Our progress with the development of housing options continues to recognize that many individuals, who have a disability, including individuals who have a serious and persistent mental illness, can live successfully in the community if they have appropriate supports and services."

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Schuylkill County's PATH Master Case Manager has dual expertise – in mental health and in housing. With these skills, along with a supportive community, PATH consumers have multiple housing options in the City of Pottsville and surrounding areas including permanent supportive housing, public housing and apartments supported through Housing Choice (Section 8) Vouchers.

Other Designated Funds
The PATH program is well supported by additional funds.

The primary source of additional funds that serve PATH consumers is Reinvestment Contingency Funds. These funds support PATH consumers in a variety of ways, including:

a. monthly rents
b. security deposits
c. basic household supplies
d. fees for obtaining state issued identification, birth certificate, social security card or other documents required for state and federal housing
e. criminal background and application fees to obtain permanent supportive housing
f. money owed to a Public Housing Authority in order to become eligible for a Section 8 Housing Choice Voucher or other Project Based Subsidy Housing
g. cleaning and maintenance repairs necessary to pass housing inspections
h. temporary housing costs, for up to six nights, while in transition to permanent supportive housing

Another 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 (as capital projects) in partnership with real estate developers
f. emergency motel vouchers
g. rent in arrears

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

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g. transportation costs
h. utility costs
i. moving 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.

Programmatic and Financial Oversight

Schuylkill County's PATH's programmatic integrity is continuously monitored and supported by Pennsylvania's Department of Human Services. The Human Services Program Specialist, who is our PATH contact at the Bureau of Policy, Planning, & Program Development, reaches out multiple times each week with updates related to PATH. In addition, questions are addressed often through emails or phone calls. Statewide PATH provider conference calls occur on a quarterly basis. Site visits by the Human Services Program Specialist are also scheduled.

The County's Office of Mental Health's fiscal staff maintains an ongoing dialogue with Service Access and Management, Inc.'s fiscal staff. In addition, the County's Office of Mental Health fiscal staff and administration conduct monthly meetings with Service Access and Management, Inc.'s fiscal staff and administration to review financial history, activity and forecasted expenditures.

Each PATH provider is also required to provide regular budget updates to Pennsylvania's Department of Human Services.
Ultimately, Service Access and Management, Inc.'s PATH program is subject to fiscal audits by local and state auditors.

SSI/SSDI Outreach, Access, Recovery (SOAR)

The number of staff trained in SOAR

Two of 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 county human service agency staff enrolled in SOAR training.)

The number of staff who provided assistance with SI/SSDI applications using the SOAR model

No staff were able to provide beginning-to-end comprehensive assistance with SI/SSDI applications using the prescribed SOAR model.

The number of consumers assisted through SOAR

No consumers were provided beginning-to-end comprehensive assistance with SI/SSDI applications using the prescribed SOAR model. 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

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apply that knowledge when assisting PATH funded consumers in completing the Social Security application process.

Application eligibility results (i.e., approval rate on initial application, average time to approve the application)
There is no available data.

The number of staff dedicated to implementing SOAR, part- and full-time [If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI), timely determination of eligibility, and the outcomes of those applications (i.e., approval rate on initial application, average time to approve the application). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.]
There are currently no staff members dedicated to implementing SOAR, part or full-time. There is only one PATH position funded with our $46,421 PATH grant and that PATH Master Case Manager is focused on outreach and assisting the homeless with finding housing. The SAM Housing staff and SAM's Blended Case Managers (BCMs) do assist with the completion of SSI/SSDI applications. This is done by guiding the consumer through the application process, helping the consumer gather the necessary information and informing the consumer as to how the process works.

The PATH Master Case Manager and Housing Coordinator are on the SOAR email list and receive regular updates about the program and participate in SOAR webinars when possible.

Housing
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.

b. The Housing Coordinator at Service Access and Management, Inc. has become a single point of contact with the housing authorities in matters regarding persons with mental health illnesses who are homeless or at imminent risk of homelessness. This single point of contact concept, and Service Access and Management, Inc.'s relationships with the housing authorities, has enhanced the services provided by the PATH Master Case Manager.

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c. Bridge Housing. The Bridge House Program is a transitional housing program operated by Schuylkill Community Action for residents of Schuylkill County who are homeless or at imminent risk of homelessness. The program serves men, women and children with residency limited to three to twelve months. Residents must follow rules, attend programs and participate with case management and goal plans. The PATH Master Case Manager has Bridge Housing as an option that may be pursued when working with PATH consumers. The Housing Coordinator also serves on the Screening Committee for the Bridge Housing program.

d. 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.

e. 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.

f. 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.

g. Community Rehabilitative Residence (CRR). In Schuylkill County, there are two Community Rehabilitative Residence sites (CRRs). Service Access and Management, Inc. staff is integral in the placement and monitoring of consumers as they enter and exit the CRRs. The PATH Master Case Manager has regular updates as to the availability of openings in the CRRs should that be an appropriate strategy for a PATH client. The PATH Master Case Manager also assists consumers move from the CRRs into more traditional housing.

h. Permanent Supportive Housing (PSH). Through the use of HealthChoices Reinvestment funds, local Base funds and Block grant funds, multiple permanent supportive housing apartments have been developed. During phase one of the development of permanent supportive housing, twelve beds became available. Another bed was added during phase two. Two more beds were added in phase three. Phase four is complete and has provided three more beds.

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i. Permanent supportive housing beds first became available in June 2012. Currently, twenty-one (21) permanent supportive housing beds are available in the City of Pottsville. Another two (4) beds will be available in 2018-2019.

j. 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.

k. Servants To All/My Father's House. Beginning November 2015, My Father's House has served as a homeless daytime resource center for Schuylkill County. The PATH Master Case Manager coordinates with My Father's House to screen for PATH eligibility. My Father's House assists with temporary housing, housing searches, food, job searches, clothing, spiritual needs and referrals to other services.

l. Servants to All Overnight Shelter. Beginning November 2016, Servants to All opened an overnight shelter for men at the United Presbyterian Church in Pottsville. PATH consumers are eligible as overnight guests. In the fall of 2017, after some modifications to the site, the shelter also opened for women, as well.

m. Rooming Houses. Servants to All provides overnight shelter to individuals who may not be appropriate for the overnight shelter in contracted rooming houses. PATH consumers are eligible to stay in the Servants to All rooming houses.

n. Transition Age Youth Program. Beginning August 1, 2015, Service Access and Management, Inc. implemented a housing support services program dedicated to assisting transition age youth. The program was funded with Health Choices Reinvestment Funds. The program was scheduled to end June 30, 2017; however, an extension was granted. Eligible transition age youth receive assistance with rental costs, security deposits, moving costs, rents in arrears, furniture purchases, personal identification fees, household supplies and have access to professionals who will assist them with accessing housing and becoming successful tenants. Funding was exhausted in March 2018 but, because of a PHARE grant received through the Pennsylvania Housing Finance Agency, the Transition Age Youth Program will continue into 2018 – 2019. Block Grant monies were used to finance the gap between March 2018 and June 2018.

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Coordinated Entry

Service Access and Management, Inc.'s PATH program is engaged and using the Coordinated Entry System that became available January 2018. Service Access and Management, Inc. signed the Coordinated Entry Agreement to use the Coordinated Entry System in the PATH Master Case Manager's region.

Service Access and Management, Inc. has six programs, including the PATH program, that are listed in the Coordinated Entry System that covers the region. This allows anyone utilizing the Coordinated Entry System to be screened and, then, to be immediately referred to the PATH program if they are appropriate. The Service Access and Management, Inc. PATH Master Case

Manager receives these referrals via email from the Coordinated Entry System and then contacts the referred individual to begin the intake process.

Service Access and Management, Inc.'s PATH Master Case Manager is also able to assist consumers contact the Coordinated Entry System by having them utilize the 2-1-1 phone system. This ensures that every consumer receives the same thorough screening and appropriate referrals.

The Eastern PA Continuum of Care holds monthly "Community Q Scrubs" meetings. Each provider that participates in the Coordinated Entry System is invited to attend. During the meeting, providers may discuss their recent referrals, difficult cases, issues with the system and more. Typically, there are representatives from the Collaborative Applicant and DCED are in attendance. Currently, the monthly meeting for the Central Valley Regional Homeless Advisory Board is run by Chris Kapp.

Justice Involved

Currently, Schuylkill County does not have any Crisis Intervention Teams. Training has been offered by the Family Training and Advocacy Center; however, no police departments have been able to commit to the training. Training opportunities will continue to be offered.

Staff Information

Describe the demographics of staff serving your clients

The Service Access and Management, Inc. Schuylkill County staff, including all management, professional and administrative support staff, totals sixty-six (66). Of this total, fifty-eight (58) are females and eight (8) are males. The age range is twenty-three (23) years of age to sixty-eight (68) years of age. The staff consists of sixty-five (65) Caucasians and one (1) Hispanic/Latino.

Explain how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients

All Service Access and Management, Inc. staff members are trained to be sensitive to age, gender, disabilities and racial/ethnic differences of clients. In addition, there are periodic trainings available that address the area of lesbian, gay, bisexual and transgender. Upon employment with our organization, all new staff members complete an intensive New Staff Orientation (NSO). Trainings begin with a Company Overview and presentation of Service Access and Management, 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

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- 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.

Discuss the extent to which staff are receptive to differences of clients
In addition to the new staff orientation and mandated trainings regarding respect for others’ differences, Service Access and Management, Inc. is accredited by the Commission on Accreditation of Rehabilitation Facilities. Through that intensive accreditation process, Service Access and Management, Inc. must pass a rigorous process to affirm its receptiveness to differences in our clients.

In addition to the formalized trainings and assessments, Service Access and Management, Inc. operates in forty-eight (48) Pennsylvania counties and six (6) New Jersey and, therefore, faces differences on a day-to-day basis within our own company.

Identify the extent to which staff receive periodic training in cultural competence and health disparities

NOT FINAL

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.

How many of your PATH staff are Certified Peer Specialists or Certified Recovery Specialists?
Our county only employs one PATH staff member. That PATH Master Case Manager is not a Certified Peer Specialists or Certified Recovery Specialists.

Client Information
Describe the demographics of the client population
The demographics of the client population during the most recent annual report follow:

AGE

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0	17 and Under
14	18 – 23 years
28	24 – 30 years
43	31 – 50 years
12	51 – 61 years
0	62 and over
0	Don't know
0	Refused

GENDER

50	male
47	female
0	Don't Know
0	Refused

RACE/ETHNICITY

1	American Indian or Alaskan Native
1	Asian
4	Black or African American
0	Native Hawaiian or other Pacific Islander
87	White
0	Two or More Races
5	Don't Know
0	Refused

HOUSING STATUS (AT FIRST CONTACT)

2	Outdoors (e.g. street, abandoned or public building, automobile)
45	Short term shelter
0	Long term shelter
47	Own or someone else's apartment, room or house hotel, SRO, boarding house
2	Halfway house, residential treatment program, institution (psychiatric or other hospital, nursing home, etc.)
1	Jail or correctional facility
0	Other
0	Unknown

LENGTH OF TIME LIVING OUTDOORS OR IN SHORT TERM SHELTER AT FIRST CONTACT

NOT FINAL

22	Less than 2 days
34	2 to 30 days
15	31 to 90 days
14	91days to one year
12	Over one year
0	Unknown

Project the number of adult clients to be contacted
The projected number of adult clients to be contacted during the 2018 – 2019 fiscal year using PATH funds by the PATH Master Case Manager will be approximately three hundred (300). Because Service Access and Management, Inc. either provides or oversees all mental health case management services contracted through Schuylkill County's MH/DS Program, our PATH Master Case Manager will have a sound network of sources to identify persons who have a mental health illness and who are homeless or at imminent risk of homelessness.

Identify expected number of adult clients to be enrolled
The projected number of adult clients who have a mental health illness and who are homeless or at imminent risk of homelessness and who will be enrolled by the PATH Master Case Manager will be approximately ninety (90).

Give estimated percentage of adult clients to be served using PATH funds who are literally homeless
The percentage of adult clients to be served with PATH funds and who are projected to be "literally" homeless will be approximately sixty percent (60%) of clients served with PATH funds.

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.

Individuals who are homeless and have serious mental illnesses, along with their 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 Bylaws, 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.

NOT FINAL

b. The day-to-day operations of Schuylkill County's MH/DS Program are managed through a contractual relationship with Service Access and Management, Inc. The Board of Directors of Schuylkill County's MH/DS Program includes consumer membership

c. Service Access and Management, Inc. is involved with the local chapter of the National Alliance on Mental Illness (NAMI) on an on-going basis. Consumers participate in NAMI

d. Service Access and Management, Inc. is a member of the Schuylkill County Recovery Team. The purpose of the Recovery Team is to support the mission of recovery. The partnership includes consumers, family members, providers and interested stakeholders.

e. Service Access and Management, Inc. is a member of the Schuylkill Employment Transformation Committee. This committee is composed of professionals from a variety of arenas and also includes consumers and family members. The committee's purpose is to study and develop initiatives that place value in hiring persons who are disabled.

f. Service Access and Management, Inc. is a member of the Community Support Program (CSP). The CSP membership includes consumers, family members, professionals and community representatives. The CSP, through collaboration of the members, strives to assess the effectiveness of the behavioral health system, decrease stigmas and increase awareness.

g. Service Access and Management, Inc. is a member of the Schuylkill County Forensics Task Force. Membership often includes a peer specialist along with appropriate professionals. The committee focuses on improving service delivery between systems

h. A mental health consumer is a member of the Service Access and Management, Inc. Program Committee

i. During the development of the most recent capital project, consumer input was sought regarding the location and amenities of an apartment building that would be selected to be renovated for mental health consumers

NOT FINAL

Health Disparities Impact Statement

Since assuming the role of PATH provider in Schuylkill County in July 2010, we have integrated the comprehensive disparity trainings and knowledge provided by Service Access and Management, Inc. into the operation of the PATH program. The PATH staff has been sensitive to the culture of Service Access and Management, Inc. in respect to acknowledging and responding to any disparities recognized in the individuals we serve.

In addition, our closest community partner, the Servants to All homeless program, has been invested in a formal study of social determinants among the homeless population since July 2017.

We see complementary threads tying together health disparities and social determinants.

Ultimately, we find that Schuylkill County, in respect to the PATH population and HMIS data, demonstrates few, if any, health disparities. Our county does not serve as a social magnet to draw into the county any specific population that would tend to be labeled under the definition of health disparities. And, within the county, we find no evolving sub-population that would be defined as one of a significant health disparity; however, an aging population may eventually be a concern.

The following information was extracted from our HMIS data.

AGE

0	17 and Under
14	18 – 23 years
28	24 – 30 years
43	31 – 50 years
12	51 – 61 years
0	62 and over
0	Don't know
0	Refused

GENDER

50	male
47	female
0	Don't Know
0	Refused

RACE/ETHNICITY

1	American Indian or Alaskan Native
1	Asian
4	Black or African American
0	Native Hawaiian or other Pacific Islander
87	White
0	Two or More Races
5	Don't Know
0	Refused

Currently, there are no HMIS questions for the PATH program that reference sexual or gender minority groups.

NOT FINAL

The unduplicated number of YYA individuals who are expected to be served using PATH funds
The PATH Master Case Manager expects to serve fifty-one (51) YYA during the 2018 – 2019 fiscal year.

The total amount of PATH funds expected to be expended on services for the YYA population
The total amount of funds expected to be expended for services for the YYA population for during the 2018 – 2019 fiscal year is $30,000.

The types of services funded by PATH that are available for YYA individuals
The primary service that is available to YYA individuals that is funded by PATH is case management and outreach.

The primary source of supplemental funds that are available to serve PATH YYA consumers is Reinvestment Contingency Funds. These funds can support PATH YYA consumers in a variety of ways, including:

a. monthly rents
b. security deposits
c. basic household supplies
d. fees for obtaining state issued identification, birth certificate, social security card or other documents required for state and federal housing
e. criminal background and application fees to obtain permanent supportive housing
f. money owed to a Public Housing Authority in order to become eligible for a Section 8 Housing Choice Voucher or other Project Based Subsidy Housing
g. cleaning and maintenance repairs necessary to pass housing inspections
h. temporary housing costs, for up to six nights, while in transition to permanent supportive housing

Another source of additional funds that can serve PATH YYA consumers is County Block Grant funds. Block Grant funds may be used to assist PATH YYA consumers in a variety of ways, including:

a. monthly rents
b. security deposits
c. furniture
d. basic household supplies
e. apartment renovations (as capital projects) in partnership with real estate developers
f. emergency motel vouchers
g. rent in arrears

A data-driven quality improvement plan that implements strategies to decrease the disparities in access, service use, and outcomes both within the YYA population and in comparison to the general population
In Schuylkill County, we do not believe that there are disparities in access, service use, and outcomes both within the YYA population and in comparison to the general population.

NOT FINAL

Actually, we believe the contrary is true. Since August 2015, Schuylkill County has invested Reinvestment Funds, Block Grant monies and a PHARE Grant from the Pennsylvania Housing Finance Agency to target the 18 through 25 age population. We have committed staff directly to this population and have used our funding sources to assist with:

a. monthly rents
b. security deposits
c. furniture
d. basic household supplies
e. rents in arrears
f. personal identification document costs
g. moving costs

Now that we have learned that the disparate population of Youth and Young Adult (YYA, ages 18-30) is the group currently being targeted, we will expand our focus group from ages 18 through 25 to ages 18 to 30.

Limited English Proficiency

The most recent census data reports:

"The most common language spoken in Schuylkill County, Pennsylvania, other than English is Spanish. 4.6% of Schuylkill County citizens are speakers of a non-English language. That is lower than the national average of 21%."

Even though, statistically, more than ninety-five percent (95%) of PATH consumers speak English, Service Access and Management, Inc. is well-prepared to address the needs of limited English proficient (LEP) persons. With Spanish being the language spoken by the majority of limited English proficient (LEP) persons, Service Access and Management, Inc. is well-equipped to address the needs of that population. Service Access and Management, Inc. employs many individuals who speak Spanish and have developed many forms and other material in Spanish.

Ultimately, no matter what language is spoken by our PATH consumers, Service Access and Management, Inc. has a contract with Interpretalk which provides immediate access to interpreters in all languages. Never has the needs of a limited English proficient (LEP) person hampered the delivery of PATH services.

Budget Narrative

PATH costs that are certain are:

a. Case management services and outreach services costs include health, dental, vision, life insurance, FICA, Worker's Compensation. ($68,014.00)

   The PATH Master Case Manager will:

NOT FINAL

- Prepare a plan for the provision of community mental health services to eligible homeless individuals, and review such plan not less than once every 3 months;

- Provide assistance in obtaining and coordinating social and maintenance services for eligible individuals who experience homelessness, including services related to daily living activities, peer support, personal financial planning, transportation, habilitation and rehabilitation, prevocational and vocational training, and housing;

- Provide assistance to eligible individuals who experience homelessness in obtaining income support services, including housing assistance, food stamps, and supplemental security income benefits;

- Refer eligible individuals who experience homelessness for such other services as may be appropriate; and

- Provide representative payee services in accordance with section 1631(a)(2) of the Social Security Act if the eligible individuals who experience homelessness are receiving aid under title XVI of such act and if the applicant is designated by the Secretary to provide such services;

The PATH Master Case Manager will also provide outreach by seeking out and assisting individuals who do not access traditional services. This will include (a) limited face-to-face interactions with literally homeless who live in nontraditional settings such as living on the street, (b) distribution of flyers and other methods of public announcements and (c) "inreach" as a form of outreach where the PATH Master Case Manager will visit food banks, soup kitchens, the Salvation Army and other areas that are frequented by persons who are homeless.

Our PATH Master Case Manager will provide persons who are homeless with linkages to local agency services. To support persons who are homeless as they move into housing, Service Access and Management, Inc.'s PATH Master Case Manager will assist in referring these individuals to supported living programs offered by two local providers.

The PATH Master Case Manager will also measure, track and respond to behavioral health disparities from any subpopulation that may have disparate access to, use of, or outcomes from PATH services

b. Travel costs. ($2,797.00)

   The PATH Master Case Manager will incur travel expenses while working directly with PATH clients and while conducting outreach activities.

c. Supplies and cell phone costs. ($500.00)

NOT FINAL

We want the PATH Master Case Manager to be mobile, yet responsive to the immediate needs of clients, potential clients, local agencies and outreach sites. A cell phone will make this possible.

d. Indirect costs. ($6,801.00)

This is the allowable Block Grant rate and includes costs for services such as accounting, insurance and human resources.

NOT FINAL

PATH Budget for FY 2018-2019
Schuylkill: Service Access and Management, Inc.

- Federal PATH Funds: $34,816
- State PATH Funds: $11,605
- County Block Grant Funds to supplement the PATH Master Case Manager costs: $25,894

Category	Annual Budget	Federal PATH Funds	State PATH Funds	County Block Grant Funds
EXPENDITURES				
Personnel (Case Manager 1.0 FTE)	36,589.00	17,616.00	5,871.73	13,102.00
Fringe Benefits (FICA and Worker's Compensation [2,799] and Health Insurance [22,585])	25,384.00	12,221.00	4,073.59	9,089.00
Travel	2,797.00	1,347.00	448.86	1,002.00
Supplies and cell phone costs	971.00	467.00	155.82	348.00
Total Direct	65,741.00	31,651.00	10,550.00	23,540.00
Indirect	6,574.00	3,165.00	1,055.00	2,354.00
TOTAL	72,315.00	34,816.00	11,605.00	25,894.00
REVENUE				
Federal PATH Funds	34,816.00			
State PATH Funds	11,605.00			
County Block Grant Funds	25,894.00			
TOTAL	72,315.00			

Budget Narrative – Provide a budget narrative that includes the local-area provider's use of PATH funds.

Budgets and budget Narratives are required for every Intended Use Plan

Answer the Yes/No question below for the narrative questions for each Intended Use Plan, If you check "No" please provide any updates to the following narrative questions for the associated IUP

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.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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

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

- How the services to be provided using PATH funds 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;
- Any gaps that exist in the current service systems;
- A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
- A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH-enrolled clients.

Data – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to ensure that PATH staff have completed the SOAR Online Course and which staff plan to assist consumers with SSI/SSDI applications using the SOAR model and track the outcomes of those applications in the SOAR Online Application Tracking (OAT) system. If the provider does not use SOAR, describe the system used to improve accurate and timely completion of mainstream benefit applications (e.g. SSI/SSDI). Also describe the efforts used to train staff on this alternative system and what technical assistance or support they receive to ensure quality applications if they do not use the SAMHSA SOAR TA Center.

Housing – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

Staff Information – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.

Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

I certify that the responses to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

Planning Period From **7/1/2019** to **6/30/2020**

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

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

No Data Available

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

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

NOT FINAL

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
g. Housing	**$ 0**	**$ 0**	**$ 0**	

No Data Available

h. Construction (non-allowable)

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
i. Other	**$ 117,470**	**$ 17,078**	**$ 134,548**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Office: Other (Describe in Comments)	$ 117,470	$ 17,078	$ 134,548	Detailed budgets and narratives are included in individual provider IUPs.

j. Total Direct Charges (Sum of a-i)	$ 117,470	$ 17,078	$ 134,548	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0**	**$ 0**	**$ 0**	**n/a**
l. Grand Total (Sum of j and k)	$ 117,470	$ 17,078	$ 134,548	

Source(s) of Match Dollars for State Funds:

York County will receive a total of $68,312 in federal and state PATH funds to use in York County.
York County will also receive an additional $71,627 ($66,236 federal and $5391 state match) specifically for training and HMIS development/monitoring. Federal PATH funds will total $117,470, which combined with $22,469 in state match funds gives a grand total of $139,939.

Estimated Number of Persons to be Contacted: 170

Estimated Number of Persons to be Enrolled: 80

Estimated Number of Persons to be Contacted who are Literally Homeless: 50

Number staff trained in SOAR in grant year ending in 2018: 2

Number of PATH-funded consumers assisted through SOAR: 62

NOT FINAL

Bell Socialization Services
PATH Intended Use Plan 2019-2020
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, intellectual disabilities, 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 18-80. The only age requirement is that they be over the age of 18. The services are provided predominately in York City, however services are not limited to the city, but include all of York County. Bell also subcontracts with York County MH/IDD as a provider for PATH services.

Provider Information:

Bell Socialization Services	York County MH/IDD
160 S. George St.	100 W. Market St.
York, Pa 17401	York, Pa 17401

***Provider name as it appears in PDX: Bell Socialization Services**

Indicate the amount of PATH funds the organization will receive.

$51,234 is the federal PATH allocation
$17,078 is the state PATH allocation
$68,312 is the total allocation

See attached budget for expenditure breakdown

Collaboration with HUD Continuum of Care
The Program Coordinator and Assistant Director of the Mental Health Department are currently working with York County Continuum of Care PA-512 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. The Program Coordinator along with several members of the CoC have recently developed a SOAR sub-committee in order to increase the participation of SOAR providers in York County and provide online course trainings to those who assist individuals with obtaining SSI/SSDI benefits.

NOT FINAL

Collaboration with Local Community Organizations

Mental Health:

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, T.W. Ponessa, Pressley Ridge, Family First Health, Pennsylvania Counseling Services, Community Health Center, Susquehanna Counseling Services, and Wellspan Behavioral Health Services at Edgar Square (part of Wellspan Behavioral Health). The SHP 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, LifePath Christian Ministries, and the domestic violence Access Shelter. Not only can these shelters make referrals to the SHP for mentally ill individuals, but often the SHP staff will guide the individuals to these shelters as appropriate in order to get immediate assistance to prevent them from being on the street or in a potential 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 Next Door Program within Bell Socialization Services which provides rental assistance, connections to info & resources, professional one-on-one guidance, step-by-step success planning, case management, and in some cases emergency funding for an overnights stays at a motel, should the shelters be filled to capacity. Community Progress Council- which provides case management with housing and rental counseling and education. 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.

NOT FINAL

Social/Financial:
The SHP works with Mental Health America in order to assist consumers with gaining a Representative Payee in order to assist them with 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 also assists consumers at the Social Security Office in order to assist with applying for SSI/SSDI 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.

Permanent Housing:
The SHP works closely with several 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.

Further Housing Support:
The SHP further works closely with Bell Socialization Services, Inc. Community Residential Apartment Services (CRAS) program. The SHP receives referrals from various organizations 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.

Service Provision

PATH Eligibility:
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 other necessary referrals are made, then the consumer's information is transmitted into our HMIS ServicePoint database where the caseworker will also complete their progress notes, and all demographic information is documented by the Program Coordinator. Supported Housing staff makes the initial contact to these providers and attends first appointment and meetings at the consumers request.

Outreach:
Street outreach is conducted on a monthly basis at various homeless camps and hangouts throughout the city of York. The Program Coordinator and the caseworkers outreach at local shelters, soup kitchens, and other organizations that service the homeless population. Outreach also includes any face-to-face contact with consumers that link them to services. All outreach is conducted by a PATH-funded caseworker.

NOT FINAL

PATH Fund Maximization:

The agency maximizes using PATH funds by provided case management services and trainings to SHP staff. These case management services include: providing assistance in obtaining and coordinating social maintenance services for the eligible homeless, assist with general housing needs of the consumer, making referrals 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. Trainings are offered throughout the year based on practicality and usefulness to the staff's job requirements.

Gaps in the current service system**:**

There are currently a few gaps that need to be addressed. First, is the limited staff that are currently in place for the overload of caseloads of mentally ill consumers in need of support services. Second, are the lack of support services offered for the SHP consumers in order to keep them out of the state and local hospitals. Third, would be the lack of financial assistance that is given for PATH consumers with rent and security deposits that meet their budget requirements.

The fourth 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. Finally, 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.

The final 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.

Co-occurring:

Supported Housing staff continue to work with dual diagnosis facilities such as True North, White Deer Run, and Wellspan Behavioral Health. Caseworkers with Supported Housing general work with Wellspan Behavioral Health due to the establish relationship with the 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 with medication management, and progress throughout treatment. 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

NOT FINAL

Services, Alcoholics and Narcotics Anonymous and a local Dual Diagnosis group that meet weekly. In addition, the SHP staff has a working relationship with York County's Drug and Alcohol Case Management.

42 CFR Part 2:
Currently our agency is not required to follow 42 CFR Part 2 regulations.

Criminal Justice:
The SHP does not discriminate to those who have a criminal justice history. The caseworkers currently refer, engage, and collaborate with the York County Prison and York County Probation office in order to better serve those who have a criminal justice background. Bell Socialization Services recently become engaged into the "Stepping Up" initiative for York County which is supposed to help reduce the amount of individuals with a mental illness going into the county jail system.

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.

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. The York County Planning Commission also provides new HMIS users a reference manual explaining how to properly use the system. The HMIS administrator administers the manual to the new users as needed.

HMIS Administrator: Kelly Blechertas
Program Reporting Specialist-York Planning Commission
28 E. Market St. York, Pa 17403

Alignment with PATH Goals
SHP has developed program goals to outreach to homeless individuals at local shelters, libraries, individual businesses, and soup kitchens. We also provide outreach services at Bell Socialization's drop-in center, where individuals frequently drop in to socialize, make phone calls, and receive support from staff. In an effort to further service the chronic homeless population, the SHP developed a "street outreach" goal where once a month the Program Coordinator and PATH-funded Caseworkers go out into the community and walk the streets of downtown York City, visiting homeless camps and or any area where there has been an influx of homeless individuals residing.

NOT FINAL

Alignment with State Mental Health Services Plan
Currently SHP Program Coordinator has developed and implemented an emergency response fact sheet to give to consumers in our program. Caseworker will review emergency response knowledge with the consumer on a quarterly basis to ensure that consumers are aware of emergency exit plans, emergency numbers and nearest shelter facilities in case of weather or nuclear disaster. The Program Coordinator for SHP has also developed an emergency planning kit for consumers in our program. PATH Supported Housing Program (SHP) staff work along with Case Management staff by teaching consumers the necessary procedures in an emergency situation. There is a joint working relationship between PATH Supported Housing Program and case management to ensure continuity of care.

The Supported Housing Program (SHP) staff continue to make efforts to reach out to local shelters by visiting them on a monthly basis in order to make contact with the homeless individuals residing there. 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. 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, LifePath Christian Ministries, and the Women and Family Shelter among other services providers that also assist the homeless population.

NOT FINAL

Other Designated Funds
Currently Bell Socialization Supported Housing PATH Program does not receive funds from Mental Health Block Grant nor Substance Abuse Block Grant.

Programmatic and Financial Oversight
PATH funds are dispersed to York County MH/IDD, which are then dispersed to Bell Socialization Services. On an annual basis, the budget is reviewed and reports are developed and submitted to York County MH/IDD. The Director and Assistant Director of Finance from Bell Socialization Services, Inc. monitor the PATH funds that are given to the agency. Budget review of the PATH funds are completed annually.

SSI/SSDI Outreach, Access, Recovery (SOAR)
The SHP Program currently has the SOAR Local Team Lead for York County as its Program Coordinator. The Program Coordinator recently attended the SOAR Leadership Academy in February 2018 and is now one of the regional coordinators for the area. Currently, the Program Coordinator has two caseworkers who are currently certified, but will have the fellow three

caseworks also certified by the end of the year. The Program Coordinator plans on providing guidance and assisting the caseworkers in completing and tracking the outcomes online through the OAT system. Once all of the caseworkers have been certified, the caseworkers will use the SOAR model in order to complete SSI/SSDI applications. Currently none of the PATH supported caseworkers have completed any applications using the SOAR model.

Housing

The PATH supported housing caseworkers have established working relationships with local landlords and property management companies and receive 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 also links 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 assists consumers in accessing 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)
- LifePath Christian Ministries, Adams County Rescue Mission, and the York County YMCA. These three community partners offer emergency shelter and subsidized rents for individuals.

Coordinated Entry

Currently, the PATH SHP does engage with the local coordinated entry system. The York City/County Continuum of Care Coordinated Entry System is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and re quickly identified, objectively assessed for, referred, and connected to housing and assistance based on their strengths and needs. The YCCCES goals are to: improve coordinated care for and services to homeless persons in York City/County, create a unified, community-wide, prioritized waiting list

NOT FINAL

for housing services, create an objective referral process that requires only one assessment that can house consumers with the most pressing needs as quickly as possible, and finally shift from an overall approach of "first come, first serve" to serving those with the most severe needs first.

York County Planning Commission will manage the coordination of the Coordinated Entry implementation, with the help of the Coordinated Entry Planning Committee and prioritization & Referral committee, both under the umbrella of the CoC. YCPC will coordinate the inclusion of additional "phases" of providers into the Coordinated Entry system. YCPC will maintain the prioritized waiting list and monitor the entry of assessment data into HMIS.YCPC will provide initial and periodic training updates to core Agency staff on the Coordinated Entry process, with the expectation that the Agency will take responsibility for conveying this information to all appropriate Agency staff.

The SHP Program Coordinator participates weekly in the Coordinated Entry call to discuss current individuals on the homeless queue and those VISPDAT assessments that were being completed. Currently, all of the PATH-funded caseworkers have received training on how to complete VISPDATS on the HMIS system.

CoC's assessment/prioritization process produces only one barrier to housing/treatment for PATH-eligible consumers. The only barrier is that the time that it takes to find, approve, and designate a particular housing option for those who are in an emergency housing situation can sometimes be lengthy due to the lack of affordable housing options for those with little or no income. Typically, the shelters in the county are filled daily in which alternative housing options are needed quickly.

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 20% of consumers who have some type of criminal history. CIT trained officers are currently being implemented in York County as of 2018. These CIT trained officers have received positive feedback from consumers and agency staff who use their services on a frequent basis.

Staff Information

The Supported Housing staff is representative of the culturally diverse population of the service area. Currently there are 1 African Americans, 4 Caucasian, and 1 Latino staff. Staff that directly works with PATH consumers consist of 1 African Americans and 2 Caucasian individuals. 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.

NOT FINAL

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. Currently, the Supported Housing Program Coordinator is the only staff member that is a Certified Recovery Specialist.

Client Information

In recent past we serviced 40 individuals in our PATH Program. Of the individuals served in the PATH program 70% resided in emergency shelter, 2% resided in transitional housing for homeless individuals, 15% stayed with family, 10% stayed with friends and 3% lived in conditions uninhabitable for humans. 20% of individuals served were experience homelessness less than two days, 50% 2-30 days, 7% 31-90 days, 9% 91 days to 1 year, 10% over 1 year and 4% unknown amount of time. 39% of our consumers have co-occurring substance use disorders and 61% have no co-occurring substance use disorder. 2% of clients were Veterans and 98% were non-Veterans. 1% of the population served is American Indian or Alaskan Native, 39% are African American, 60% are Caucasian. 24% are between the ages of 18-23, 46% are ages 24-30, 16% 31-50 and 14% 51-61. 54% of the population served is females and 46% are males. 69% of our individuals were in imminent of losing their housing and 31% are unstably housed and at risk of losing their housing. Of the population that are in the PATH Program, 50% have major mental health diagnosis such as Schizophrenia, Major Depression, Psychotic Disorder and Bi-Polar.

Through daily contact with individuals who are experiencing homelessness or at risk of homelessness, we anticipate to increase our PATH recipients by enrolling four individuals per month to total 48; which in turn we will be servicing a total of 59 individuals receiving PATH services and anticipate that we will have to outreach 10% of those individuals. It is anticipated that we will contact roughly 175 consumers. We are hoping that out of the 175 consumers we are in contact with, that we can enroll approximately 87 consumers. Out of those 87 consumers, we can see 60 of those consumers being literally homeless as shown by recent data. To date we currently services 36 individuals with four pending PATH intakes and continue to strive to reach our goals to service more individuals who meet PATH requirements. Our goal continues to grow the program and service 50 individuals on a regular basis during 2018-2019.

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

NOT FINAL

opportunities. Mailers are sent out annually to get feedback from family members concerning ideas they may have to better the program and services. A quarterly survey is conducted for SHP consumers to both solicit feedback on quality of the services received and ideas for improvement. Consumers currently assist with new-hire trainings and goal planning within the agency. Consumers are encouraged to participate in both competitive employment and volunteer opportunities within the agency.

Health Disparities Impact Statement

In most recent history, our PATH program serviced 71% of consumers who are between the ages of 18-30. Currently we service 40 PATH individuals, 13 of which are between the ages of 18-30. Currently PATH funds are geared towards case management. In trying to further expand our services to the Transitional Age Youth (TAY), Supported Housing would like to explore the option to merge with a current Supported Housing program that services consumers between the ages of 18-29 in which we call our Young Adult Program. By merging these programs individuals who meet the criteria could identify more housing options by utilizing PATH funds. In Supported Housing we feel case management would be beneficial to TAY consumers to help further their independence by teaching them budgeting skills, cooking(as needed), daily living, medication management and linkage with vocational opportunities. At this time, our Supported Housing program receives no extra funds to support TAY consumers, but we are willing to further the conversation about merging programs that are already both operated under the Support Housing Program. Currently consumers in our Young Adult Program are supported by an Occupancy Coordinator who serves as a landlord for the program. Consumers would also receive support from a support case worker who works with consumers on their daily living skills, medication management and various other tasks to keep our individuals independent. Currently the supports case worker can also be contacted outside of normal business hours to provide support to the Young Adult consumers in emergent situations.

Limited English Proficiency

PATH caseworkers attempt to identify disparities and advocate for the best healthcare available for the consumer. PATH staff has developed relationships with community partners and referrals are made by PATH staff to ensure appropriate continuity of care. Trainings are presented by members of the community and address topics such as; Veterans Affairs, Jewish Cultural, Hispanic/Latino Cultural, African American and Native American Cultural. Referrals are also made from The Spanish American Center to SHP. The Supported Housing staff is responsive and sensitive to the culturally diverse population of the service area. Language barriers are addressed at the initial assessment and enrollment into the PATH program. If a need is identified; referrals or translation needs are handled accordingly to ensure appropriate in-language primary care services.

NOT FINAL

Budget Narrative

Allocated funds for York County 2019-2020 are as follows:

$51,234 -- federal PATH allocation
$17,078 -- state PATH allocation
$68,312 -- TOTAL ALLOCATION

All Path funds are used for 2.5 Case Manager Salaries and benefits. Funding covers 100% of the salaries for the positions but only 8% of the benefits being paid by Bell for these positions. However, even at 100%, the salaries for the case managers remain below average for the York/Adams County area.

Personnel Salaries:

Funding of $65,354 is being requested to provide for the full-time salary of 2.5 MH Housing Case Managers. These positions will be located in the Bell Socialization Services' Mental Health Department at 160 S George St in York,PA. The Mental Health Department's 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.

Fringe Benefits:

Funding of $2,958 is being requested to be applied towards the full-time fringe benefits for 2.5 MH Housing Case Managers. Full cost of Fringe benefits includes the following:

- FICA 7.65% — $ 5,000
- Health insurance — $24,000
- Dental, Vision, EAP 2% — $ 1,307
- Unemployment Insurance 1% — $ 658
- Workman's Comp 2% — $ 1,307
- Retirement 6% — $ 3,921
- Total request for benefits — $36,188

Total requested funding for Salaries & Benefits is $68,312.

NOT FINAL

BELL SOCIALIZATION BUDGET
Supported Housing - County PATH Program
FY 2019-2020 Budget

PERSONNEL Position	Annual Salary	PATH-funded FTE	PATH-funded salary	TOTAL
Case Manager	$25,605	1.0	$25,605	$25,605
Case Manager	$26,000	1.0	$26,000	$26,000
Case Manager	$27,497	.5	$13,749	$13,749
sub-total	**$79,102**		**$65,354**	**$65,354**
FRINGE BENEFITS Position				
FICA Tax	$ 5,000			$ 2,958
Health Insurance	$24,000			0
Dental, Vision, EAP	$ 1,307			0
Unemployment	$ 653			0
Workman's Comp	$ 1,307			0
Retirement	$ 3,921			0
sub-total	**$36,188**			**$ 2,958**
TRAVEL				
sub-total				
SUPPLIES/EQUIPMENT				
sub-total				
Total PATH Budget	**$115,290**			**$68,312**

NOT FINAL

NOT FINAL

III. State Level Information

A. Operational Definitions

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes (selected) No

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

III. State Level Information

B. Veterans

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to describe how the state gives consideration in awarding PATH funds to entities with demonstrated effectiveness in serving veterans experiencing homelessness.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes (selected) No

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

III. State Level Information

C. Alignment with PATH Goals

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to 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.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes (selected) No

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

III. State Level Information

D. Alignment with State Comprehensive MH Services Plan

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to describe how the services to be provided using PATH funds are consistent with the State Comprehensive Mental Health Services Plans.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◯ No ◉

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

2019 PA Alignment with Comprehensive State MH Services Plan

State Comprehensive Mental Health Services Plan

The PATH services offered collectively throughout Pennsylvania are consistent with the general mental health services offered through Pennsylvania's comprehensive mental health service plan. This is supported by the inclusion of PATH services in Pennsylvania's Community Mental Health Services Block Grant (CMHSBG), 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 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 SPC 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.

While the CMHSBG is the general rule of thumb for mental health services in PA, various other documents and legislation have necessitated PA's PATH program to integrate with other movements in the state as well.

Pennsylvania Consolidated Plan

PATH activities are also coordinated with Pennsylvania's 2019-2023 Consolidated Plan. The Consolidated Plan for the Commonwealth of Pennsylvania (Consolidated Plan) describes the efforts of the Commonwealth in addressing the housing, community, homeless, and economic development needs of its constituents. The Consolidated Plan is intended to outline the goals, strategies and resources to be utilized in addressing those needs as well as related information on performance in realizing these goals. Each year the Commonwealth is required to submit an Annual Action Plan based on the goals of the Consolidated Plan as part of its application process to the HUD.

The Pennsylvania Consolidated Plan also recognizes the special needs of the PATH population. The Consolidated Plan covers the needs of the residents that are not directly funded with HUD

NOT FINAL

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 Consolidated Plan details the efforts of the Commonwealth in addressing the housing, community, homeless and economic development needs of its constituents, with specific focus on extremely low-, low-, and moderate-income persons and communities. The Consolidated Plan is intended to outline the goals, strategies and resources to be utilized in addressing those needs as well as related information on performance in realizing these goals. This Consolidated Plan is developed for a five-year period encompassing Fiscal Years of 2019 through 2023. Each year, the Commonwealth is required to submit an Annual Action Plan based on the goals of the Consolidated Plan as part of its application process to the U.S. Department of Housing and Urban Development (HUD). This document also includes the Commonwealth's Action Plan for Federal Fiscal Year (FFY) 2019 and the program year that began on January 1, 2019.

The Consolidated 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. In Pennsylvania the Department of Community and Economic Development (DCED) is responsible for the Consolidated Plan and OMHSAS is provides input and support into the development.

The Commonwealth's overarching direction for its Consolidated Plan is outlined in the mission of DCED. The mission is applicable to the Commonwealth's efforts to provide housing, homelessness and community and economic development assistance through both federal and state resources.

"The Department of Community and Economic Development's mission is to encourage the shared prosperity of all Pennsylvanians by supporting good stewardship and sustainable development initiatives across our commonwealth. With a keen eye toward diversity and inclusiveness, we act as advisors and advocates, providing strategic technical assistance, training, and financial resources to help our communities and industries flourish."

In order to fulfill this mission for housing, homeless and community and economic development programs, the Consolidated Plan establishes six goals. In pursuing these goals, the Commonwealth has also established priorities for the use of its resources. Those priorities emphasize targeting of activities, leveraging other resources and public investments, and promoting community changing impact. The Action Plan for FFY 2019 continues allocating the state's resources toward these priorities and achieving the goals set forth in the Consolidated Plan.

I. Affordable Housing
Improve access to the full spectrum of quality affordable housing for Pennsylvanians

a. Increase the supply of affordable housing opportunities through development of new housing units for rental or homeownership opportunities and preserve the long-term affordability of homes through rehabilitation of existing vacant or owner-occupied units.

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b. Provide direct housing assistance to assist potential buyers to purchase a home, rapidly house those who are homeless or prevent or divert homelessness or provide decent, affordable housing to persons living with HIV/Aids.
c. Provide housing services and supports in the form of counseling – homebuyer or rental and case management services to ensure persons are and remain stably housed.

II. Community Stabilization
Prevent and arrest the decline of Pennsylvania neighborhoods and promote revitalization

a. Support targeted code enforcement
b. Demolish vacant, blighted buildings
c. Cleanup of contaminated properties
d. Support strategic acquisition and disposition activities

III. Public Facility and Infrastructure
Acquisition, construction, installation, rehabilitation, or improvement of facilities to support safe, sustainable, resilient communities

a. Water/Sewer/Storm Systems
b. Park, recreation, youth, senior facilities
c. Streets and sidewalk improvements
d. Health and safety facilities
e. Increase access to broadband infrastructure

IV. Public Services
Provide public services to ensure all Pennsylvanians have access to opportunities to improve their quality of life (non-homeless)

V. Economic Development
Develop opportunities to improve the economic environment by creating or retaining business and employment opportunities for low income and diverse Pennsylvanians

a. Create and retain jobs
b. Create and expand businesses

VI. Community Planning and Capacity Building
Encourage local and regional planning activity to facilitate understanding of current housing, community development, and resiliency needs and develop a plan for their sustainable future.

a. Provide training and technical assistance to communities to build their capacity to address housing and community development needs
b. Assist communities to identify achievable goals to further community needs
c. Align community goals with funding opportunities to meet those goals

To achieve the Consolidated Plan's goals, DCED relies on interaction of the following entities: PA Housing Finance Agency (PHFA), Regional Housing Advisory Boards (RHABs), PA

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Housing Advisory Committee (PHAC), PA's 16 Continuums of Care (CoCs), Housing Alliance of PA, PA Emergency Management Agency, and The Governor's Office of Broadband Initiatives. The latest work is in draft form as the 2019-2023 Consolidated Plan and 2019 Annual Action Plan (dated June 14, 2019).

Pennsylvania Housing Advisory Committee

The PA Affordable Housing Act of Dec 18, 1992 P.L. 1376, No. 172 emphasized the writing and yearly updates of The Commonwealth's Statewide Comprehensive Housing Affordability Strategy (CHAS), as nationally established by the Cranston-Gonzalez National Affordable Housing Act (Public Law 101-625, 42 U.S.C. § 12701 et seq.), also known as the National Affordable Housing Act of 1990(NAHA). To meet this requirement, the PA Housing Advisory Committee (PHAC) was established, with the primary mission of preparing and maintaining The PA Consolidated Plan. Legislation dictates composition of the PHAC. The PHAC meets twice annually, once in fall and once in spring.

Homelessness Program Coordination Committee

The Homelessness Program Coordination Committee (HPCC) is a statewide committee comprised of the public agencies, housing and service providers, and stakeholders of the homeless community, which serves as the working body to support The Pennsylvania Interagency Council on Homelessness (aka Pennsylvania Housing Advisory Committee (PHAC)). The HPCC replaces the previous Homeless Steering Committee for overseeing broader planning responsibilities and coordination of all resources of the state in a manner to best serve the homeless population.

The HPCC will be able to identify those statewide policies for assisting homeless people, recommend the resources to eradicate homelessness conditions, and propose action steps to the PHAC so the Commonwealth may effectively assist the homeless population in gaining stability and limit its effect on the lives of homeless individuals and families.

The Committee is responsible for reviewing Statewide housing, community development and support services, needs and priorities, as well as advising the Department of Community and Economic Development (Department) in the preparation of the Commonwealth's Consolidated Plan, annual action plans and the coordination of Federal, State and local resources to manage the implementation of these plans.

As part of the planning process for the 2019—2023 Consolidated Plan and 2019 Action Plan, the Committee met in April 2019 in an open forum to discuss the Consolidated and Action Plans and how this year's allocation of Community Development Block Grant (CDBG), the HOME Investment Partnerships, the Emergency Solutions Grant, CDBG Disaster Recovery, Neighborhood Stabilization Program, Housing Opportunities for Persons with AIDS and National Trust Fund funding will be distributed once received from the United States Department of Housing and Urban Development.

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DCED and DHS/OMHSAS continue to chair this committee and the State PATH Contact is a member of this team. The HPCC is still in transitional stages and is to meet quarterly.

Urban counties and local PATH providers are encouraged to participate in the development of their local Consolidated Plan, a piece completed by the direct entitlements of HUD. This participation allows for the identification of needs and goals across all systems. One outcome of coordination of providers and OMHAS on the former PA CoC Steering Committee was the establishment of housing specialists in some of the (48) County MH/ID programs. Many of the county PATH contacts also serve as housing specialists or work closely with the housing specialists.

In 2016, the previously established CoC Homelessness Steering Committee was restructured with the implementation of local level CoC meetings as the new governing method. Included are the 14 county-based CoCs and 2 regional CoC's, which are collectively known as "Balance of State." The Balance of State covers 53 of Pennsylvania's 67 counties. This includes 33 counties that are part of the Eastern PA CoC, and 20 counties in the Western PA CoC. 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."

In 2018, the Governor's Policy Office also established an informal group called Health, Housing and Homelessness to review higher level policy issues related to its namesake on a statewide level. Their work is to parallel that of the Interagency Council to End Homelessness. The SPC has requested membership in this group and is supported in this endeavor by the Bureau Director of OMHSAS's Bureau of Policy, Planning and Program Development. The HHHW is scheduled to meet quarterly.

Local Housing Option Teams

PA OMHSAS provides technical assistance in formation of 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.

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The State Planning Board

One other group affecting PATH's work in PA is the State Planning Board, which is an advisory board within the Governor's Office. It was established by the Administrative Code of 1929 as re-enacted and amended. There are 25 members, including citizens, legislators and state department heads.

The Board's duties include studying demographic, economic, and development trends, and preparing strategic plans to promote the welfare of the Commonwealth. It was instrumental in creating the Pennsylvania Turnpike, planning the State Capitol grounds, establishing planning agencies in Pennsylvania's counties, and enacting the Municipalities Planning Code in 1968.

The Board works with DCED to prepare the State Land Use and Growth Management Report every five years. The report studies development patterns and local government land use planning, and makes recommendations for state agency action, regulations, and programs. The State Planning Board meets quarterly at a Harrisburg location on the second Friday of January, April, July, and October.

Alignment with State Plan to End Homelessness

Previously, Pennsylvania only employed the 2005 Commonwealth-developed "Agenda for Ending Homelessness in Pennsylvania" to govern the work of the Interagency Council and guide the efforts of the Homeless Steering Committee and local Continuums of Care. While there has been no update to this particular document, other efforts have built upon it for a more comprehensive approach to end homelessness in the state.

The PA General Assembly recognized the need to complete a comprehensive analysis of Pennsylvania's homelessness problem and developed a set of recommendations that would move the Commonwealth toward permanently reducing and eliminating homelessness. In March 2014, House Resolution 550 of 2014 directed the Joint State Government Commission to establish a bipartisan legislative task force and an advisory committee to conduct a study on the occurrence, effects and trends of homelessness in Pennsylvania and to report its findings and recommendations to the House of Representatives. The *Joint State Commission Report on Homelessness in PA – Causes Impacts and Solutions, A Task Force and Advisory Committee Report (HR 550)* was released in April, 2016. The report is attached for your convenience and may be viewed at http://jsg.legis.state.pa.us/publications.cfm?JSPU_PUBLN_ID=447.

Suggestions presented in the document specifically cite the PATH grant and SSI SSDI Outreach Access and Recovery (SOAR) program as resources for addressing homelessness. In addition, PATH employs data collection and application in its Homelessness Management Information System mandate. PA PATH is further consistent with the HR 550 in its provision of services and housing options to specialized subpopulations among those experiencing homelessness or at risk of homelessness including: co-occurring, justice-involved, veterans, and transition-age youth.

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Pennsylvania's *"Agenda for Ending Homelessness in Pennsylvania"* is based upon three state-driven strategies that correlate with the HR 550. These strategies outline steps that will occur at both the state and local levels, including:

- Improve coordination between state agencies and promote targeting of resources consistent with the state vision and guiding principles. A central part of the Agenda is to assess the effectiveness of the current state and local housing and human service delivery systems, and to ensure that they support the above vision and guiding principles.

- Foster and support local efforts to end homelessness. Given the size and diversity of the Commonwealth, the health of the local network of homeless housing and service providers is a critical factor in successfully implementing the Agenda for Ending Homelessness in Pennsylvania. Since every region of the state is different, the Plan must be designed to support local participation, while accommodating regional differences. Training and technical assistance are needed to build local capacity, especially in areas of the state where resources are limited.

- Promote recovery-oriented housing and services for homeless individuals with serious mental illness, substance abuse and/or co-occurring disorders. PA OMHSAS 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.

DHS Five Year Affordable Housing Strategy

The State PATH Contact also works very closely with the OMHSAS Housing Specialist, the PA Department of Human Services (DHS) Executive Housing Director, PHFA, DCED, and others contributing to the DHS Five-Year Affordable Housing Strategy.
The DHS Five-Year Affordable Housing Strategy, released in May 2016, in partnership with Pennsylvania Housing Finance Agency and DCED, is a comprehensive plan to connect Pennsylvanians to affordable, integrated and supportive housing. It has since been updated and titled *Supporting Pennsylvanians Through Housing: 2017-18 Update*.
DHS will leverage internal and external resources and collaborate with all levels of government and private agencies to make housing resources and services more accessible and available to a wide range of individuals served by DHS, which include:

- Individuals who live in institutions but could live in the community with housing services and supports
- Individuals and families who experience homelessness or are at-risk of homelessness
- Individuals who have extremely low incomes and are rent-burdened

The 2017-18 Update includes strategies, goals and action steps through 2020 to address challenges faced by these populations. These strategies include:

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1. Connecting people to housing
2. Strengthening services and supports that address housing needs
3. Expanding funding opportunities for housing
4. Measuring and communicating progress

Some of the action steps announced in the 2017-2018 Update that have been met or have made significant progress in furthering housing strategies for populations, including people with serious mental illness and/or co-occurring serious mental illness and substance use disorder, are as follows:

- Expand the 811 Program service area to respond to consumer needs for housing by increasing the number of 811 apartments from 100 to 250
    - As of June 18, 2019, three hundred and thirty-six (336) units have been created, which exceeds the goal

- Deploy 300 units of public housing or Housing Choice Vouchers that Public Housing Authority partners committed in support of the 811 Program
    - As of June 18, 2019, three hundred and sixty-one (361) Housing Choice Vouchers have been leveraged

- Determine the benefit of Permanent Supportive Housing (PSH) by comparing Medicaid costs before and after housing is secured; partner with the University of Pittsburgh, DCED, and the Continuums of Care
    - This study is complete and the findings suggest that entry in PSH appears to address some health needs for this population (i.e. reduced acute care utilization including emergency department, inpatient and residential utilization including residential treatment for substance use disorder and increase in community mental health services) and the potential for Pennsylvania Medicaid program to realize long-term savings when Medicaid enrollees who are experiencing homelessness receive permanent supportive housing

- Sustain and increase funding by MCOs, health systems, government entities, and philanthropic organizations
    - In 2019, the Pennsylvania Departments of Drug and Alcohol Programs and Human Services awarded $15 million in federal SAMHSA grants for a new program to provide case management and housing support services for Pennsylvanians with an opioid used disorder
    - The sixteen pilot programs will assist individuals as they become and remain engaged in evidence-based treatment programs and will provide individuals with support services such as pre-tenancy and tenancy education services to maintain stable housing

Since 2016, the number of regional housing coordinators has expanded to eleven and a “team approach” has been implemented, providing a team of 3 to 4 regional housing coordinators per region (3 regions), along with a dedicated manager to better coordinate and direct their efforts regionally and statewide. Below is an overview of how the RHC role has expanded across PA

NOT FINAL

DHS mental health and intellectual disabilities systems as provided by the Self-Determination Housing Project of Pennsylvania:

- RHCs provide technical assistance to social service and other professional staff statewide with the goals of ensuring adequate housing is available to meet the needs of people with disabilities and older adults

- The RHCs attend local housing meetings with service providers and other agencies in their service area to identify the needs of the service area

- RHCs facilitate the Prepared Renter Education Program (PREP) Train the Trainer Program and have been doing so for 10 years
    - PREP provides information on everything a prospective tenant needs to know
        - how to apply for housing
        - how to be a successful tenant
        - addiction protection tools
        - how to apply for benefits including SSI and SSDI
        - many other things

- The RHCs can assist in helping social service professionals' work with property owners and property managers/landlords to understand the needs of consumers with disabilities

- The RHCs provide technical assistance on providing reasonable accommodation, Fair Housing issues with landlords, and solving difficult housing issues

- The RHCs are on various boards, Local Housing Option Teams and are always at the table with latest information from HUD, PHFA etc.

- The RHCs work directly with the Local Lead Agencies and provide waitlist management and direct support to the Local Referral Network on the roll-out of the 811 Program

PATH as part of State Disaster Preparedness Plan

PA has both state and county level disaster preparedness plans. As an Emergency Medical Technician, the SPC has utilized background in mass casualty incident command, emergency medical services and preparedness planning to guide county providers in including their local emergency management agencies in the development of their individual protocols. In 2015, the SPC attended the PA Disaster Preparedness Summit and continues to acquire additional training from PA Emergency Management Agency and Emergency Medical Services outlets.

The SPC actively participates in all levels of disaster preparedness planning to stay current with protocols. Since the Fall of 2016, the SPC has represented OMHSAS on the evacuation team for Commonwealth Towers, the location of OMHSAS headquarters. By working directly with the OMHSAS Continuity of Operations Plan Coordinators, the SPC presented, built, disseminated and activated the building evacuation plan. Drills are held twice a year with evaluation,

NOT FINAL

discussion and modifications as needed. The SPC was recently appointed to be the OMHSAS Continuity of Operation Planning (COOP) Team Lead.

In addition, the SPC attended the Governor's 2017 Emergency Preparedness Summit and was also the OMHSAS lead for the August 2017 2-day Keystone 6 Mass Care Exercise, a training focusing on disaster shelter operation coordination in both Shippensburg, PA and Middletown, PA.

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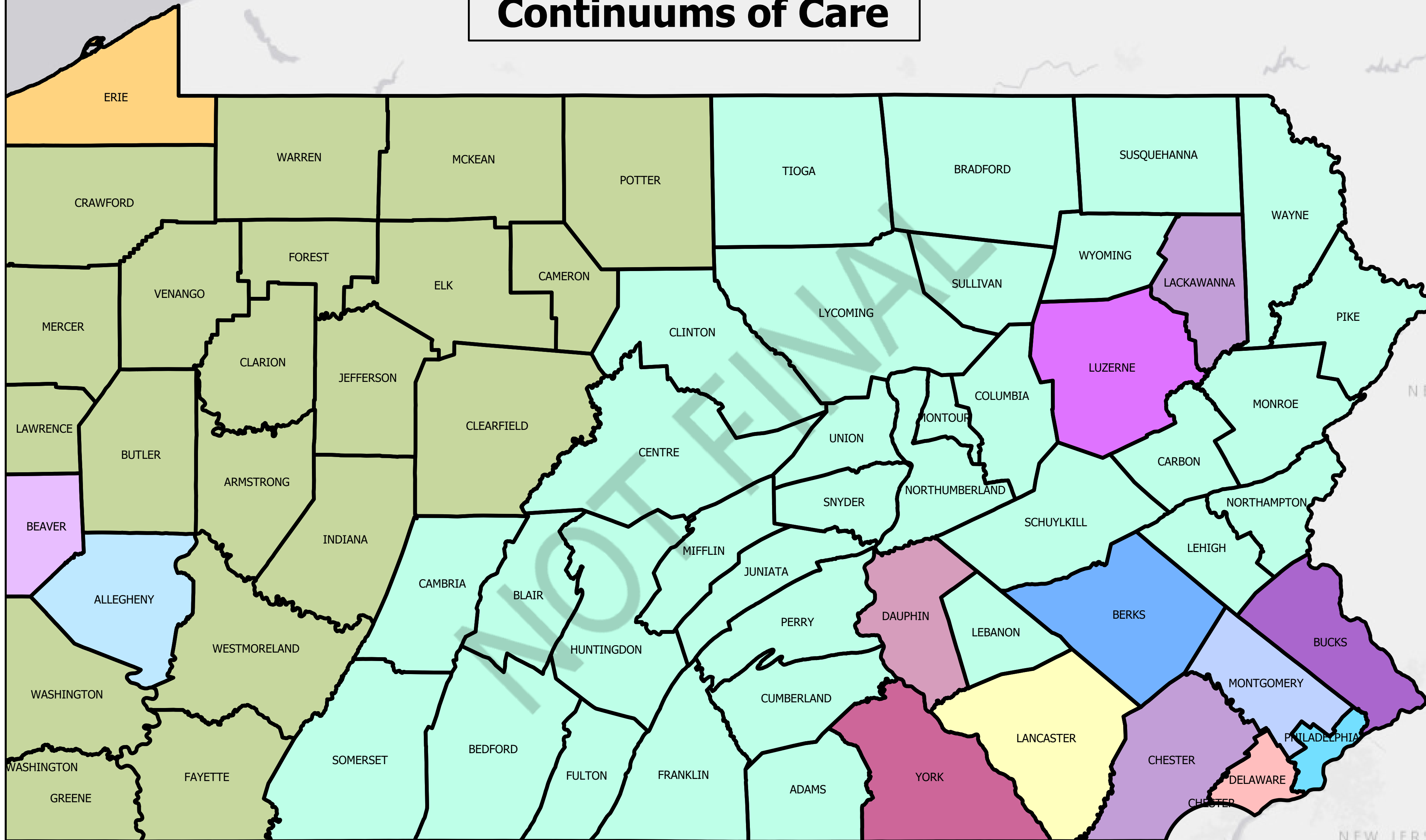

Pittsburgh/McKeesport/Penn Hills/Allegheny County CoC
Beaver CoC
Reading/Berks County CoC
Bristol/Bensalem/Bucks CoC
Chester County CoC
Upper Darby/Chester/Haverford/Delaware County CoC
Erie City & County CoC
Eastern Pennsylvania CoC
Harrisburg/Dauphin County CoC
Lancaster City & County CoC
Lower Merion/Norristown/Abington/Montgomery County CoC
Scranton/Lackawanna County CoC
Wilkes-Barre/Hazleton/Luzerne County CoC
Philadelphia CoC
Western Pennsylvania CoC

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III. State Level Information

E. Process for Providing Public Notice

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to describe the process for providing public notice to allow interested parties (e.g., family members; individuals who are PATH-eligible; mental health, substance use disorder, and housing agencies; 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.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes ◉ No ○

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

III. State Level Information

F. Programmatic and Financial Oversight

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to 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.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes (selected) No

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

III. State Level Information

G. Selection of PATH Local-Area Providers

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to 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).

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes (selected) No

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

III. State Level Information

H. Location of Individuals with Serious Mental Illnesses who are Experiencing Homelessness

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to 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.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

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 - 2019
1. Southeast PA	
Philadelphia County	1,808
Delaware County	90
Montgomery County	63
Bucks County	94
Chester County	58
Total Southeast PA	**2,113**
2. Eastern PA	
Eastern PA CoC (Adams, Bedford, Blair, Bradford, Cambria, Carbon, Centre, Clinton, Columbia, Cumberland, Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lehigh, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Wayne, and Wyoming Counties) **Note:** County-level data provided on the next page	262
Berks County	136
Dauphin County	101
Lackawanna County	67
Lancaster County	80
Luzerne County	23
York County	58
Total Eastern PA	**727**
3. Western PA	
Western PA CoC (Armstrong, Butler, Cameron, Clarion, Clearfield, Crawford, Elk, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, McKean, Mercer, Potter, Venango Warren, Washington, and Westmoreland Counties) **Note:** County-level data provided on the next page	169
Allegheny County	211
Beaver County	16
Erie County	94
Total Western PA	**490**
PA TOTAL HOMELESS WITH SERIOUS MENTAL ILLNESS	**3,330**

NOT FINAL

Note: See Attachment for map of Pennsylvania Continuums of Care

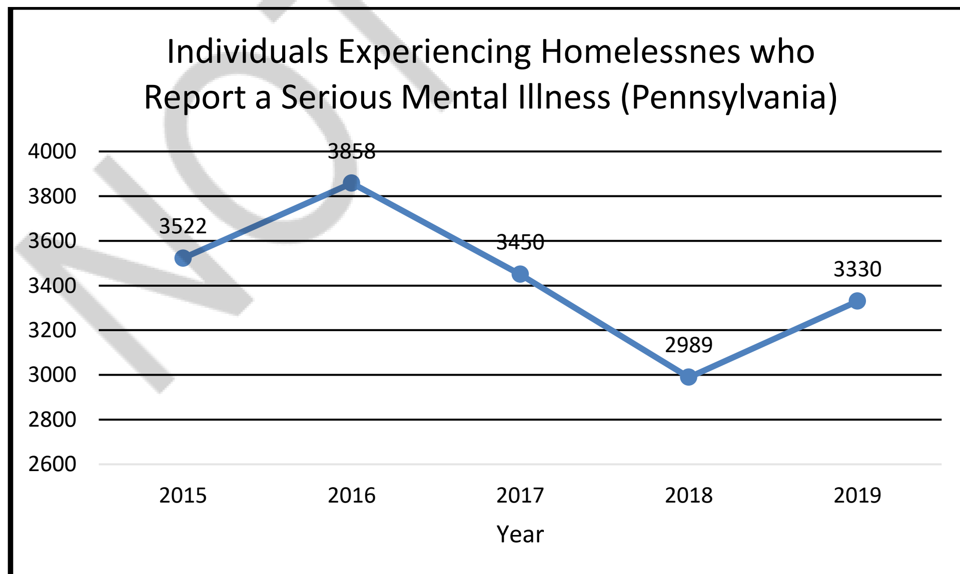
Regional CoCs by County	Number of Homeless with SMI - 2019
Eastern PA CoC	**262**
Adams County	5
Bedford County	3
Blair County	8
Bradford County	2
Cambria County	0
Carbon County	0
Centre County	11
Clinton County	5
Columbia County	0
Cumberland County	24
Franklin County	24
Fulton County	0
Huntingdon County	1
Juniata County	1
Lebanon County	7
Lehigh County	44
Lycoming County	22
Mifflin County	3
Monroe County	21
Montour County	2
Northampton County	38
Northumberland County	1
Perry County	3
Pike County	0
Schuylkill County	19
Snyder County	7
Somerset County	3
Sullivan County	0
Susquehanna County	0
Tioga County	7
Union County	0
Wayne County	1
Wyoming County	0
Western PA CoC	**169**
Armstrong County	9
Butler County	40
Cameron County	0
Clarion County	1
Clearfield County	17
Crawford County	8
Elk County	6
Fayette County	18
Forest County	0
Greene County	8
Indiana County	10
Jefferson County	8
Lawrence County	1

NOT FINAL

McKean County	1
Mercer County	3
Potter County	0
Venango County	2
Warren County	2
Washington County	19
Westmoreland County	16

The data presented above was collected on a single night during the last week in January 2019, in most cases, the night of January 23, 2019. Each CoC in Pennsylvania provided the data that they assembled for submission to HUD on the 2019 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 2019 Point-in-Time count.

The data collected shows an increase from 2018 to 2019 of 341 individuals experiencing homelessness who report a serious mental illness from 2989 in 2018 to 3330 in 2019, an 11% increase over the past year. The number of individuals experiencing homelessness who report a serious mental illness has remained relatively stable over the past 5 years. Over the past 5 years there has been a decrease of 5% in the number of individuals experiencing homelessness who report a serious mental illness.



At the individual CoC level, 10 Pennsylvania CoCs saw increases in the number of individuals experiencing homelessness who report a serious mental illness. from 2018

to 2019, ranging from 1% to 36% increases. 5 CoCs saw a decrease, ranging from 4% to 31% decrease. 1 CoC saw no changes from 2018 to 2019.

The CoCs that saw the most significant decrease were:

Western PA CoC: 245 in 2018 to 169 in 2019- decrease of 76 individuals (31%)
Bucks County: 113 in 2018 to 94 in 2019- decrease of 19 individuals (17%)

Philadelphia County, Allegheny County, and the Eastern PA CoC- the three CoCs with the largest populations of people experiencing homelessness who have a serious mental illness- all saw increases from 2018 to 2019. Philadelphia saw a 22% increase from 1,482 individuals to 1,808 individuals. Allegheny County saw a 23% increase from 171 individuals to 211 individuals. The Eastern PA CoC saw a small increase of 1% from 259 individuals to 262 individuals.

Related to individuals experiencing homelessness with serious mental illness residing in specific project types, from 2018 to 2019:

- There was a 14% increase in individuals with a serious mental illness residing in emergency shelter (1480 to 1689).
- There was a small increase (0.5%) in individuals with a serious mental illness residing in safe havens (221 to 238).
- There was a 21% decrease in individuals with a serious mental illness residing in transitional housing (644 to 509).
- There was a 22% decrease in individuals residing in unsheltered situations (645 to 502).
    - During the 2019 Point-in-Time County, 80% of all unsheltered individuals with serious mental illness across the state were identified in the Philadelphia CoC (406 out of 502 individuals).
    - Delaware County CoC identified 31 unsheltered individuals with serious mental illness during the Point-in-Time Count; Dauphin County CoC identified 20; Allegheny County CoC identified 13. The 12 remaining CoCs identified less than 10 unsheltered individuals with serious mental illness during the Point-in-Time Count.

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).

NOT FINAL

3. The data on the number of homeless who have serious mental illness is often self-reported by the individuals being surveyed or by shelter staff or outreach workers through observation. Some CoCs (Allegheny County, in particular) base their PIT results on HMIS data rather than interviews on the night of PIT. Their HMIS is based on actual assessments rather than self-reporting to determine the number of individuals with Serious Mental Illness in the CoC.

It is anticipated that the count of the number of individuals who are experiencing homelessness who have serious mental illness will continue to decline as a result of several HUD policy priorities:

- HUD has encouraged CoCs to eliminate or reduce the amount of Transitional Housing in favor of creating more permanent housing resources, both Rapid Rehousing and Permanent Supportive Housing. As a result, fewer individuals with Serious Mental Illness are living in Transitional Housing (21% decrease from 2018 to 2019, from 644 individuals to 509 individuals).

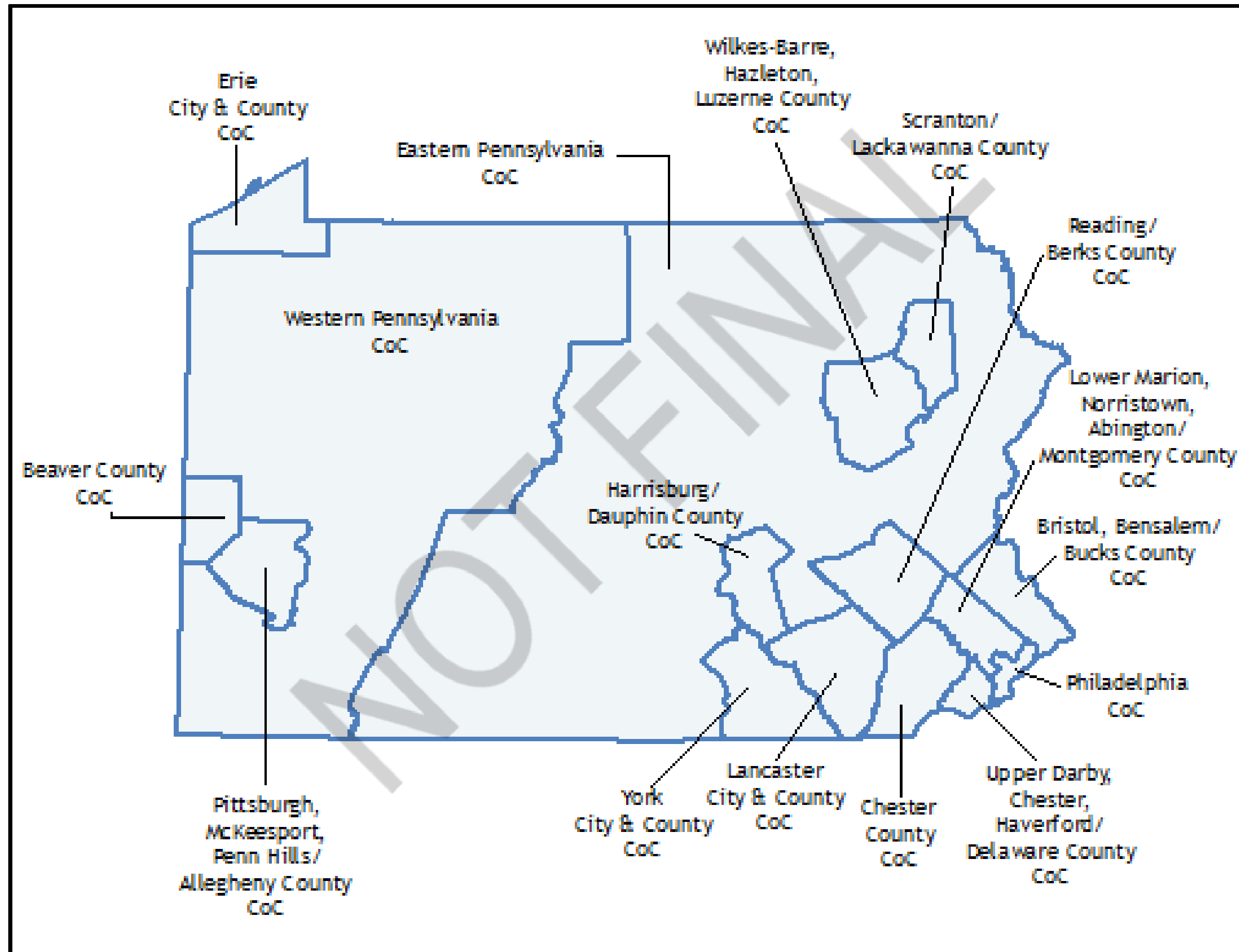
- Most CoCs have adopted HUD's prioritization standards under Notice CPD 16-11 to prioritize those individuals with the most severe service needs and the longest length of time homeless for Permanent Supportive Housing, facilitating entrance into PSH by individuals with Serious Mental Illness.

- As of January 2018, all CoCs have implemented Coordinated Entry through which each household is assessed for vulnerability and length of time homeless, in order to offer housing to those who would benefit most from it. As this requirement is still relatively new, CoCs are still assessing its impact and working to right-size their systems based on the needs in their community.

All three of these policy priorities have increased access to permanent housing resources for individuals with serious mental illness and should, over time, continue to result in a reduction in the number of individuals with serious mental illness who are experiencing homelessness.

NOT FINAL

Pennsylvania Continuums of Care



III. State Level Information

I. 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.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

Baxter, Michelle

From: Polcyn, Kent
Sent: Wednesday, May 22, 2019 11:04 AM
To: Baxter, Michelle
Cc: Hamme, Dawn; Fagan, Shannon; Tickner, Michael; Golden, Stephanie; Polcyn, Kent
Subject: Matching Funds Confirmation

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Michelle,

This is to confirm that in state fiscal year 2019-2020 (July 1, 2019 - June 30, 2020) 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 $2,367,227 we will allocate a minimum of $789,076 in state matching funds.

Kent Polcyn | Accountant
Department of Human Services | Office of Mental Health & Substance Abuse Services
Bureau of Financial Management and Administration
Commonwealth Towers, 12th Floor, 303 Walnut Street | Harrisburg, PA 17101
Phone: 717.787.3697 | Fax: 717.787.2866
kpolcyn@pa.gov | www.dhs.pa.gov

Mental Illness affects 1 out of every 4 persons. OMHSAS challenges you to change a life, save a life and commit to participation in a Mental Health First Aid Class.

NOT FINAL

III. State Level Information

J. Other Designated Funding

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to 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.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes (•) No ( )

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

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NOT FINAL

III. State Level Information

K. Data

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to describe the state's and provider' participation in HMIS and describe plans for continued training and how the state will support new local-area providers. For any providers not fully participating in HMIS, please include a transition plan with an accompanying timeline for collecting all PATH data in HMIS.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

If No, please upload documentation with changes for FY19.

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2019 PA Data

The Pennsylvania Department of Community and Economic Development (DCED) has established a Homeless Management Information System, known as PA HMIS, for the 54 counties included in the two rural regions of Pennsylvania. In addition, nine of the ten urban, or proprietary, counties/joinders have established their own HMIS system. The remaining proprietary county uses PA HMIS.

In FY 2012-13, 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.

To bring all PATH providers into compliance for the full implementation of HMIS by SAMHSA's June 30, 2016 deadline, the State PATH Contact applied for and was granted technical assistance. In April 2016, PA hosted the PA PATH HMIS Technical Assistance (TA) Conference in State College, PA. Fifty PATH Coordinators, HMIS Directors and members of PA OMHSAS management attended. Pivoting on the upcoming SAMHSA deadline for full HMIS implementation, the training highlighted everything from SAMHSA's participation policy, goals and expectations of PATH providers, HMIS data standards and elements and outreach to the technical topics including physical data entry, system requirements, staff coordination with HMIS directors and using reports for advanced planning and reporting. Clarification on these topics was enhanced by having two of SAMHSA's Homeless and Housing Resource Network trainers as well as a representative from ICF, a HUD TA provider, facilitate the training. The instructors were able to address participant concerns and questions from Continuum of Care and overlapping funding perspectives at once. In addition, having the HMIS Directors, including the PA HMIS Director, present allowed for immediate intervention from the programming side. Each participant was charged with implementing action steps before the June follow-up phone sessions. Feedback has been overwhelmingly positive with participants citing increased understanding and potential for better, more quantitative, outcomes.

Currently, 24 of the 24 PATH-funded counties (and their provider agencies) are utilizing an HMIS for PATH services. Of these 24 counties/joinders, 15 utilize the PA HMIS established by DCED and 9 utilize their own HMIS. OMHSAS fully utilized HMIS for collecting PATH data by the end of FT 2016-17 for 23 of its counties/joinders. Continued technical assistance is employed to continue needed modifications as HUD provides their updates to required data elements.

All PATH and CoC HMIS software vendors receive periodic updated data standards collection requirements released by HUD and the other federal partners. Vendors then must modify their systems to be fully compliant with the new PATH and CoC HMIS data standards. Continued technical assistance is employed to continue needed modifications as HUD provides their updates to required data elements.

NOT FINAL

The various Continuums of Care continue to work toward generating a count of homeless with serious mental illness using the Homeless Management Information System (HMIS) in each CoC; however, the current level of participation is still not adequate for an accurate count. In Jan 2017, HUD published coordinated entry requirements to be implemented no later than Jan 23, 2018. This mandate has increased the organized and systematic use of HMIS in CoCs. As part of annual reporting and applications, CoCs now must incorporate HMIS data from SAMHSA programs such as PATH and Emergency Solutions Grant.

With the implementation of Coordinated Entry throughout the CoCs, more information will be collected in HMIS on households being served. This information provides an opportunity to more thoroughly determine the flow of people through the system, identify gaps, and needs and assess the effectiveness of programs and strategies. This information can be used to set the priorities of various grants to assure that the best use of the funds.

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 the Homeless Prevention and Rapid Re-housing Program (HPRP) was a designation of people who are not homeless but received homeless prevention services. This will enable the HMIS to also report on people with mental illness who are at risk of homelessness and therefore PATH eligible. PA HMIS has accommodated this pre-enrollment population; proprietary HMIS have either already augmented their system or have a plan in place to do so.

Continued Training

PA has several methods in place to address ongoing HMIS training. First, OMHSAS will MOU 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 PA HMIS system enhancements, OMHSAS will utilize federal PATH funds. The total cost for system enhancement will be divided among each PATH provider and subtracted from the total federal allocation.

Second, upon hire, each new PATH HMIS user with be trained on the respective systems. This will be facilitated by County PATH Coordinators and/or PATH supervisors. For PA HMIS users, DCED has compiled a comprehensive educational base, which includes webinars, desk guides, tutorials and a sand box training environment. Non-PA HMIS systems have been asked to produce user manuals for their respective systems.

Third, PA plans to include HMIS updates in quarterly statewide PATH calls, State PATH Conferences and various electronic communications. The SPC plans to have representatives from PA HMIS and other systems speak about HMIS integration at the next State PATH Conference.

Fourth, PA SPC is strongly encouraging all proprietary HMIS systems to have a written manual for reference by both seasoned and new PATH providers.

NOT FINAL

Fifth, PATH HMIS Learning Communities are consistently provided SAMHSA's Homeless and Housing Resource Network. The SPC strongly encourages participation by all providers.

In addition, the SPC will conduct random quality tests with HMIS reports to identify trends and issues. The SPC is also in the planning stages of building a mentor system for HMIS use. Future TA will also be considered as needed.

NOT FINAL

III. State Level Information

L. Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR)

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to 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.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes ○ No ◉

If No, please upload documentation with changes for FY19.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

2019 PA SSI/SSDI Outreach, Access and Recovery (SOAR)

PA continues to have a strong SSI/SSDI Outreach, Access and Recovery program. With the growth of SOAR in PA, the State SOAR Team Lead has restructured the SOAR steering committee to implement the Fundamentals format and include other updates. To date, twenty (20) of the 24 PATH MH/ID counties and 1 non-PATH county have received SOAR training and several others are exploring potential for training. The State PATH Contact will continue to work with all PATH counties to have at least one SOAR trained staff within each PATH program across the state by the end of FY 18/19.

Nationally, PA's SOAR program was again ranked #1 in quality. PA's program was also recognized for consistently reporting over 100 benefit decisions for at least 3 years. While the national average days to benefit decision nationwide is 96 days, PA has an average of 79 days in rural SOAR programs and only 58 days in the Philadelphia SOAR program.

In the 2018 SOAR Outcomes, PA was recognized for several achievements: over 2000 decisions, over 1000 approvals, being in the top 10 approval rates, consistent capacity, and most improved capacity. Complete 2018 SOAR Outcomes infographic is attached and a consolidated graph is below.

Initial applications:

State	Locality	2018 Decisions	2018 Approvals	2018 Allowance	2018 Average Days	Years of Data	New Cumulative Decisions	New Cumulative Approvals	Cumulative Allowance Rate
PA	Multiple sites Including Phila	364	313	85.98%	67	9	2880	2625	91.11%
	Phila only	195	187	95.89%	58	11	2172	2122	97.70%

And appeals:

State	Locality	2018 Appeals Decisions	2018 Appeals Approvals	2018 Appeals Allowance Rate	2018 Appeals Average Days	Years of Data	New Appeals Cumulative Decisions	New Appeals Cumulative Approvals	Cumulative Appeals Allowance Rate
PA	State	5	1	20%	282	5	148	74	50%

PA's SOAR initiative had two great advances this year. First, with funding from Community Mental Health Services Block Grant, eighteen SSI/SSDI Outreach, Access and Recover (SOAR) leaders participated in the 2019 Statewide SOAR Leaders Summit held May 15-16, in Boalsburg, PA. The summit pivoted around in-person sharing of the expansive knowledge and experience bases of 24 counties, the Social Security Administration (SSA), the SOAR TA Center, and the PA SOAR State Lead with the goal of proliferating best practices in SOAR as well as synchronizing local lead efforts to assist the SOAR State Lead. Programs represented

NOT FINAL

ranged from newly-funded Continuum of Care efforts, rural endeavors, and Veterans' initiatives, to nationally recognized urban programs. Topics covered included Online Course review, roles and responsibilities of SOAR Local Leads, State and national program updates, effective relationships with SSA, outcomes management, special populations, and SOAR funding/sustainability. In-depth face-to-face discussions from various perspectives led to the unification and reenergizing of all SOAR Local Leads both in their responsibilities and in sustaining and expanding SOAR in PA. As one participant noted, "The resources, perspectives, tools, and shared knowledge everyone provided were extremely beneficial towards, not only our program, but to everyone in the room." Requests for funding to expand the Summit to include Bureau of Disability Determination representatives next year.

Second, creation of a SOAR database has been financially approved by funding by Community Mental Health Services Block Grant. The database would feature essential SOAR provider information such as location, scope of SOAR practice, organization name, contact information etc to efficiently match those in need with proper SOAR resources. Similar information on PATH providers would be included as well to heighten the effectiveness of the data to be queried.

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 representatives in attendance. PA is inviting both Social Security Administration and Bureau of Disability Determination representatives to all SOAR trainings for added benefit to participants.

SPC duties include being the statewide Lead SOAR Trainer. In addition, the SPC continues to create a complete database of statewide PATH and SOAR contact information for more efficient distribution of materials and procedural updates. Quarterly SOAR conference calls will also be implemented to ensure statewide cohesion of SOAR process.

Various funding streams continue to be taken advantage of for SOAR training. In the past, sources such as Staunton grant, Substance Abuse and Mental Health Services Administration's Cooperative Agreements to Benefit Homeless Individuals (CABHI) and various foundations have been sources of SOAR initiative funding. In FY 2018-2019, Delaware County Continuum of Care (CoC) applied for a Home4Good grant, funded through the PA Housing and Finance Agency and FHL Bank Pittsburgh, and was awarded $149,000 to implement SOAR into their CoC's coordinated entry process.

The second largest organized SOAR effort in PA, Pittsburgh Mercy, was able to secure two additional SOAR caseworker positions this spring. By leveraging their impressive outcomes against the growing needs of area provider agencies, additional funds were allocated through Allegheny County Department of Human Services. That brings Pittsburgh Mercy's total complement to 5.33 FTE for an group that completed over 100 applications in FY18-19.

NOT FINAL

Having Department of Veterans Affairs (VA) caseworkers trained to assist veterans with SOAR applications further enhances PA's efforts to expand services to the veteran community. In May 2017, the VA released a new memorandum encouraging Veterans Health Administration (VHA) homeless programs staff to be trained in and use the SOAR model. In addition, SSVF grantees have also been told to either have a SOAR-trained staff member or have a specific place to refer potential SOAR clients The PA SOAR Program has also been coordinating with both VA Hospitals and SSVF grantees to provide SOAR training for the who directly serve the Veteran population. To date, Lebanon VA had approximately 24 HUD-VASH Social Workers trained through the SOAR online course and Fundamentals in-person review. Arrangements are being made to train the remaining VA Hospital and SSVF staff statewide.

One of the staff for the Veterans Multi-Service Center, and SSVF grantee, attended the SOAR Leadership Academy and is now a local lead providing technical assistance and training to other SSVF grantees. This person will also function as the central state representative on the regional SOAR training team.

The regional SOAR training team is being formed to expand PA's SOAR initiative. This tier of leadership will allow for more-timely scheduling of Fundamentals, regionalized communications and a stronger overall SOAR presence in PA. To date, there are three western trainers, a central trainer, one southeastern trainer, and one northeastern trainer. Other locations will be filled as space is available in Leadership Academy slots.

Allegheny County Jail continues to expand SOAR efforts as a result of Allegheny County receiving one of six national technical assistance awards to advance SOAR use in the criminal justice environment. The program has implemented protocols and is progressing. This project will enhance SOAR progress already being made by the Bucks Co Jail in the eastern part of the state.

NOT FINAL

III. State Level Information

M. PATH Eligibility and Enrollment

Narrative Question:

Answer the Yes/No question below. If you check "No" please provide any updates to describe how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented.

I certify that the response to this Narrative Question in the FY18 PATH Application is still accurate. Yes (selected) No

If No, please upload documentation with changes for FY19.

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PATH Reported Activities

Charitable Choice for PATH

Expenditure Period Start Date: 7/1/2017 Expenditure Period End Date: 6/30/2019

Notice to Program Beneficiaries - Check all that apply:

- ☐ Used model notice provided in final regulation.
- ☐ Used notice developed by State (please attach a copy to the Report).
- ☐ State has disseminated notice to religious organizations that are providers.
- ☐ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☐ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA's Treatment Facility Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.
- ☐ ______ Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

FY 2019 PATH FOA Catalog No.: 93.150 FOA No.: SM-18-F2 Approved: 05/07/2018

Footnotes:

NOT FINAL

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR

May 22, 2019

Ms. Virginia Simmons
Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear Ms. Simmons:

This is to inform you that I hereby designate Valerie Vicari, Acting Deputy Secretary for Pennsylvania's Office of Mental Health and Substance Abuse Services, to sign, on behalf of the Commonwealth, the set of agreements that certify Pennsylvania's compliance with the requirements for receiving grant funds under the Projects for Assistance in Transition from Homelessness (PATH) program. This authorization is valid until otherwise noted.

Sincerely,

TOM WOLF
Governor

NOT FINAL

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