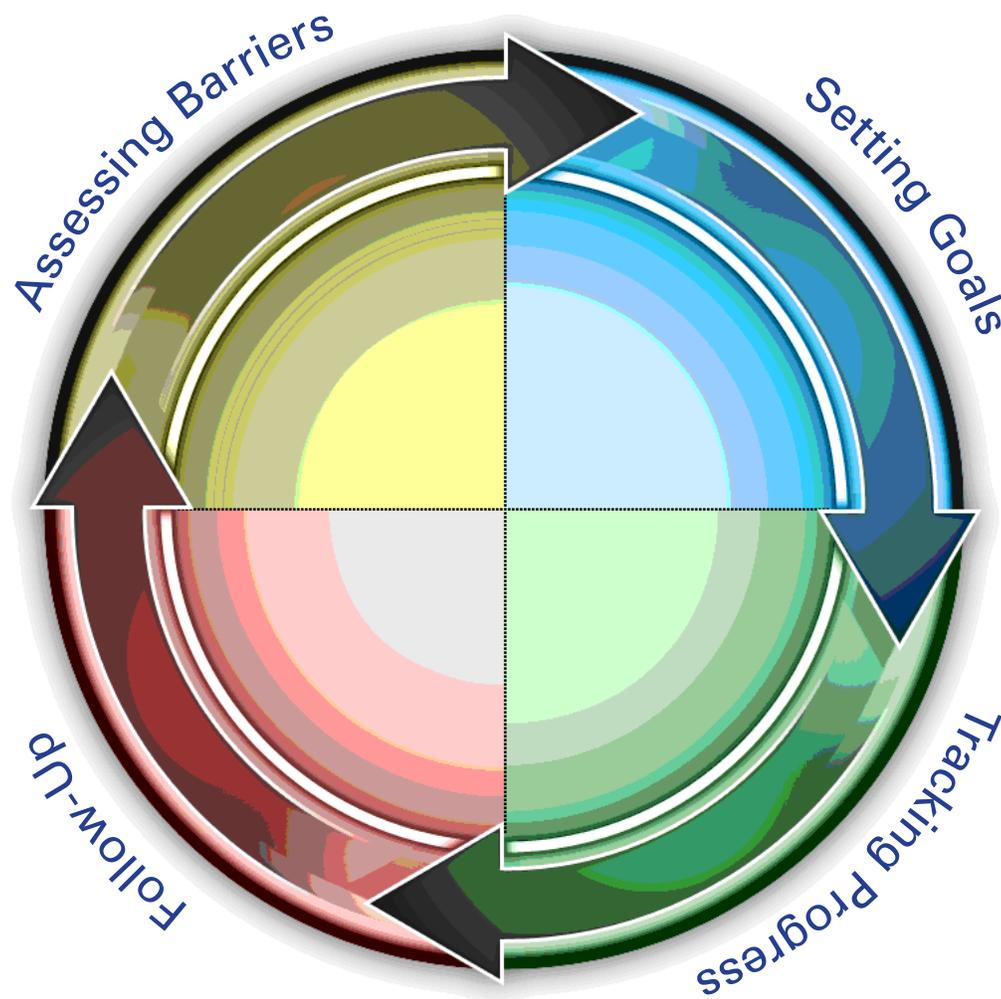


# Housing Support Standards

## Implementation Guide



Georgia Department of Community Affairs  
State Housing Trust Fund for the Homeless

Version 1.1

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## Introduction

The State Housing Trust Fund for the Homeless (HTF) within the Department of Community Affairs (DCA) provides funding to service providers across the state of Georgia. These state and federal dollars are provided to a wide range of grantees providing a host of different services. Some grantees provide support services only, and others provide both housing and services, up to and including permanent supportive housing. The mission of the State Housing Trust Fund is to support the efforts of organizations that provide housing and essential services for individuals and families striving to end their state of homelessness.

The State Housing Trust Fund for the Homeless has developed the Housing Support Standards (HSS) to ensure that the services provided by all DCA grantees meet a basic standard of care. These standards are not comprehensive nor are they meant to replace standards and guidelines required by licensing agencies. Rather, through the implementation of these basic standards, we hope to see a reduction across the State of Georgia in the amount of time participants experience homelessness and an increase in each participant's housing stability as they are moved through the Continuum of Care.

The requirements for Prevention programs differ slightly. Grantees receiving prevention funds should refer to the Housing Support Standards for Prevention Grantees in the Appendix to clarify which of the standards apply to them.

This Implementation Guide is meant to be a tool for DCA grantees to understand the requirements and suggested guidelines for all DCA grantees. Where possible, we have attempted to describe the basis for each standard in place. We have also included instructions on how to comply with required procedures. Most of the required HSS you will see must be documented within PATHWAYS COMPASS (the Homeless Management Information System of Georgia). As some of these reflect new capabilities of the system, step by step instructions and screen shots are provided in the appendices.

In the interest of keeping this manual succinct and user friendly, we have not gone into depth on each standard, but have provided a list of "suggested readings" and other resources which will supply useful information for programming. This information will be found at the end of each topic area. We recognize that many of you are already providing outstanding services and we hope that over time you will share your best practices with us and the other grantees. As we continuously expand upon this guide, we will add information about best practices across the State of Georgia and nationally.

We hope that you find this manual useful in the quest to continuously improve the quality of care and service your agency provides to the community. We also hope that you find it useful in understanding your responsibilities as a DCA grantee. This is the first version of the Housing Support Standards Implementation Guide from the Georgia Department of Community Affairs. As we are also striving to continuously improve the quality of service offered to *you*, our grantees, and to the community, we welcome your feedback! For questions, suggestions, or feedback on the Housing Support Standards or the Implementation Guide, please contact: *Lindsey Stillman, Planning Coordinator, State Housing Trust Fund for the Homeless* (404-327-6813; [lstillma@dca.state.ga.us](mailto:lstillma@dca.state.ga.us))

## A Note about Wording & Definitions

Agencies use different terms to describe the people they work with and the services they provide. The following identifies the terms we have chosen to use within this guide and briefly describes how we intend for the terms to be understood.

*Participant:* Throughout the HSS Implementation Guide, the term *participant* is meant as any *client*, *consumer*, or an individual or household who utilizes services provided by your agency.

*Housing Stability Goal:* A Housing Stability Goal is an individualized set of goals created in collaboration with the participant being served, to identify key needs of the participant. These goals should focus primarily on the issue of attaining and maintaining stable housing, though may also include a wide range of other aspects (employment, mental health, etc.). Your agency might also have goals like this in an *Individualized Service Plan*, *Case Plan*, or *Treatment Plan*.

*Provider:* The term *provider* or *service provider* is used as an umbrella term. *Provider* can represent an entire agency, an individual *counselor*, *case manager*, *clinician*, or other individual(s) who provides services to the program participant.

*Target Population:* Although many agencies will provide services to a range of individuals with a wide variety of needs, the term *target population* is used in reference to the main population your agency intends to serve.

*Best Practices:* Suggestions around program development and implementation which we refer to as *best practices* have been gathered from various agencies nationwide and from research conducted in the field.

## A. Program Philosophy

*A program philosophy is the theoretical framework that describes and explains a program's approach to service. A strong program philosophy respects the strengths and dignity of service recipients; serves as the basis for how the program will meet the needs of service recipients; and guides the implementation and development of program activities and services based on program goals and the best available evidence of service effectiveness. (Council on Accreditation)*

### A.1 Underlying Principles

**Program is guided by program philosophy that values participant choice, promotes respect between staff and participants, and utilizes a strengths based approach to promoting housing stability.**

Barker (1999, defined “strength-based approach” as:

*“...an orientation in practice that accentuates the client's personal resources, abilities, social support network, and drive to face issues and overcome misfortune.”*

A strengths based approach is based on a team model of service delivery which incorporates the participant, the service provider, and the community. This approach focuses on individuals' positive attributes rather than deficits and emphasizes that:

- Each person deserves to be heard, respected, and taken seriously
- Each person is an active participants in the helping process
- All people have strengths, often untapped or unrecognized
- Strengths foster motivation for growth

The program philosophy should reinforce participants' rights.

Participants' rights should be clearly stated in writing and provided to the participant no later than at the point of intake.

### A.2 Crisis Prevention Strategies

**Services are provided in a safe and supportive environment, where crises are minimized through the implementation of comprehensive crisis prevention strategies.**

Strategies to prevent and manage crisis situations are imperative. Below you will find a set of requirements and a list of recommendations or “best practices”, which are aimed at preventing crises. For Crisis Support Services, see C.3.

## Georgia Housing Support Standards Implementation Guide

### Requirements:

- As a component of staff training, each staff member must be educated on crisis intervention and what to do in case of an emergency.
- Agency has developed and implemented policies and procedures to provide additional services and/or supports for participants who appear to be de-compensating or otherwise experiencing a failure to thrive in their program(s).
- Agency has relationships with other providers in the community who can provide mental health and/or other necessary services to participants who appear to be on the verge of a crisis. (24 Hour Access).

### Additional best practices for crisis prevention include:

1. Identify centers of tension
2. Identify and anticipate stressors
3. Pay attention to changes in participants' behaviors
4. Provide extra support around transitions
5. Intervene sooner rather than later
6. Train all staff to de-escalate conflicts *and* crises
7. Learn from experience

*(Corporation for Supportive Housing: Preventing Crisis and Conflict)*

Council on Accreditation suggests that direct service providers participate in ongoing training that includes:

- a) Assessing needs in crisis situations;
- b) Special issues regarding age, substance use and mental health conditions, developmental disabilities, and other needs typically presented by the service population;
- c) De-escalation techniques for crisis situations;
- d) Procedures for making referrals; and
- e) Prevention of compassion fatigue or “burn-out.”

*(Council on Accreditation)*

### A.3 Individualized & Culturally Competent Services

#### Services provided are individualized and culturally competent.

Agencies must respect the diversity of its participants, and the community at large. All eligible individuals should have the right to services regardless of their political or religious beliefs, ethno-cultural background, ability, gender identity (where applicable), and sexual orientation.

*“Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.”*

– National Association of Social Workers, 2001

Staff must respect and promote participants’ rights, including their right to express social, cultural, and religious beliefs. While protecting the rights of respect and safety for all participants, each individual participant should be able to live according to their belief system.

Indicators of a culturally competent program include:

1. Participants are treated as individuals with unique needs.
2. The program is responsive to ethno-specific and linguistic needs of the participants.
3. Staff are aware of the social, cultural, and religious beliefs important to the participants.
4. Where necessary, provisions are made to support participants in their religious, cultural, or spiritual activities.\*
5. Participants’ sexuality is respected as a legitimate aspect of their identity.

*\*See ESG Regulations (Section 576.23) and DCA Program Participation Agreement (Exhibit E Contract Specifications Section 2F) for information on primarily religious or faith-based organizations.*

**Section A – For More Information:**

- A.1 President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry

<http://www.hcqualitycommission.gov/cborr/exsumm.html>

MAACLink – Strengths Based Homeless Case Management

<http://www.maaclink.org/hcm.htm>

Council on Accreditation:

<http://www.coastandards.org/index.php>

- A.2: Corporation for Supportive Housing:

*Preventing Crisis and Conflict*

[www.csh.org](http://www.csh.org)

Council on Accreditation: <http://www.coastandards.org/index.php>

- A.3: National Healthcare for the Homeless Council

*Sustaining Community Dialogue and Response*

<http://www.nhchc.org/ShelterHealth/Community.pdf>

National Association of Social Workers

*NASW Standards for Cultural Competence in Social Work Practice*

<http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf>

Project Liberty

*Providing Culturally Competent Crisis Counseling Services*

<http://www.projectliberty.state.ny.us/Resources/PLCultural.pdf>

## **B. Training and Supervision**

*It is essential that providers have the skills and experience necessary to meet the needs of participants. Providers should be knowledgeable of current issues in the field involving services in their area, available to their participants, and best practices for working with their target population.*

### **B.1 Staff Support**

**Agency holds staff meetings at least once a month to discuss program issues and participants' progress and service needs. In the case of specialty services, qualified personnel (as evidenced by applicable degree and experience in service delivery) are present at staff meetings to provide supervision.**

The human services field is a rewarding and often stressful profession. The reasons behind supervision and staff meetings are multifaceted. On the most basic level, staff meetings provide the venue to share information, collaboratively brainstorm challenges facing participants, and provide support among agency staff.

Under the guidance and leadership of managing staff, providers should be kept up to date on policies, provisions, and current issues in the field in order to continuously improve the quality of care provided to their participants.

Providers continually strive to meet the evolving needs of their clients including the implementation of new practices. Where this is not possible, for the protection of the population served, providers must refer their participants to agencies with staff that has the knowledge and expertise to meet the individual's needs.

DCA requires that an agency supervisor provides supervision to direct service staff at least twice per month.

### **B.2 DCA Housing Support Training**

**Any staff member that delivers HSS services funded by DCA attends mandatory DCA Housing Support training.**

DCA will attempt to provide periodic training and guidance regarding the implementation of the Housing Support Standards and other best practices. We will notify all grantees of upcoming training. Information about available training will also be posted at: <http://www.dca.state.ga.us/housing/specialneeds/programs/HousingSupportStandards.asp>.

## C. Access to Services

*Staff at agency should strive to support the independence and autonomy of every participant. Participants should be fully informed, in a language and manner understood by them, the provisions and limitations of the services accessible through the agency. Services available to the participant should reflect the level of care needed by the individual. As a participant's needs change, this should be acknowledged with the participant and documented in their service plan.*

### C.1 Access to Essential Services

**Agency makes every effort to ensure participant has access to the following types of services by providing services themselves or through other community agencies with which they have agreements:**

We suggest that agencies maintain a clear outline of the services they provide, and for services that other agencies have agreed to provide to their participants. This information may be thought of as a type of “service menu”, identifying exactly what services the agency has the capability to provide, either in-house or through working partnerships with other agencies. It is important to provide participants with access to services that address all dimensions of their lives in order to provide a holistic approach to attaining/maintaining their housing stability.

The types of services that your program should offer (either directly or through partnerships with other agencies) are:

**Housing Services** (e.g. assistance obtaining housing and remaining housed, education on tenant rights and responsibilities, support addressing potential threats to housing stability, etc.)

**Skills Training** (e.g. activities of daily living, household management, budgeting and money management, credit and debt counseling, personal safety, use of community resources, use of public transportation, interpersonal communication, etc.)

**Support Services** (e.g. educational services, crisis intervention, transportation, legal assistance, case advocacy, parent education and family support, child care, accessing mainstream resources and benefits, etc.)

**Health** (e.g. routine medical and dental care, substance abuse and mental health services, medication management and/or monitoring, general health education, harm reduction, etc.)

**Employment & Vocational Support** (e.g. work habits, skills and self-awareness essential to employability; writing resumes, completing job applications, and preparing for interviews; finding and accessing local employment resources and placement options including on-the-job training, etc.)

## C.2 Resource Directory

**Agency maintains a current resource directory for all staff. At a minimum, the directory contains information regarding where participants can access each of the types of services listed above, eligibility requirements of other service providers, intake procedures, and available services of each resource.**

As many agencies serve a specific target population, (e.g. age, family size/status, women only, etc), the appropriate resources and referrals available to participants will somewhat differ between agencies. For this reason, each agency must develop their own resource directory that contains all pertinent information for their target population.

General resources which already exist (e.g. United Way 211) will be useful at times, yet it is more efficient and advantageous to the agency and its participants to have relevant referral information, including any known agency contacts, readily available.

At a minimum, developing a resource directory can be as simple as organizing printed information into binders labeled with the service provided (e.g. emergency shelter, food pantry, etc). Agencies without an existing resource directory may look to the following to gather information regarding resources available in their area:

- Local homeless social service coalitions
- Local Family Connections Partnership ([www.gafcp.org](http://www.gafcp.org))
- The Continuum of Care in their area (see Contacts pg. 48)
- Local government and Chamber of Commerce
- United Way ([www.liveunited.org](http://www.liveunited.org) , [www.211.org](http://www.211.org))

It is often helpful to have employees at your agency talk with the staff at other agencies periodically to ensure the information in the resource directory is correct and that they understand the eligibility requirements, services available, and intake procedures.

Having an accurate understanding of the services each agency provides and the manner in which they provide them can help to increase collaboration.

## C.3 Crisis Support Services

**Participants have access to some type of crisis support services 24 hours a day, 7 days a week.**

One definition of the term *crisis* is: “an emotionally significant event or radical change of status in a person's life” (<http://www.merriam-webster.com/>). Many agencies see this manifest at some point as participants who exhibit self-harming or suicidal thoughts or behaviors. However, crises might include any “crucial stage or turning point” which causes a participant stress.

Examples of crisis support include:

- 24 hour access to a local mental health provider (either through an on-call in house provider, or other mental health agency)
- 24 Crisis Hotline (e.g. GA Access & Crisis Line)
- Staff trained in Crisis Intervention Strategies (see A.2 pg. 3)



In 2006, Behavior Health Link began a unique collaboration with the Georgia Department of Human Resources Division of Mental Health, Developmental Disability and Addictive Disease. For the first time, individuals from across the state can call a

single number for access to care or help in a crisis. The Georgia Crisis & Access Line is staffed with professional social workers and counselors 24 hours per day, every day to assist those with urgent and emergency needs. Those callers who need more routine services are directly connected with the agency of their choice and given a scheduled appointment.

All staff members must be educated on procedures to follow in the event of a crisis or emergency. This information is readily available to staff at all times. Crisis or emergency policies and procedures should include information on who to contact and within what timeframe after an incident has occurred, must contact be made. Staff must also be trained on how to appropriately document a crisis or emergency.

In the event of a medical emergency or when participants are of harm to themselves or others, staff should immediately contact 911.

#### **C.4 Specialty Services**

**Agency only provides specialty services for which they are qualified and for which they have received specific training.**

If an agency is unable to appropriately, safely, and ethically provide support to a participant at any point in time, every effort must be made to immediately refer the participant to a more appropriate agency.

Agencies wishing to provide behavioral health services should contact the Department of Human Resources, Division of Mental Health Developmental Disabilities and Addictive Diseases (MHDDAD – [www.mhddad.dhr.georgia.gov](http://www.mhddad.dhr.georgia.gov)) to learn about the qualification guidelines for service providers including acceptable agency accreditation.

Recognizing when a trained professional is appropriate to meet the specific needs of a participant is paramount. Mental health and substance abuse issues are two primary reasons for referring participants to specialized services. When a participant has not been previously diagnosed, it may be necessary to assess the participants' needs.

It is important that staff be able to recognize some of the signs of mental illness and substance abuse. Below is information intended to assist staff in recognizing the need for a referral for a clinical assessment.

*The ability to see a person's behavior as a symptom of mental illness will allow you to manage the behavior within your program; address any discomfort other program participants may have; and work effectively with mental health providers to determine the level of services the person may need. You don't have to be an authority: you only need to recognize how a mental illness can affect a person's behavior, personality, sleep patterns, energy levels, speech, and the ability to care for him or herself. The following are some ways to do this.*

- A. *Evaluate a person's behavior. People with a mental illness may:*
- a. Isolate themselves, stare vacantly, or appear totally apathetic;*
  - b. Have difficulty processing information quickly, or appear confused;*
  - c. Present illogical thoughts, irrational fears, or false perceptions, such as seeing or hearing things that are not present; or*
  - d. Engage in self-talk, laugh out loud, or experience severe mood swings.*

*It is also important to remember that some people with a serious mental illness do not demonstrate outward signs or symptoms. Relate to someone who seems withdrawn to assess him or her at a deeper level.*

- B. *Use visual cues. People with a mental illness may:*
- a. Wear multiple layers of clothing regardless of the weather;*
  - b. Fashion protective devices around themselves;*
  - c. Have extreme body odor, or appear soiled and unkempt; or*
  - d. Have medication side effects, such as, dry mouth, tremors, muscle stiffness, or confusion.*

*Engaging People Who Are Homeless with a Mental Illness (Illinois Department of Human Resources)*

Substance abuse assessments include observing a range of physical, behavioral, and cognitive indicators. The US Department of Health and Human Services – Substance Abuse and Mental Health Services Administration (SAMHSA - <http://mentalhealth.samhsa.gov/>) provide the following list of possible substance abuse indicators. Some of these may also be indicators of a mental illness or health condition.

***Physical/Emotional Indicators***

- *Has smell of alcohol on breath or marijuana on clothing*
- *Has burned fingers, burns on lips, or needle track marks on arms*
- *Slurs speech or stutters, is incoherent*
- *Has difficulty maintaining eye contact*
- *Has dilated (enlarged) or constricted (pinpoint) pupils*
- *Has tremors (shaking or twitching of hands and eyelids)*
- *Is hyperactive and overly energetic Appears lethargic or falls asleep easily*
- *Exhibits impaired coordination or unsteady gait (e.g., staggering, off balance)*
- *Speaks very rapidly or very slowly*
- *Experiences wide mood swings (highs and lows)*
- *Appears fearful or anxious; experiences panic attacks*
- *Appears impatient, agitated, or irritable*
- *Is increasingly angry or defiant*

***Personal Attitude/ Behavior Indicators***

- *Talks about getting high, uses vocabulary typical among drug users*
- *Behaves in an impulsive or inappropriate manner*
- *Denies, lies, or covers up*
- *Takes unnecessary risks or acts in a reckless manner*
- *Breaks or bends rules, cheats*
- *Misses interviews, appointments, or meetings or arrives intoxicated*
- *Fails to comply with program requirements without easily verifiable reasons (may be verbally uncooperative to disguise the problem or divert attention)*

***Cognitive/Mental Indicators***

- *Has difficulty concentrating, focusing, or attending to a task*
- *Appears distracted or disoriented*
- *Makes inappropriate or unreasonable choices*
- *Has difficulty making decisions*
- *Experiences short-term memory loss*
- *Experiences blackout*
- *Needs directions repeated frequently*
- *Has difficulty recalling known details*
- *Needs repeated assistance completing ordinary paperwork (e.g., forms)*

*Substance Abuse and Mental Health Services Administration*

Staff should also be conscious that some physical health conditions are more frequent among individuals that have experienced homelessness and may require a referral to a medical professional.

*The rates of both chronic and acute health problems are extremely high among the homeless population. With the exception of obesity, strokes, and cancer, homeless people are far more likely to suffer from every category of chronic health problem. Conditions which require regular, uninterrupted treatment, such as tuberculosis, HIV/AIDS, diabetes, hypertension, addictive disorders, and mental disorders, are extremely difficult to treat or control among those without adequate housing.*

*Many homeless people have multiple health problems. For example, frostbite, leg ulcers and upper respiratory infections are frequent, often the direct result of homelessness. Homeless people are also at greater risk of trauma resulting from muggings, beatings, and rape. Homelessness precludes good nutrition, good personal hygiene, and basic first aid, adding to the complex health needs of homeless people. In addition, some homeless people with mental disorders may use drugs or alcohol to self-medicate, and those with addictive disorders are also often at risk of HIV and other communicable diseases.*

*National Coalition for the Homeless Fact Sheet #8*

### **C.5 Duplication of Services**

**Agency does not duplicate services that are readily available through other mainstream agencies in the community.**

Agencies should strive to provide services that may be lacking in the community, rather than duplicating services readily available. Through close inter-agency collaboration, a wider provision of services can be offered to participants in need.

### **C.6 Local & Regional Planning**

**Agency participates in any local or regional planning and discussions of service gaps pertaining to homelessness.**

DCA holds 12 regional application workshops each year, at which local and regional issues regarding homeless services are discussed. In addition, the state may hold additional planning meetings.

Agencies should also participate in any local coalition or planning meetings regarding homelessness and affordable housing.

**Section C – For More Information:**

C.3 GA Crisis & Access Line  
1-800-715-4225  
[www.mygcal.com](http://www.mygcal.com)

National Suicide Prevention Lifeline  
(800) 273-TALK (8255)

SAMHSA National Helpline  
(800) 662-HELP (4357) (English and Español)  
(800) 487-4889 (TDD)

C.4 National Mental Health Information Center (NMHIC)  
P.O. Box 42557, Washington, DC 20015  
(800) 789-2647 (English and Español)  
(866) 889-2647 (TDD)  
[mentalhealth.samhsa.gov](http://mentalhealth.samhsa.gov)

Mental Health Services Locator  
(800) 789-2647 (English and Español)  
(866) 889-2647 (TDD)  
[mentalhealth.samhsa.gov/databases](http://mentalhealth.samhsa.gov/databases)

Substance Abuse Treatment Facility Locator  
(800) 662-HELP (4357)  
(Toll-Free, 24-Hour English and Español Treatment Referral Service)  
(800) 487-4889 (TDD)  
[www.findtreatment.samhsa.gov](http://www.findtreatment.samhsa.gov)

Information on the Mental Status Exam  
<http://meded.ucsd.edu/clinicalmed/mental.htm>  
Mini-Mental Status Exam  
<http://www.chcr.brown.edu/MMSE.PDF>

Engaging People Who Are Homeless with a Mental Illness:  
Keys to Recognizing Mental Health Problems  
(Illinois Department of Human Resources):  
<http://hacchicago.org/engagement.html>

National Coalition for the Homeless  
Health and Homelessness Fact Sheet  
<http://www.nationalhomeless.org/PUBLICATIONS/facts/health.html>

C.6 National Healthcare for the Homeless Council  
Sustaining Community Dialogue and Response  
<http://www.nhchc.org/ShelterHealth/Community.pdf>

## D. Screening and Intake

*The first step involved in establishing and developing a helping relationship with your participants begin with the engagement process at intake. This is a critical time when providers establish a professional rapport with their participants while assisting them in identifying their particular needs or concerns. Good intake practices not only facilitate the development of good working relationships between participants and providers, but aids in appropriately identifying what services are needed, informs the development of goals and objectives toward attaining housing stability, determining the individual's eligibility for services, and ascertaining the appropriateness of referrals to be made.*

### D.1 Barriers to Housing Stability Assessment

**Participants receive the Barriers to Housing Stability Assessment within one week of intake, in order to identify areas of need.**

The Barriers to Housing Stability Assessment (BHSA) was developed by Hennepin County, Minnesota as a tool to rapidly assess participants' needs. The assessment targets issues which undermine the individual's ability to maintain self-sufficient housing. This assessment should be used to inform the development of housing stability goals. Likewise, as many agencies have established intake procedures in place, providers can incorporate the information obtained through their established intake procedures in order to complete the Barriers to Housing Stability Assessment. Without duplicating work for the provider, the BHSA is meant as a simple tool to succinctly gather a breadth of vital data. The BHSA should not be considered to be a comprehensive assessment tool or to replace existing assessment tools. The BHSA should, however, be used in conjunction with any other assessment tool(s) required by an individual provider or licensing agency.

This assessment is available electronically through Pathways, and should be completed on the Pathways system for all participants who have signed an HMIS authorization. However, when authorization has not been provided, the assessment may be downloaded and printed from the DCA website. In this case, a hard copy of the BHSA must be contained in the participants' file.

**Instructions for accessing and completing the Barriers to Housing Stability Assessment can be found in Appendix 3.**

### D.2 Referrals

**Any participant not meeting program eligibility criteria or receiving only short-term, critical need services is referred to other appropriate services. Every reasonable effort is made to enter these participants into Pathways.**

We suggest that each agency attempt to enter universal data elements on individuals not served by the program into the Pathways system. This allows DCA to understand the extent of unmet need in your community in order to appropriately allocate resources. In addition, if possible, the agency should provide an appropriate referral to another agency in the community. This can also be tracked through the Pathways system.

**Instructions for documenting Referrals in Pathways can be found in Appendix 4.**

### **D.3 Intake**

**A participant file is initiated upon intake into the program. Intake information for participants providing authorization is entered into Pathways in a timely manner. Current housing status, employment status and mainstream benefits status should be updated in Pathways.**

DCA requires grantees to keep the following documentation in the participant file:

- Verification of Homelessness
- Certification of Disability (if necessary)
- Pathways Authorization

In addition to the documentation required by DCA, it is recommended that the participant file contain the following information:

1. Case Notes
2. Information from other providers or agencies.
3. What the participant prefers to be called.
4. Names and contact information for persons who contribute to the care and support of participant, if any.
5. Names and contact information for family, friends, or other individuals that participant may wish to have involved in the development, implementation, or revision to the housing stability plan.
6. Any specific communication needs the participant may have.
7. What communication arrangements need to be put in place if the participant's first language is not English or if the participant is unable to read, write, hear, or speak.
8. When, and in what circumstances others (e.g. family, friends, other care provider) will be contacted (e.g. due to health or personal circumstances).

## Georgia Housing Support Standards Implementation Guide

It is also recommended that you provide informational materials to the participant when they enter your program including:

1. A program brochure or clear explanation of the services provided by the agency.
2. An explanation of how to use the services, including a statement regarding the participant's choice to discontinue the program.
3. Information on how the quality of services is monitored.
4. An explanation of participants' rights and responsibilities.
5. Policies and procedures of the program, including policies and procedures for managing risk and recording and reporting incidents.

It is **required** that the agency provide participants with the termination and grievance policies and procedures for participants to report complaints, violations to their rights, or involuntary termination from the program. Termination and grievance policies and procedures for participants must include the steps the agency will take to respond to participants' concerns.

**Instructions for updating Participant Status can be found in Appendix 5.**

**Section D – For More Information:**

D.2 The National Health Care for the Homeless Council  
Checklist for Making Successful Referrals.  
<http://www.nhchc.org/ShelterHealth/Community.pdf>

D.3 National Healthcare for the Homeless Council  
Shelter Health: Essentials of Care for People Living in Shelter  
<http://www.nhchc.org/shelterhealth.html#toolkits>

Council on Accreditation  
Intake and Assessment  
[http://www.coastandards.org/standards.php?navView=public&core\\_id=207](http://www.coastandards.org/standards.php?navView=public&core_id=207)

Corporation for Supportive Housing  
Housing Operations: Tenant Screening, Selection and Move-In  
<http://www.csh.org/index.cfm?fuseaction=page.viewPage&PageID=3676&C:\CFusionMX7\verity\Data\dummy.txt>

Pathways Compass  
Sample Client Intake Form  
[www.pcni.info](http://www.pcni.info)

## E. Service Planning and Delivery

*Service planning should be conducted such that individuals and families retain as much personal responsibility and self-determination as possible and/or desired. (Council on Accreditation)*

### E.1 Housing Stability Goals

**Each individual participates in the development and *ongoing review* of Housing Stability Goals. The Housing Stability Goals and progress toward goals should be tracked in Pathways unless authorization is not obtained.**

Participants should take an active role in developing these goals with the assistance of a provider. Participants may request a hard copy of the cooperative housing stability goals at any time and may *propose* changes or amendments as they see appropriate. Participants should feel confident that the goals address their individual needs.

The Housing Stability Goals should reflect the way the services provided are individualized to meet the participant's specific needs. The goals should also contain steps needed to reach each goal.

The U.S. Department of Housing and Urban Development (HUD) advanced a Supportive Housing Training Curriculum which guides providers in the development of goals. Learning Points included:

1. Goals should be clear, succinct, attainable, and reinforced.
2. Goals should be [participant] driven.
3. Along the way, problems will come up and [provider] will have an opportunity to assist with re-establishing goals.
4. The investment in completing a goal is greater if the steps focus on what the [participant] wants.

The Housing Stability Goals must be maintained within the Pathways system for those individuals who have completed an Authorization Form. When setting a goal in Pathways, providers should choose the goal domain (e.g. housing, employment, etc.) as well as a goal type (e.g. obtain transitional housing, job training, etc.). The provider can then type the specific goal for that individual in a free-response field. A list of the available goal domains and goal types can be found in Appendix 9.

When providers are setting the Housing Stability Goals, they should also make sure they update the Current Status Fields (housing, employment, mainstream benefits). Every effort should be made to keep these fields as current and accurate as possible.

For participants who have not provided authorization, equivalent documentation must be provided in the participants' file.

**For more information on documentation requirements, see Section G.**

**Information on setting and tracking Housing Stability Goals in Pathways can be found in Appendices 6 & 7.**

## **E.2 Participant Contact**

**Participants have contact with a provider at least twice per month. Contact occurs more frequently during the first three months of services.**

It is recommended that participants are able to meet with providers frequently, especially when they begin to receive services. This should assist the provider with understanding the needs of the participant and creating a trusting relationship with the individual. It also helps the participant to focus on their set goals and the required action steps to attain those goals.

Whenever possible, participants should be assigned an alternate or secondary agency contact, in the event that their primary staff provider is inaccessible.

## **E.3 Tracking Progress**

**Progress toward goals is regularly documented in Pathways. Referrals to outside agencies are followed up on and documented in Pathways and if appropriate through the Housing Stability Goals.**

At each meeting, the participant and provider should discuss progress or challenges with meeting established goals, status changes, needs changes, or other issues relevant to the participant at that time. When significant changes have occurred from the last contact, providers should update the Housing Stability Goals and relevant information in the Pathways system or in the participant file for those individuals who have not signed a Pathways authorization.

When providers are updating the Housing Stability Goals, they should also make sure they update the Current Status Fields (housing, employment, mainstream benefits) as appropriate. Every effort should be made to keep these fields as current and accurate as possible.

Documentation, in the form of goal setting and progress, service delivery, or status updates should be made in the Pathways system within a week whenever possible.

#### **E.4 Interagency Collaboration**

**When multiple agencies are simultaneously serving the same participant, there is evidence of interagency collaboration on the housing stability plan.**

Agencies providing housing services to a participant should be viewed as the primary service provider. When a participant receives services only, but no housing support, the agency which provides the most intensive and frequent services should be viewed as the primary service provider.

Primary service providers are responsible for initiating and maintaining participant documentation in the Pathways system. When referrals have been made to other agencies for specialty service, it is the responsibility of that agency (considered the secondary provider) to maintain documentation within the system as it relates to those issues. (For example, if an agency is providing employment assistance to a participant, they are responsible for updating goals, goal progress, and status updates within the domain of employment.) However, the primary agency should still follow up with the participant and/or the other agency regarding their connection with other services. Collaborating agencies and key personnel should be documented within the participant's housing stability goals and case notes.

When participants sign a Pathways Community Network Client Authorization Form, they are agreeing to permit other agencies to *look* at the information contained within the Pathways System, they have not necessarily granted permission for agency personnel to *discuss* the participant. Ensure that you are complying with your agency's privacy standards regarding the release of personal information.

**Section E – For More Information:**

- E.1 National Healthcare for the Homeless Council  
Shelter Health: Essentials of Care for People Living in Shelter  
<http://www.nhchc.org/shelterhealth.html#toolkits>  
  
HUD Supportive Housing Training Series  
<http://www.hudhre.info/documents/SHPCaseManagement.pdf>
- E.3 The National Health Care for the Homeless Council  
Checklist for Making Successful Referrals.  
<http://www.nhchc.org/ShelterHealth/Community.pdf>
- E.4 National Healthcare for the Homeless Council  
Sustaining Community Dialogue and Response  
<http://www.nhchc.org/ShelterHealth/Community.pdf>

## F. Case Closing and Follow-Up

*Every effort to connect participants (current and former), to needed appropriate services should be made. Although this may not always be possible, it is in the best interest of the participant that agencies who have served them continue to exhibit a commitment to ensuring that they are appropriately housed and moving toward or maintaining housing stability.*

### F.1 Follow-Up: Emergency Shelter and Supportive Services

**Emergency shelters and supportive service providers will attempt to update the current housing status, employment status and mainstream benefits status of a participant 90 days after the Barriers to Housing Stability Assessment is completed. If the participant is no longer receiving services with the agency at that time, reasonable effort is made to follow-up with the individual in order to update status.**

As emergency shelter stays are frequently brief, and the participant may no longer be residing in the emergency shelter 90 days after the Barriers to Housing Stability Assessment is conducted, service providers are asked to make a *reasonable effort* to follow up with former participants. Due to the nature of your organization, the number of staff you have, and the amount of resources available to your agency, more or less time and energy may be able to be devoted to this process. At a minimum, it is anticipated that providers will contact the last known (or anticipated) placement of the participant. If the participant is unable to be located or their status is unable to be verified, providers may choose the “Unknown” option in any of the status update fields.

If at the time of follow-up another agency has very **recently** updated current status, you should not update the existing current status unless you are certain that their status listed has changed, especially if your agency has been unable to contact the participant.

<p><b>For instructions documenting Status Updates in the Pathways system, see Appendix 5.</b></p>
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### F.2 Follow-Up: Transitional and Permanent Supportive Housing

**Participants leaving transitional or permanent supportive housing should be contacted at 30, 90 and 180 days after they leave the program at which time their current status, employment status and mainstream benefits status should be updated in Pathways. If the participant should require additional support at the time of follow-up, the agency will facilitate access to appropriate services available at their agency or with another provider in the community. The agency makes every effort to ensure that, even after a case is closed, the participant remains in some type of stable housing.**

## Georgia Housing Support Standards Implementation Guide

Participants planning to leave the program should be provided with transitional planning which includes transferring more responsibility from the service provider to the participant. Participants and service providers should meet to discuss progress and any barriers encountered during this process and should address barriers in a timely fashion to ensure smooth transition toward independence and housing stability.

Agency should provide education to participants about the level of support and follow up services they are eligible to receive from the agency once they have terminated the program.

Discharge planning and paperwork should include a list of currently available community resources. These materials must be provided to the participant in writing prior to or at the time of exit. The status of the participant should be updated in the Pathways system denoting not only when the participant discontinued services, but where the participant has exited to, and any other services the participant has begun accessing.

Participants no longer receiving services by the agency should be discharged in the Pathways system within 7 days from their exit. The date entered into the system should reflect the actual date they left the program.

Providers should attempt to contact participants 30, 90 and 180 days after they leave the program. When participants can be located, providers should document the current status of the participant in each domain (housing, employment, benefits). Providers should inquire if the participant requests or could benefit from referrals to available supportive services.

If at the time of follow-up another agency has very **recently** updated the participant's current status within Pathways, you should not update the existing current status unless you are certain that their status listed has changed, especially if your agency has been unable to contact the participant.

Creative ways to engage in follow up with your participants may include:

1. Regular peer networking groups.
2. Provider drop-in hours.
3. Monthly telephone correspondence with providers.
4. E-mail correspondence.
5. Social engagement activities.

The Council on Accreditation provides the following guidelines for aftercare planning and follow-up:

*While the decision to develop an aftercare plan is based on wishes of the individual, unless aftercare is mandated, the organization is expected to be proactive with respect to aftercare planning.*

1. *An aftercare plan is developed sufficiently in advance of case closing to ensure an orderly transition.*

2. *Aftercare plans identify services needed and desired by the individual and specify steps for obtaining identified services.*
3. *The organization takes the initiative to explore suitable resources and make contact with service providers when appropriate and with the permission of the person, family, or legal guardian.*
4. *The organization follows up on the aftercare plan, as appropriate, when possible, and with permission of the individual.*

The following are a brief list of best practices when beginning the transitional planning process with participants. They have been adapted from The Critical Time Intervention Training Manual:

1. *Before the [participant] first moves to [the] community, [the provider(s)] formulate a treatment plan with specific attention to five areas of facilitating community stability:*
  - a. *Psychiatric treatment and medication compliance*
  - b. *Money management*
  - c. *Substance abuse management*
  - d. *Housing crisis management*
  - e. *Family interventions.*

*Special attention is given to factors precipitating housing loss in the past, as well as current needs and difficulties. The main task is linking the [participants] to appropriate resources.*

2. *When a [participant] first leaves, separation issues will arise. Times of transition and separation may revive past traumatic experiences. Providers must provide the opportunity for gradual, empathetic separation. Providers should be aware that in some cases, [participants] may sabotage progress they have made.*
3. *New relationships (in the residence, community, and with mental health providers) will become the bedrock of the client's adjustment to their new living situation. Participants who do not form new relationships easily may need the provider to be a bridge between the participant and those with whom the participant will be forming new relationships.*
4. *Daily living skills must be assessed and it may be necessary to teach or model skills that the participant has yet to master (e.g. doing laundry, cooking, balancing a checkbook, etc.) When possible, the provider should try to mobilize the participant's own natural support network in acquiring and applying living skills.*
5. *The participant will need to be able to ask for advice or support during the initial transitional time. Providers should encourage the participant to call them for assistance especially when a participant seems unlikely to do so on their own.*

<p><b>Instructions documenting Status Updates in Pathways can be found in Appendix 5.</b></p>
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### F.3 Termination of Service

**Criteria for termination from the program are clearly defined and communicated to participants. If a participant is asked to leave the program, the organization makes every effort to link the person with appropriate services in the community. Current housing status should be updated in Pathways.**

At intake, the agency must provide participants with the termination and grievance policies and procedures for participants' to report complaints, violations to their rights, or involuntary termination from the program. Termination and grievance policies and procedures for participants must include the steps the agency will take to respond to participants' concerns.

If a participant is terminated from the program, discharge planning and paperwork should include a list of currently available community resources and appropriate referrals. The agency should make every effort to connect the participant with more appropriate services before they leave the program.

The status of the participant should be updated in the Pathways system denoting not only when the participant discontinued services, but where the participant exited to, and any other services the participant has begun accessing.

### F.4 Unexpected Exits

**If a participant leaves a transitional or permanent supportive housing program without warning, the agency will make an effort to locate and follow-up with the participant. Providers must make every effort to refer a participant who no longer wishes to receive services to another appropriate service provider. Current housing status should be updated in Pathways.**

Where possible, providers should make a *reasonable effort* to follow up with participants that have left the program unexpectedly. If they are able to locate the participant they should attempt to engage them in order to provide appropriate referrals to any needed services. At a minimum, participants should be provided with a list of currently available community resources.

The status of the participant should be updated in the Pathways system denoting not only when the participant discontinued services, but where the participant has exited to (if known).

**Section F – For More Information:**

- F.1** Council on Accreditation  
Aftercare and Follow Up  
[http://www.coastandards.org/standards.php?navView=private&core\\_id=719](http://www.coastandards.org/standards.php?navView=private&core_id=719)
  
- F.2** Council on Accreditation  
Aftercare and Follow Up  
[http://www.coastandards.org/standards.php?navView=private&core\\_id=719](http://www.coastandards.org/standards.php?navView=private&core_id=719)
  
- F.3** The Critical Time Intervention Training Manual  
V. The Three Phases of CTI - (Transition Planning Pg. 31-41)  
<http://www.acbhcs.org/Housing/doc/Critical%20Time%20Intervention%20Training%20Manual.pdf>

## G. Documentation

### G.1 Documentation Timeline Requirements

**Agency will comply with all documentation requirements including entry of all relevant participant information into Pathways Compass in a timely manner.**

#### Minimum Timelines Documentation Table

Initial Intake in Pathways	One Week after Intake
Barriers to Housing Stability Assessment	One Week after Intake
Set Housing Stability Goals	One Week after Intake
Update Goals	Twice a Month
Update Current Status	Intake As Necessary Discharge 90 Days after Barriers Assessment (Emergency and Services) 30, 90 and 180 days after Discharge (Transitional and Permanent Supportive Housing)
Participant Discharge from Pathways	One Week after Discharge

### G.2 Documentation with Participants Who Refuse Authorization

**For those participants that refuse authorization for Pathways, equivalent documentation (Barriers to Housing Stability Assessment, Housing Stability Goals and updated progress toward goals) is kept in the case file. In addition, if a participant refuses authorization, documentation of refusal must be in their case file.**

The hard copy of all documents will be made available on the Department of Community Affairs website: <http://www.dca.state.ga.us/housing/SpecialNeeds/index.asp>.

### G.3 Documenting Current Status Updates

**Agencies will update current status fields in Pathways Compass at designated time periods (intake, discharge and 30, 90 and 180 days post discharge for transitional and permanent supportive housing; intake, discharge and 90 days post Barriers to Housing Stability Assessment for emergency shelter and supportive services; intake and 180 days post assistance for prevention) and when significant changes in status occur.**

Providers are asked to make a *reasonable effort* to follow up with former participants. Due to the nature of your organization, the number of staff you have, and the amount of resources available to your agency, more or less time and energy may be able to be devoted to this process. At a minimum, it is anticipated that providers will contact the last known (or anticipated) placement of the participant. If the participant is unable to be located, providers may choose the “Unknown” option in any of the status update fields.

**Section G – For More Information:**

Pathways Compass

[www.pcni.info](http://www.pcni.info)

Department of Community Affairs

State Housing Trust Fund for the Homeless

<http://www.dca.state.ga.us/housing/SpecialNeeds/index.asp>

## Appendix 1: Housing Support Standards

### DCA Emergency Shelter Grantees Support Standards

*Objective: Provide access to services that help participants achieve housing stability*

#### A. Program Philosophy

A.1 Program is guided by a program philosophy that values participant choice, promotes respect between staff and participants, and utilizes a strengths based approach to promoting housing stability.

A.2 Services are provided in a safe and supportive environment, where crises are minimized through the implementation of comprehensive crisis prevention strategies.

A.3 Services provided are individualized and culturally competent.

#### B. Training and Supervision

B.1 Agency holds staff meetings at least once a month to discuss program issues and participants' progress and service needs. In the case of specialty services, qualified personnel (as evidenced by applicable degree and experience in service delivery) are present at staff meetings to provide supervision.

B.2 Any staff member that delivers HSS services funded by DCA attends mandatory DCA Housing Support training.

#### C. Access to Services

C.1 Agency makes every effort to ensure participant has access to the following types of services by providing services themselves or through other community agencies with whom they have agreements:

Housing Services (e.g. assistance obtaining housing and remaining housed, education on tenant rights and responsibilities, support addressing potential threats to housing stability, etc.)

Skills Training (e.g. activities of daily living, household management, budgeting and money management, credit and debt counseling, personal safety, use of community resources, use of public transportation, interpersonal communication, etc.)

Support Services (e.g. educational services, crisis intervention, transportation, legal assistance, case advocacy, parent education and family support, child care, accessing mainstream resources and benefits, etc.)

Health Services (e.g. routine medical and dental care, substance abuse and mental health services, medication management and/or monitoring, general health education, harm reduction, etc.)

Employment and Vocational Support (e.g. work habits, skills and self-awareness essential to employability; writing resumes, completing job applications, and preparing for interviews; finding and accessing local employment resources and placement options including on-the-job training, etc.)

C.2 Agency maintains a current resource directory for all staff. At a minimum, the directory contains information regarding where participants can access each of the types of services listed above, eligibility requirements of other service providers, intake procedures, and available services of each resource.

C.3 Participants have access to some type of crisis support services 24 hours a day, 7 days a week.

C.4 Agency only provides specialty services for which they are qualified and for which they have received specific training.

C.5 Agency does not duplicate services that are readily available through other mainstream agencies in the community.

C.6 Agency participates in any local or regional planning and discussions of service gaps pertaining to homelessness.

#### **D. Screening and Intake**

D.1 Participants receive the Barriers to Housing Stability Assessment within three working days of intake in order to identify areas of need.

D.2 Any participant not meeting program eligibility criteria or receiving only short-term, critical need services is referred to other appropriate services. Every reasonable effort is made to enter these participants into Pathways.

D.3 A participant file is initiated upon intake into the program. Intake information on participants providing authorization is entered into Pathways in a timely manner. Current housing status, employment status and mainstream benefits status should be updated in Pathways.

#### **E. Service Planning and Delivery**

E.1 Each individual participates in the development and ongoing review of housing stability goals. Housing stability goals and progress toward goals should be tracked in Pathways unless authorization is not obtained.

E.2 Participants have contact with their housing support provider at least twice per month. Contact occurs more frequently during the first three months of services.

E.3 Progress toward goals is regularly documented in Pathways. Referrals to outside agencies are followed up on and documented in Pathways through the housing stability goals.

E.4 When multiple agencies are simultaneously serving the same participant, there is evidence of interagency collaboration.

## **F. Case Closing and Follow-Up**

F.1 Emergency shelters and supportive service providers will attempt to update the current housing status, employment status and mainstream benefits status of a participant 90 days after the Barriers to Housing Assessment is completed. If the participant is no longer receiving services with the agency at that time, reasonable effort is made to follow-up with the individual in order to update status.

F.2 Participants leaving transitional or permanent supportive housing should be contacted at 30, 90 and 180 days after they leave the program at which time their current housing status, employment status and mainstream benefits status should be updated in Pathways. If the participant should require additional support at the time of follow-up, the agency will facilitate access to appropriate services available at their agency or with another provider in the community. The agency makes every effort to ensure that even after a case is closed, the participant remains in some type of stable housing.

F.3 Criteria for termination from the program are clearly defined and communicated to participants. If a participant is asked to leave the program, the organization makes every effort to link the person with more appropriate services. Current housing status should be updated in Pathways.

F.4 If a participant leaves a transitional or permanent supportive housing program without warning, the agency will make an effort to locate and follow-up with the participant. Providers must make every effort to refer a participant who no longer wishes to receive services to another appropriate service provider. Current housing status should be updated in Pathways.

## **G. Documentation**

G.1 Agency will comply with all documentation requirements including entry of all relevant participant information into Pathways Compass in a timely manner.

G.2 If a participation refuses to provide authorization to enter their information into Pathways, equivalent documentation (Barriers to Housing Stability Assessment, Housing Stability Goals and updated progress toward goals) is kept in the case file. In addition, documentation of their refusal to enter information into Pathways must be kept in their case file.

G.3 Agencies will update current status fields in Pathways Compass at designated time periods (intake, discharge and 30, 90 and 180 days post discharge for transitional and permanent supportive housing; intake, discharge and 90 days post assessment for emergency shelter and supportive services; intake and 180 days post assistance for prevention) and when significant changes in status occur.

*For questions regarding the Housing Support Standards, please contact:*

*Lindsey Stillman (404-327-6813; [lstillma@dca.state.ga.us](mailto:lstillma@dca.state.ga.us))*

*Updated Information about the Housing Support Standards is posted at:*

*<http://www.dca.state.ga.us/housing/specialneeds/programs/HousingSupportStandards.asp>*

## **Appendix 2: Housing Support Standards - Prevention**

### **DCA Emergency Shelter Grant Program Support Standards – Prevention Programs**

*Objective: Provide access to services that help participants achieve housing stability*

#### **A. Program Philosophy**

A.1 Program is guided by a program philosophy that values participant choice, promotes respect between staff and participants, and utilizes a strengths based approach to promoting housing stability.

A.2 Services are provided in a safe and supportive environment, where crises are minimized through the implementation of comprehensive crisis prevention strategies.

A.3 Services provided are individualized and culturally competent.

#### **B. Training and Supervision**

B.1 Agency holds staff meetings at least twice a month to discuss program issues and participants' progress and service needs. In the case of specialty services, qualified personnel (as evidenced by applicable degree and experience in service delivery) are present at staff meetings to provide supervision.

B.2 Any staff member that delivers HSS services funded by DCA attends mandatory DCA Housing Support training.

#### **C. Access to Services**

C.1 Agency makes every effort to ensure participants have access to the following types of services by providing services themselves or through other community agencies with which they have agreements:

Housing Services (e.g. assistance obtaining housing and remaining housed, education on tenant rights and responsibilities, support addressing potential threats to housing stability, etc.)

Skills Training (e.g. activities of daily living, household management, budgeting and money management, credit and debt counseling, personal safety, use of community resources, use of public transportation, interpersonal communication, etc.)

Support Services (e.g. educational services, crisis intervention, transportation, legal assistance, case advocacy, parent education and family support, child care, accessing mainstream resources and benefits, etc.)

Health Services (e.g. routine medical and dental care, substance abuse and mental health services, medication management and/or monitoring, general health education, harm reduction, etc.)

Employment and Vocational Support (e.g. work habits, skills and self-awareness essential to employability; writing resumes, completing job applications, and preparing for interviews; finding and accessing local employment resources and placement options including on-the-job training, etc.)

C.2 Agency maintains a current resource directory for all staff. At a minimum, the directory contains information regarding where participants can access each of the types of services listed above, eligibility requirements of other providers, intake procedures, and available services of each resource.

C.3 Agency only provides specialty services for which they are qualified and for which they have received specific training.

C.4 Agency does not duplicate services that are readily available through other mainstream agencies in the community.

C.5 Agency participates in any local or regional planning and discussions of service gaps pertaining to homelessness.

## **D. Screening and Intake**

D.1 Participants receive the Barriers to Housing Stability Assessment in order to identify areas of need at the time of assistance.

D.2 Any participant not meeting program eligibility criteria or receiving only short-term, critical need services is referred to other appropriate services. Every reasonable effort is made to enter these participants into Pathways.

D.3 A participant file is initiated upon intake into the program. Intake information on participants providing authorization is entered into Pathways in a timely manner. Current housing status, employment status and mainstream benefits status should be updated in Pathways.

## **E. Documentation**

E.1 Agency will comply with all documentation requirements including entry of all relevant participant information into Pathways Compass in a timely manner.

E.2 For those participants that refuse authorization for Pathways, equivalent documentation is kept in the case file. In addition, if a participant refuses authorization, a signed refusal to enter information into Pathways form must be in their case file.

E.3 Agencies will update current housing status in Pathways Compass at 180 days post assistance.

*For questions regarding the Housing Support Standards, please contact:  
Lindsey Stillman (404-327-6813; [lstillma@dca.state.ga.us](mailto:lstillma@dca.state.ga.us))*

*Updated Information about the Housing Support Standards is posted at:  
<http://www.dca.state.ga.us/housing/specialneeds/programs/HousingSupportStandards.asp>*

### Appendix 3: Barriers to Housing Stability Assessment

#### Accessing & Completing the Barriers to Housing Stability Assessment in Pathways

The BHSA can be found under the assessment tab in the client visit menu.

**PATHWAYS COMPASS**

**MAIN** Client General Information

Search  
Client  
My Agency  
My Region  
I & R  
Reports  
Help  
Tutorial  
Switch User  
Log Out

Client: 253400-MOVER, AAA ID: \*\*\*\*\*4213 Age: 22 Mail: (None)

Photo Upload client photo

	First Name	Middle Name	Last Name	Suffix
Current	AAA		MOVER	
Previous				

Comprehensive Client Report Save Updated 09/15/2008

**CLIENT VISIT**

Services  
Programs  
Med Help  
Medical Survey  
Assessment  
Custom  
Goals  
Messages  
Case Notes

ID Type	Full SSN	Identification	645 78 4213	Date of Birth / Age	11/11/1985 22
Gender	Male	Marital Status	Married		
Veteran	No	Ethnicity	Non-Hispanic		
Race	[check all that apply]				
	<input type="checkbox"/> Asian	<input checked="" type="checkbox"/> Black or African American	<input checked="" type="checkbox"/> White	<input type="checkbox"/> Other	
	<input checked="" type="checkbox"/> Amer-Indian or Alaskan	<input type="checkbox"/> Pacific Islander			

From the drop down menu, select Barriers to Housing Stability Assessment (NEW), and then click “Next”.

**PATHWAYS COMPASS**

**MAIN** Client Assessment

Search  
Client  
My Agency  
My Region  
I & R  
Reports  
Help  
Tutorial  
Switch User  
Log Out

Client: 253400-MOVER, AAA ID: \*\*\*\*\*4213 Age: 22 Mail: (None)

Completed: N/A

ASSESSMENT: Name - Create date - Update date  
Name - Create date - Update date  
Barriers to Housing Stability Assessment (NEW)  
Happiness Scale (NEW)

Next Cancel

**CLIENT**

General  
Household  
Residence  
Emergency  
Finance  
Education  
Veteran  
Benefits

## Appendix 3 Cont. – Barriers to Housing Stability Assessment

The assessment will appear and you are ready to begin.

### Instructions for completing the Barriers to Housing Stability Assessment

1. All barriers should be assessed for all Head of Household or Individuals on their own. Use “Not Assessed” for the few cases that may arise when you are unable to obtain information from clients.
2. Complete in Head of Household’s record for all household members (includes singles and unaccompanied youth).
3. There are three sections of this assessment. Complete each question in the section including the impact on housing question. The impact question is your own view of how the barrier affects their life.
4. Click on **Complete & Save** when done.



MAIN Client Assessment	
Search	Client 277423-MOVER, AAA ID *****9876 Age 18 Mail [AAAL]
Client	Completed: N/A
My Agency	ASSESSMENT: Barriers to Housing Stability Assessment (NEW)
My Region	
I & R	
Reports	
Help	
Tutorial	
Switch User	
Log Out	
<b>Barriers to Housing Stability Assessment</b>	
<b>TENANT BARRIERS</b>	
<b>Rental History</b>	
General	Have you ever had a lease for an apartment or home in your name? Yes
Household	Have you had utilities in your names? Yes
Residence	How many times have you been evicted from housing? 2-3
Emergency	Would a prior landlord(s) give you a bad reference? Yes
Finance	<b>Credit History</b>
Education	Do you have unpaid rent or utility bills in your name? Yes
Veteran	Do you have a credit history? Yes
Benefits	Do you have poor credit? Yes
<b>CLIENT VISIT</b>	
Services	<b>Criminal History</b>
Programs	Have you ever been convicted of one or more misdemeanors? Yes
Med Help	Have you ever been convicted of a felony? Yes
Medical Survey	If yes, did the felony involve drugs, weapons, or a sex crime? No
Assessment	
Custom	
Goals	
Messages	
Case Notes	

# Georgia Housing Support Standards Implementation Guide

Do you need permanent assistance to get or keep housing?	Yes
If you are living in a house or apartment, what percent of income do you spend on housing (rent/mortgage AND utilities)?	36-50%
If you are not living in your own house or apartment, how much money can you spend on housing each month?	Please Select
<b>Other Income-Related</b>	
Are you currently receiving Social Security or disability?	Yes
Are you currently receiving TANF?	Yes
Are you currently receiving assistance from the public housing authority?	No
Are you currently receiving food stamps?	Yes
Do you have a steady, full time job?	No
Do you have a high school diploma or GED?	Yes
Job Barrier: Is English your second language?	Yes
Job Barrier: Do you have a working car or other reliable transportation to get to work?	No
Job Barrier: If you have small children, do you have affordable child care?	N/A
<b>SUMMARY OF IMPACT OF INCOME BARRIERS ON HOUSING</b>	Major Effect

Save Complete & Save



**You will notice that the completed assessment will show up at the top of the page and that the record of your assessment will also be stored in the drop-down menu.**

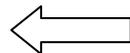


**MAIN**      **Client Assessment**

Search  
 Client  
 My Agency      Client 253400-MOVER, AAA      ID \*\*\*\*\*4213      Age 22      Mail (None)  
 My Region  
 I & R  
 Reports  
 Help  
 Tutorial  
 Switch User      Completed: Barriers to Housing Stability Assessment-10/27/2008  
 Log Out

**CLIENT**      ASSESSMENT: Name - Create date - Update date  
 General  
 Household      Name - Create date - Update date  
 Residence      Barriers to Housing Stability Assessment (NEW)  
 Emergency      Happiness Scale (NEW)  
 Finance      Barriers to Housing Stability Assessment-10/27/2008-10/27/2008  
 Education  
 Veteran  
 Benefits

**CLIENT VISIT**  
 Services      Client Assessment      bob      Pathways  
 Programs



## Appendix 4: Service Transactions & Referrals

### Service Transactions & Referrals in Pathways for Participants Not Served

1. For participants not served by the agency, providers will conduct an Intake, using Universal Data Elements.
2. Next, a service transaction will be made with the Outcome listed as “Services not Provided”.
3. The Reason Denied should also be recorded.
4. When a referral has been made to a more appropriate agency, providers should, whenever possible, record the referral information.

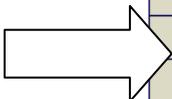
Service Information	
Service Date	10/28/2008

Need Information	
Need	LH-260.170-Dental Referrals
Outcome	Services not Provided ▾ <input type="checkbox"/> Disbursement <input checked="" type="checkbox"/> Referral <input type="checkbox"/> Reservation
Reason Denied	Didn't meet program criteria ▾
Note	

Referral Information	
Referred To	Hosea Feed the Hungry and the Homeless
Referral Message	
Referral Status	(None) ▾
Insurance Status	(None) ▾
Send Email	<input type="checkbox"/>
Referral Form	<input type="checkbox"/>



Save Cancel

## Appendix 5: Participant Status

### Updating Participant Status in Pathways

There are three domains for status updates:

- Housing**
- Employment**
- Income/Benefits**

**MAIN** Client Information

Search  
Client  
My Agency  
My Region  
I & R  
Reports  
Help  
Tutorial  
Switch User  
Log Out

Client 432707-Mover, John ID \*\*\*\*1370 Age 58

**Client Goals**  
New  
No Records Exist

**Client Current Status**

Indicator	Current Status	Description	Date Updated	Agency Updating	
Housing					<a href="#">Show History</a>
Employment					<a href="#">Show History</a>
Income/Benefits					<a href="#">Show History</a>

**CLIENT**  
General  
Household  
Resident  
Benefits

**CLIENT VISIT**  
Services  
Programs

Click on the icon to the left of the Indicator you wish to update (e.g. Housing).

A drop-down menu will appear. Once you make your selection, press Save.

**Update Current Status**

Indicator: Housing

Current Status: (Select Current Status)

Description: (Select Current Status)

- Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway)
- Emergency shelter
- Hotel or Motel Paid for by Voucher or Financial Assistance
- Hotel or motel paid for without emergency shelter voucher or agency assistance
- Prevention Funds/Financial Assistance to Maintain Current Housing
- Substance abuse treatment facility or detox center
- Hospital (non-psychiatric)
- Jail, prison or juvenile detention facility
- Foster care home or foster care group home
- Transitional housing for homeless persons (including homeless youth)
- Staying or living in a family member's room, apartment, or house
- Staying or living in a friend's room, apartment, or house
- Permanent Housing for formerly homeless persons
- Permanent Supportive Housing
- Room, apartment, or house that is rented -with a rental subsidy
- Room, apartment, or house that is rented - without a rental subsidy
- Apartment or Home that is owned
- Other
- Unknown

Services  
Programs

Once completed, a summary of the participant’s current status will appear in the window.

**Client Current Status**

	Indicator	Current Status	Description	Date Updated	Agency Updating	
	Housing	Emergency shelter		10/27/2008	F6E	<a href="#">Show History</a>
	Employment	Unemployed		10/27/2008	F6E	<a href="#">Show History</a>
	Income/Benefits					<a href="#">Show History</a>

## Appendix 6: Setting Goals

### Setting Housing Stability Goals in Pathways

Under the Client Visit menu, press Client Progress.

At the top of the screen, you will see Client Goals. Press the New link.

**MAIN** Client Information

Search  
Client  
My Agency  
My Region  
I & R  
Reports  
Help  
Tutorial  
Switch User  
Log Out

Client 432707-Mover, John ID \*\*\*\*\*1370 Age 58

**Client Goals**

[New](#)  
No Records Exist

**CLIENT**

	Indicator	Current Status	Description	Date Updated	Agency Updating	
	Housing					<a href="#">Show History</a>
	Employment					<a href="#">Show History</a>
	Income/Benefits					<a href="#">Show History</a>

**CLIENT VISIT**

Services  
Programs  
Med Help  
Assessment  
Custom  
Goals  
Messages  
Case Notes  
Client Progress

Client Information jeanette.pollock Pathways  
v5.9.2.0

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Select the appropriate Goal Domain and Goal Type from the drop-down menu.

**Client Goals**

New Goal	
Goal Domain	(Select Goal Domain) ▾
Goal Type	(Select Goal Type) ▾
Goal	<input type="text"/>
Date Set	10/27/2008 mm/dd/yyyy
Achievement Level	(NONE) ▾
Date of Progress Update	<input type="text"/> mm/dd/yyyy
Agency Only	<input type="checkbox"/>
<input type="button" value="Save"/> <input type="button" value="Cancel"/>	

Housing ▾	(Select Goal Domain) ▾
(Select Goal Type) ▾	(Select Goal Domain)
(Select Goal Type)	Housing
Obtain Temporary/Emergency Shelter	Education
Obtain Transitional Housing	Employment
Obtain Permanent Supportive Housing	Medical Health
Locate Appropriate Permanent Housing	Mental Health
Prevention Funds/Financial Assistance to Maintain Current Housing	Substance Abuse
Housing Counseling to Maintain Current Housing	Financial
Obtain Stable Housing through Reunification	Mainstream Benefits
Obtain Temporary Rental Assistance	Legal
Obtain Permanent Rental Assistance/Subsidy	Transportation
Obtain Financial Assistance for Down Payment/Housing Placement	Basic Needs
Obtain Utility Assistance	Independent Living
Locate MORE APPROPRIATE Housing (cost, size, safety, condition, location)	Family
Other	Other

Use the Goal box to insert any specific text you wish (e.g. narrative, contact information, action steps, etc.)

Ensure that the Date Set is correct.

Press Save.

A summary of the Housing Stability Goal you have set will appear.

New

	Date Set	Agency	Goal Domain	Goal Type	Goal	Achievement Level	Date of Last Update
 	10/28/2008	Pathways	Housing	Obtain Temporary/Emergency Shelter		No Progress Made	10/28/2008

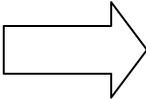
## Appendix 7: Updating Goals

### Updating Goals in Pathways

1. Updating a participant’s progress toward their established goals is as simple as updating the Achievement Level from the drop-down menu.
2. Be sure to double check that the Date of Progress Update is accurate.
3. Press Save.

#### Client Goals

New Goal	
Goal Domain	Housing
Goal Type	Obtain Temporary/Emergency Shelter
Goal	
Date Set	10/28/2008 mm/dd/yyyy
Achievement Level	No Progress Made
Date of Progress Update	(NONE) No Progress Made
Agency Only	Minimal Progress Made Expected Level of Progress Made Steps Completed/Pending Outcome Goal Completed
	Save Cancel



**Appendix 8: Status Types and Indicators**

<b>Indicator</b>	<b>Status</b>
<b>Housing</b>	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway)
	Emergency shelter
	Hotel or Motel Paid for by Voucher or Financial Assistance
	Hotel or motel paid for without emergency shelter voucher or agency assistance
	Psychiatric hospital or other psychiatric facility
	Substance abuse treatment facility or detox center
	Hospital (non-psychiatric)
	Jail, prison or juvenile detention facility
	Foster care home or foster care group home
	Transitional housing for homeless persons (including homeless youth)
	Staying or living in a family member’s room, apartment, or house
	Staying or living in a friend’s room, apartment, or house
	Permanent Housing for formerly homeless persons
	Permanent Supportive Housing
	Room, apartment, or house that is rented -with a rental subsidy
	Room, apartment, or house that is rented - without a rental subsidy
	Apartment or Home that is owned
	Other
	Unknown
	<b>Employment</b>
Obtained Part Time Employment	
Lost Part Time Employment	
Maintaining Current Part Time Employment	
Obtained Full Time Employment	
Lost Full Time Employment	
Maintaining Current Full Time Employment	
Advanced in Current Employment (Promotion, Raise)	
Other	
Unknown	
<b>Mainstream Benefits</b>	Has Not Applied for Benefits
	Not Eligible for Benefits
	Applied for SSI/SSDI
	Receiving SSI/SSDI
	Applied for Food Stamps
	Receiving Food Stamps
	Applied for TANF
	Receiving TANF
	Applied for Medicaid/Medicare
	Receiving Medicaid/Medicare
	Applied for Other Mainstream Benefit
	Receiving Other Mainstream Benefit
	Other
Unknown	

**Appendix 9: Goal Domains & Goal Types**

<b>GOAL DOMAIN</b>	<b>GOAL TYPE</b>
<b>Housing</b>	Obtain Temporary/Emergency Shelter
	Obtain Transitional Housing
	Obtain Permanent Supportive Housing
	Locate Appropriate Permanent Housing
	Prevention Funds/Financial Assistance to Maintain Current Housing
	Housing Counseling to Maintain Current Housing
	Obtain Stable Housing through Reunification
	Obtain Temporary Rental Assistance
	Obtain Permanent Rental Assistance/Subsidy
	Obtain Financial Assistance for Down Payment/Housing Placement
	Obtain Utility Assistance
	Locate MORE APPROPRIATE Housing (cost, size, safety, condition, location)
	Other
<b>Education</b>	Enroll in General Education Program
	Enroll in Specialized Education Program
	Obtain GED
	Other
<b>Employment</b>	Job Readiness
	General Job Training
	Specialized Job Training
	Obtain New Job
	Maintain Current Job
	Supported Employment
	Vocational Rehabilitation
	Other
<b>Medical Health</b>	Address Critical Health Problem
	Access Primary Care Services
	Access Specialty Care Services
	Access Women’s Health Care Services
	Address Chronic Health Condition
	Physical Exam/Health Screening
	Access Vision Care
	Access Dental Care
	Obtain Medication
	Financial Assistance with Health Care Costs
	Financial Assistance with Medication Costs

## Georgia Housing Support Standards Implementation Guide

	Other
<b>Mental Health</b>	Obtain Psychological Evaluation
	Engage in Services
	Access Crisis Care
	Access Inpatient/Residential Treatment
	Access Outpatient Care
	Access Mental Health Case Management
	Access Group Treatment
	Obtain Medication
	Continue Current Mental Health Treatment
	Continue Current Medication
	Financial Assistance with Medication Costs
	Other
<b>Substance Abuse</b>	Substance Abuse Screening
	Engage in Services
	Access Inpatient/Residential Treatment
	Access Outpatient Care
	Access Detox Program
	Access Group Treatment/Recovery Group
	Continue Current Substance Abuse Treatment
	Achieve Stability/Sobriety
	Maintain Stability/Sobriety
	Other
<b>Financial</b>	Open Bank Account/Checking Account
	Repair Credit History
	Address Outstanding Debt
	Increase Savings
	Tax Assistance
	Financial Management Training
	Create/Follow Household Budget
	Obtain Child Support
	Other
<b>Mainstream Benefits</b>	Assess for Eligible Benefits
	Obtain SSI/SSDI
	Obtain Food Stamps
	Obtain TANF
	Obtain Medicaid/Medicare
	Obtain Veterans Benefits
	Other

## Georgia Housing Support Standards Implementation Guide

<b>Legal</b>	Expunge Record
	Address Current Charges
	Comply with Probation/Parole Requirements
	Federal Bonding
	Legal Counseling
	Other
<b>Transportation</b>	Obtain Personal Transportation (Car)
	Financial Assistance with Public Transportation
	Access Private Transportation Services
	Other
<b>Basic Needs</b>	Obtain Mailing Address
	Access to Phone/Voicemail
	Access to Shower/Toilet
	Access to Storage
	Obtain Identification
	Obtain Birth Certificate
	Obtain Food
	Other
<b>Independent Living</b>	Assistance with Daily Living Activities
	Life Skills Training
	Other
<b>Family</b>	Family Reunification
	Family Mediation
	Obtain Child Care
	Enroll in School
	Increase Child School Attendance
	Obtain Parent Training
	Obtain Child Support
	Other
<b>Other</b>	Other

## Appendix 10: Contacts

For questions or feedback regarding the Housing Support Standards please contact:

Lindsey Stillman,  
Department of Community Affairs  
State Housing Trust Fund for the Homeless  
Phone: 404-327-6813  
E-mail: [lstillma@dca.state.ga.us](mailto:lstillma@dca.state.ga.us)

Jacalyn Baker  
Department of Community Affairs  
State Housing Trust Fund for the Homeless  
Phone: 404-679-0564  
E-mail: [jbaker@dca.state.ga.us](mailto:jbaker@dca.state.ga.us)

For assistance with Pathways Compass:

[www.pcni.info](http://www.pcni.info)  
Phone: 866-818-1032  
E-mail: support@pcni.org

### Georgia Continuum of Care Contacts:

#### Athens-Clarke

Mr. Evan Mills  
706-613-3155  
[emills@co.clarke.ga.us](mailto:emills@co.clarke.ga.us)

#### Augusta-Richmond

Ms. Vicki Johnson  
706-821-1797 x.1887  
[vjohnson@augustaga.gov](mailto:vjohnson@augustaga.gov)

#### Cobb County

Mr. Bill Hanson  
770-528-4640  
[Bhanson53@hotmail.com](mailto:Bhanson53@hotmail.com)

#### Columbus-Muscogee

Ms. Elizabeth Dillard-Alcantara  
706-571-3399  
[Liz@homelessresourcenetwork.org](mailto:Liz@homelessresourcenetwork.org)

#### Georgia Balance of State

Lindsey Stillman  
404-327-6813  
[lstillma@dca.state.ga.us](mailto:lstillma@dca.state.ga.us)

Savannah-Chatham

Mr. Mark Baggett

912-790-3400

[mbaggett@homelessauthority.org](mailto:mbaggett@homelessauthority.org)

**Georgia Continuum of Care Contacts (Cont.):**

Tri-Jurisdictional

Mr. Tommie Jones

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[Tommie.jones@co.fulton.ga.us](mailto:Tommie.jones@co.fulton.ga.us)

Ms. LaTrice Johnson

404-817-6704

[ldjohnson@atlantaga.gov](mailto:ldjohnson@atlantaga.gov)

Ms. Melvia W. Richards

404-286-6633

[mwrichards@co.dekalb.ga.us](mailto:mwrichards@co.dekalb.ga.us)

## Appendix 11: Suggested Additional Readings

National Association of Social Workers  
NASW Standards for Cultural Competence in Social Work Practice  
<http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf>

National Care Standards  
Housing Support Services  
<http://www.scotland.gov.uk/Resource/Doc/158834/0043132.pdf>

National Healthcare for the Homeless Council  
Shelter Health: Essentials of Care for People Living in Shelter  
<http://www.nhchc.org/shelterhealth.html#toolkits>

National Healthcare for the Homeless Council  
Sustaining Community Dialogue and Response  
<http://www.nhchc.org/ShelterHealth/Community.pdf>

The Outcomes Star: A Guide for Key Workers  
<http://www.homelessoutcomes.org.uk/resources/1/OutcomesStar/OutcomesStar.pdf>

Project Liberty  
Providing Culturally Competent Crisis Counseling Services  
<http://www.projectliberty.state.ny.us/Resources/PLCultural.pdf>

Corporation for Supportive Housing: Preventing Crisis and Conflict  
[www.csh.org](http://www.csh.org)

Successfully Housing People with Substance Use Issues, Trainers' Manual  
[http://www.aidshousing.org/usr\\_doc/SHPSUI\\_Participant\\_Manual.pdf](http://www.aidshousing.org/usr_doc/SHPSUI_Participant_Manual.pdf)

A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research  
<http://aspe.hhs.gov/ProgSys/homeless/symposium/7-Casemgmt.htm>

A Best Practice Approach to Community Reentry from Jails for Inmates with Co-Occurring Disorders: The Apic Model  
<http://cad.sagepub.com/cgi/content/abstract/49/1/79>

Educating Children without Housing  
A Primer on Legal Requirements and Implementation Strategies for Educators, Advocates and Policymakers  
[www.abanet.org/homeless](http://www.abanet.org/homeless)