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FY 2012
State of Georgia
PATH Grant Application:
Projects for Assistance in Transition from
Homelessness

Project Narrative:
Sections A through C

Section A.

EXECUTIVE SUMMARY

(Table 1)

Organization Name:	Organization Type:	PATH Federal Funding Amount	PATH State Match Funding Amount	PATH Total Funding Amount	Service Area Counties:	PATH Funded Service(s):	# Client Contacts # Literal Homeless	# CM Enrolled
Serenity Behavioral Health Services	Public, non-profit, mental health agency	\$ 119,000	\$41,320	\$160,320	Richmond	-Outreach -Case Mgt	285 200	200
First Step Staffing, Inc.	Private, non-profit	\$ 180,000	\$61,285	\$241,285	Muscogee Richmond Fulton/DeKalb Chatham	-Case Mgt -Training	250 150	150
Community Friendship, Inc.	Private non-profit, mental health agency	\$ 89,000	\$31,300	\$120,300	Fulton/DeKalb	-Outreach -Case Mgt	215 195	150
Travelers Aid of Metro Atlanta	Public, non-profit	\$118,000	\$40,900	\$158,900	Fulton /DeKalb	-Outreach -Case Mgt	130 90	116
United Way Metropolitan Atlanta	Public, non-profit, mental health agency	\$185,000	\$64,000	\$249,000	Fulton/DeKalb	-Outreach -Case Mgt	210 210	210
Grady Health Systems	Public, non-profit, health care agency	\$ 59,000	\$66,400	\$125,400	Fulton/DeKalb	-Outreach -Case Mgt	224 200	157
24/7 Gateway Homeless Service Center	Public, non-profit	\$144,000	\$50,000	\$194,000	Fulton/DeKalb	-Outreach -Case Mgt	346 275	242
St. Joseph Mercy Cares	Private, non-profit, health care agency	\$246,000	\$86,000	\$332,000	Fulton/DeKalb	-Outreach -Case Mgt	590 442	415
United Way Metropolitan Atlanta	Public, non-profit, mental health agency	\$ 85,000	\$33,395	\$118,395	Cobb/Douglas	-Outreach -Case Mgt	120 96	120
New Horizons Community Service Board	Public, non-profit, mental health agency	\$ 147,000	\$51,900	\$198,900	Muscogee	-Outreach -Case Mgt	350 210	244
Chatham-Savannah Authority for the Homeless	Public, non-profit local governing authority	\$ 136,000	\$47,500	\$183,500	Chatham	-Outreach -Case Mgt	328 295	229
GA DBHDD, Division of Mental Health	State Government	\$ 3,000	\$0	\$3,000	Statewide	-Admin.	NA	NA
2012 PATH Funding	Public/ Private & Non-Profit	\$1,511,000	\$574,000	\$2,085,000	10 Counties	-Outreach -Case Mgt	3,048 2,363	2,233

1. State Operational Definitions-

a. Homeless Individual – An individual who lacks fixed, regular, and adequate nighttime residence; or whose primary nighttime residence is a shelter designed to provide temporary living accommodations; or an institution that provides temporary residences for persons intended to be institutionalized; or a place not designed for human beings to live.

b. Imminent Risk of Becoming Homeless – Persons who are about to be evicted from or lose a housing arrangement and have no resources or supports, or are about to be discharged from a psychiatric or substance abuse treatment facility without any resources or supports for housing.

c. Serious Mental Illness – The operational definition of serious mental illness is included in the DBHDD, Division of Mental Health definition of consumer eligibility, which is based on disability and diagnosis. The disability criterion includes behavior leading to public demand for intervention; or substantial risk of harm to self or others; or substantial need for supports to augment or replace insufficient or unavailable natural resources. The diagnosis element for adults with mental illness excludes personality disorders and V-Codes.

d. Co-occurring Serious Mental Illness and Substance Abuse – The term co-occurring is a common, broad term that indicates the simultaneous presence of two independent medical disorders. Within the fields of mental health, psychiatry, and addiction medicine, the term has been popularly used to describe the coexistence of a mental health disorder and alcohol and other drug (AOD) problems. Substance Abuse is defined as an individual who has been diagnosed as having substance disorder and/or substance dependence according to the ASAM Patient Placement Criteria, and as defined in the DSM IV.

2. Alignment with SAMHSA's Strategic Initiative #3: Military Families-

When selecting a PATH provider, the Request for Proposal (RFP) includes a technical requirement that the company demonstrates work experience and background in working with veterans. Mental Health America and the Department of Veterans Affairs estimates that 25% to 40% of all adult males who are homeless are veterans. The outreach components of PATH funded projects identify, assess, treat, and support veterans who have a mental illness and are homeless. Outreach staff work closely with case managers from the Veterans Administration to engage homeless veterans in services. Regional gatherings of PATH providers and VA providers have resulted in greater collaboration to serve homeless veterans. During the routine PATH site visits, each provider is reminded of the special consideration regarding veterans as specified in Section 522 (d) of the Public Health Service Act.

3. Alignment with SAMHSA's Strategic Initiative #4: Recovery Support-

PATH services support the guiding principles of recovery. PATH funded Peer Outreach supports Georgia's overarching philosophy of Hope and Recovery and the movement toward more consumer directed and operated services. PATH services target literally homeless adults with mental illness who are unable or unwilling to seek services on their own. Through Outreach, Peer Specialists share their personal stories of recovery from homelessness, mental illness, and substance use disorders. Homeless individuals learn that recovery is possible and

consider change toward health and wellness. Each PATH Team includes a peer specialist. Employing a mental health consumer with homeless experience as a Peer Specialist to provide Peer Outreach has had a positive effect on the engagement process. As someone “who has been there”, they are better able to relate in a more experiential and relevant manner. Peer Specialists serve as a role model of “recovery”, a living demonstration that it is possible to escape the streets and regain a meaningful life in the community. Offering this hope fosters motivation to change. The consumer is empowered to drive the treatment process, and PATH interventions focus on the integration of the individual in their community.

Many PATH agencies offer multiple services, creating shortcuts for PATH clients to access these services internally. With agreements and partnerships among PATH providers and local organizations, PATH clients gain expedited access to key services including primary health, mental health, substance abuse, housing, and employment. The Department identifies individuals who are homeless as a priority population for services. Timeliness for providing these services is set within the agency contract agreement. Partnerships are established between PATH and ACT agencies to ensure rapid referrals and smooth transition into this intensive multi-disciplinary service.

Housing barriers are minimized with the use of PATH funded Benefit Specialists to obtain SSI/SSDI and medical insurance for eligible individuals. Using SOAR strategies, these Benefit Specialists increase access to SSI/SSDI benefits by using high outcome practices that dramatically expedite the application process and reduce the disability determination period.

4. Alignment with PATH Goals-

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness or co-occurring disorders to permanent housing opportunities. Therefore, 100% of PATH funds are used for Outreach and Case Management services. Both services must be delivered in accordance with the Department’s service guidelines.

Table 1 data illustrates Georgia’s increased reliance on Case Management as a priority service to access both housing and mainstream services and end homelessness for PATH clients. Other PATH service specifications such as Supervision in a Residential Setting are considered less cost effective and not readily purchased with PATH funds. In 2011, 100% of those enrolled in an ongoing PATH funded service received case management.

Utilization Rate of PATH Funded Case Management (Table 1)

PATH Annual Report	Table B (B4)	Table B (B3)	Table C (g1)	
Year	Total Receiving PATH Services	Total Enrolled in a PATH Service	# Enrolled in PATH Case Management	Case Management Utilization
2001	1776	514	403	78%
2002	1367	733	564	77%
2003	1726	830	322	39%
2004	3043	1355	630	46%
2005	3262	1287	837	65%
2006	2812	1109	928	84%
2007	3223	1289	969	75%

2008	3,071	1,741	1,415	81%
2009	2,795	1,221	1,163	95%
2010	2,563	1,385	1,340	97%
2011	2,406	1,272	1,272	100%

5. Alignment with State Comprehensive Mental Health Plan-

The State Mental Health Plan incorporates PATH funded services in response to Criterion 1 for a Comprehensive Community-Based Mental Health Service System providing for the establishment and implementation of an organized community based system of care; Criterion 4 for Targeted Services to Homeless Populations with outreach to and services for individuals who are homeless; and Criterion 5 for Management Systems that support training for mental health providers.

a. Criterion 1: Comprehensive Community-Based Mental Health Service System: Non-traditional mental health services specifically designed for the homeless mentally ill, such as intensive case management and assertive community treatment, have been shown to be successful in engaging this group. The backbone of the PATH program is easy access and face to face contact to help obtain services and resources needed by homeless people with serious mental illness. Case Management provides an assigned and accountable professional or paraprofessional staff person who is known to that consumer and who serves as point of contact and advocates in obtaining services he or she needs within or outside the agency. By providing active treatment with ongoing contact between consumer and staff person, the likelihood decreases for a homeless individual to drop out of service prior to transitioning into mainstream resources.

b. Criterion 4: Targeted Services to Homeless Populations: As illustrated in Table 6, the Department is increasing numbers of homeless individuals enrolled in PATH services since 2001. As more homeless individuals are identified and engaged, more are linked to mainstream services and resources that end the homeless cycle. Local service providers use multiple outreach strategies to identify and engage those consumers who resist intervention and need extended contacts over time to develop trust and acceptance of more traditional social and mental health services. These multiple outreach approaches include mobile outreach to streets, parks, and homeless gathering sites, fixed outreach to shelters, soup kitchens, and indigent health care clinics, and referral and walk-in outreach at the agency.

c. Criterion 5: Management Systems: Using PATH funds to provide Peer Outreach supports the State Mental Health Plan as well as Georgia's over arching philosophy and vision of the mental health system focus on Hope and Recovery for the people who receive service. Hope and Recovery are embraced in the movement toward more consumer directed and operated services. The state developed a training and certification program for Peer Specialists to assure a qualified consumer workforce. The training curriculum includes two 4-day sessions followed by a written and oral certification testing session. The program addresses issues specific to recovery, self-help, employment, and peer support. In FY11, 56 consumers successfully completed the Peer Specialist training and certification process, totaling a workforce of more than 600 Certified Peer Specialists (CPS) since 2002. Currently, 10 of the 11 PATH Programs employ Peer Specialists as equal members of the PATH Team to deliver direct care.

6. Alignment with State Plan to End Homelessness-

The Georgia State PATH Contact is a member of the Interagency Homeless Coordination Council which is charged with the review and implementation of Georgia's Plan to End Homelessness.

Goal 1: "Expand access to and use of Federal mainstream housing and support service programs by homeless families and chronically homeless individuals."

Action Step 1.2: "Decrease the average amount of time it takes homeless individuals to obtain disability benefits (SSI/SSDI)."

2011 Accomplishments:

- Georgia's PATH funded SOAR Project conducted 9, 2-day *Stepping Stones to Recovery* trainings for 157 participants.
- Georgia SOAR Providers filed 680 SSA applications with 503 approvals. This is a 74% approval rate within an average of 118 days to decision.
- Georgia PATH Programs Outreached 2,563 homeless individuals in Atlanta, Columbus, Augusta, and Savannah, enrolled 1,340 into PATH funded Case Management and discharged 724 or 54% when they linked to both housing and mainstream mental health services.

7. Process for Providing Public Notice-

The PATH Grant Application is posted annually on the Department of Behavioral Health and Development Disabilities website www.dbhdd.georgia.gov for public viewing. The PATH State Contact email address is included and viewers are encouraged to submit comments or suggestions regarding the use of PATH funds by email. This ensures direct communication between stakeholders and the PATH State Contact.

A description of Georgia's PATH services is included each year in Georgia's Annual Report on Homelessness published by the Department of Community Affairs. This publication is widely distributed within the state as an overview of how Georgia addresses homelessness. A copy of this publication can be located at www.dca.ga.gov.

8. Programmatic and Financial Oversight-

State Office Oversight: the State PATH Contact conducts a minimum of one (1) annual site visit with each PATH funded program in order to evaluate compliance with the agreements required under DBHDD and PATH. This site visit includes a meeting with the program administrator, direct care PATH funded staff, and may include clients served. The site visit takes place on the site where the PATH funded services are delivered and includes a review of randomly selected PATH client records. Through the site visit, the State PATH Contact in partnership with the DBHDD Regional Office attempts to accomplish the following objectives:

1) To provide technical assistance in reporting PATH data in the annual report; 2) To monitor the performance of the agreed upon PATH funded services as stated in the Intended Use Plan and Proposed Budget; 3) To evaluate compliance with the agreements required under the program including the Public Health Service Act and Terms and Conditions of the Award; 4) To review PATH client records; 5) To ascertain strengths of the PATH program; and 6) To determine opportunities for improvement related to the PATH Program and service delivery at the National, State and local levels.

The PATH Site Visit Monitoring Tool developed in 2004 directs a discussion focusing on issues related to personnel and staff development, policies/procedures/quality assurance and improvement activities, services, fiscal management, cultural competency, consumer involvement, and service processes. A written report summing the site visit with findings and recommendations is submitted to the related DBHDD Regional Office and PATH provider.

Georgia uses a performance based PATH Contract Annex with monthly performance expectations that includes a minimum number of outreach contacts, minimum number of clients to be enrolled, and a minimum number of PATH enrolled clients transitioned into mental health/substance use services and housing upon discharge. Providers must submit monthly performance reports to the State PATH Contact which are reviewed prior to provider payment. Those providers that fail to meet the PATH monthly performance expectations receive an adjusted payment reflecting only those PATH clients who were enrolled.

The PATH State Contact developed standardized client record documents to improve the quality of the PATH program documentation and ensure all programs consistently comply with programmatic and documentation guidelines. The standardized components of a PATH record include the Eligibility Screening & Needs Assessment, Individualized Recovery Plan, Progress Notes, and a Discharge Summary. In January 2011, the PATH TA Center posted Georgia's standardized program documents on PATH's website www.pathprogram.samhsa.gov for review and download by other states.

9. Selection of PATH Local-Area Providers-

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is charged by law to: 1) provide adequate mental health, developmental disabilities and addictive diseases to all Georgians; 2) provide a unified system which encourages cooperation and sharing among government and private providers; and 3) provide service through a coordinated and unified system that emphasizes community-based services. The governance of Georgia's public mental health system operates using a six (6) regional authority design that includes both the hospital and community service management. Each of the six DBHDD regions assumes the responsibility for resource allocation by contracting for services through a network of local providers. The decision to expand or support new services using PATH funds is based upon a demonstration of need, provider experience, program compliance with PATH legislative guidelines, availability of funds, and may be triggered by an interested provider, the DBHDD regional office, or the State PATH Contact.

An interested provider of homeless service may trigger this decision by requesting consideration of PATH funding based upon the submission of an Intended Use Plan and related budget describing the PATH funded activities they propose to offer. The DBHDD regional office reviews all submitted proposals and forwards those that comply with regional planning and PATH legislative guidelines to the State PATH Contact for further funding consideration.

The DBHDD regions may trigger this decision by contacting the State PATH Contact and request regional consideration for PATH funding based upon presented need.

The State PATH Contact may trigger this decision issuing a notification of funds available to the

DBHDD regional offices and request support information for PATH funding, including provider availability.

Once a region with the greatest service need is established, the competitive Request For Proposal (RFP) bidding process is used to select and award a contract to the PATH provider within that region. Both the regional staff and State PATH Contact jointly participate in the application review and selection process. Service Contracts may be renewed on an annual basis as long as the provider continues to meet annual performance indicators set forth by the State. When the outcomes are not met or when there is need for a new project, the State PATH Contact initiates the competitive bidding process to select a new PATH vendor by releasing a written request for proposals (RFP).

Each year, the PATH Grant Application is posted on the Department’s website at www.dbhdd.georgia.gov for public viewing and comment regarding the use of PATH funds and the availability of new funding opportunities. In addition, the regional offices annually announce the availability of PATH funds and invite public comment through local forums regarding regional PATH funding utilization and local homeless service needs.

Allocation Based on Assessed Need: According to the 2010 US Census Bureau, Georgia has a population of 9,687,653 with a 20% population growth since 2000. Table 2 identifies the nine (9) counties in Georgia with the largest population, including prevalence estimates for need of mental health services. Georgia’s PATH funding allotment is based on an urban population formula, and funding priority goes to those urban locations with the greatest concentration of homeless individuals noted by **. As supported by Table 2, these priority locations include Atlanta/Fulton and DeKalb Counties; Cobb County; Augusta/Richmond County; Columbus/Muscogee County; and Savannah/Chatham County. The State also uses data generated by the Statewide Performance Management System (Table 5) to identify service needs by region.

County Ranking Prevalence Estimate by Age for Need of Mental Health Services (Table 2)

#	Places	Youth Population < 18 years of age		Adult Population > 18 years of age		Total Population	
#	County	Population	MH Prev Est	Population	MH Prev Est	Population	MH Prev. Est
All	Georgia	2,491,552	7.40%	7,196,101	6.43%	9,687,653	6.69
1	Fulton** (Atlanta)	219,686	7.48%	700,895	5.82%	920,581	6.23%
2	Gwinnett	234,707	6.80%	570,614	5.55%	805,321	5.90%
3	DeKalb** (Atlanta)	165,136	7.38%	526,757	5.58%	691,893	6.03%
4	Cobb**	176,487	6.80%	511,591	5.40%	688,078	5.76%
5	Chatham** (Savannah)	60,007	7.73%	205,121	6.37%	265,128	6.71%
6	Clayton	74,979	7.38%	184,445	6.28%	259,424	6.61%
7	Richmond** (Augusta)	49,305	7.85	151,244	6.74	200,549	7.04
8	Muscogee** (Columbus)	48,598	7.78	141,287	6.81	189,885	7.07
9	Bibb	40,119	7.92	115,428	6.78	155,547	7.09

10. Location of Individuals with SMI who are Homeless-

Historically, few definitive counts of the homeless population existed at the local, state, or national level. Homeless data was tabulated using many different methods. These methods may have included prevalence estimates using the quantitative data collected from several resources providing a baseline to begin an estimate of need. Currently, homeless data includes the tracking of administrative data as part of a statewide performance management system; the tracking of service usage through a computerized homeless provider communication system (HMIS); and through the use of homeless shelter, street, and institutional census counts. These efforts to estimate the number of individuals in the state who are homeless with a serious mental illness (SMI) have proven beneficial in the service planning and resource allocation process.

- a. Point-in-Time Homeless Census Survey: A homeless “point-in-time” count is conducted every two years and serves as the primary source of data to understand and track homeless trends. Even though Georgia conducted its first count in 2003, more consistent and reliable practices for counting sheltered and unsheltered homeless began in 2007. Table 3 offers a homeless census comparison between the seven (7) HUD C of C jurisdictions from 2003 to 2012. In 2011, there were 1,139 or 6% more homeless individuals in Georgia when compared to 2010. The 2012 Homeless Census data was gathered in February 2012 but has not yet been released through the HUD website.

The “1996 National Survey of Homeless Assistance Providers and Clients” indicates that 45% of homeless individuals have mental health needs. Substance Abuse and Mental Health Services Administration indicates 20 to 25% of the homeless population in the United States suffers from some form of severe mental illness. Based on the 2011 homeless census count of 20,975, there is an estimated range of 4,200 to 9,500 Georgians who are homeless with mental health needs on any given day. Results continue to confirm the ranking density of homeless population concentration by city/county as Atlanta/Fulton & DeKalb counties followed by Savannah/Chatham County, then Augusta/Richmond County, Columbus/Muscogee County, Cobb County, and Athens/Clarke County.

Point-In-Time Homeless Census Survey (Table 3)

Year	Athens	Augusta	Cobb	Columbus	Savannah	Atlanta	Bal. of State	Total
2003	NA	NA	NA	NA	NA	6,956	NA	
2004	307	1,082	661	413	NA	NA	NA	
2005	436	700	555	959	1,093	6,832	1,809	12,384
2007	464	491	660	540	659	6,840	10,255	19,990
2008	462	605	660	618	1,095	6,840	9,340	19,095
2009	454	556	480	458	1,452	7,019	9,941	20,360
2010	496	556	470	468	1,077	7,019	9,750	19,836
2011	407	497	370	486	1,242	6,805	11,168	20,975
2012*	407	494	410	494	1,066	6,741	10,242	19,854

Table 4 compares 2008 through 2011 Homeless Census Subpopulation Count for Severely Mentally Ill. The 2011 data demonstrates a 5.7% increase or 1,136 more homeless individuals with severe mental illness compared to 2010. This increase is attributed to homeless individuals migrating to Atlanta from other states due to warmer weather and hopes of finding housing and employment. The 2012 SMI Sub-Population data is not yet available.

Point-in-Time Homeless Census Survey-SMI Subpopulations (Table 4)

Year	Athens	Augusta	Cobb	Columbus	Savannah	Atlanta	Bal. of State	Total
2008								1,756
2009	148	77	89	46	73	1,736	765	2,934
2010	146	77	126	30	84	1,736	760	2,959
2011	127	81	35	63	125	3,093	1,151	4,675

- b. **Homeless Management Information System (MHIS):** The Department of Community Affairs (DCA) operates as the state housing authority and supports the Homeless Management Information System (HMIS) known as PATHWAYS. Since its beginning in 2002, PATHWAYS has tracked services provided to over 207,946 homeless or at-risk Georgians by its more than 386 HMIS members statewide. Most PATH providers actively participate in Pathways, entering all clients into HMIS upon enrollment in PATH funded services. Discussion has begun regarding collaboration between PATH and HMIS for greater client data integration.
- c. **Statewide Performance Management System:** As illustrated in Table 5, the State DBHDD information system tracks the number of mental health consumers who self-report their living situation as homelessness when authorized for community mental health services. The Mental Health Planning and Advisory Council tracks this data quarterly as a part of their state monitoring responsibilities. It is interesting to note nearly 50% of Georgia's total homeless adults with mental illness are located in Region 3 which includes Atlanta/Fulton and DeKalb Counties. Therefore, Georgia dedicates approximately 50% of PATH funds to provide Outreach and Case Management services in Atlanta/Fulton and DeKalb Counties.

Number of Adults with Serious Mental Illness Reporting Homelessness by Region, Gender, Age SFY 2011 From July 1, 2010 through June 30, 2011 (Table 5)

Geographic Region	Region 1		Region 2		Region 3		Region 4		Region 5		Region 6		Total	
	F	M	F	M	F	M	F	M	F	M	F	M	F	M
9-17	0	0	0	1	0	3	0	0	1	0	0	0	1	4
18-20	18	15	13	19	36	58	3	4	16	15	4	17	90	128
21-30	73	71	63	101	155	273	22	35	65	51	49	60	427	591
31-40	84	79	77	118	242	349	34	35	60	50	43	68	540	699
41-50	102	125	114	197	341	514	39	62	78	91	75	128	749	1117
51-60	62	82	56	136	237	376	27	33	51	56	33	106	466	789
>60	10	9	6	15	39	57	9	6	7	7	6	10	77	104
Sub Total	349	377	321	582	1037	1609	133	174	277	268	209	382	2326	3392
FY11 Total	726 (13%)		903 (16%)		2646 (46%)		307 (5%)		545 (10%)		591 (10%)		5,718 (100%)	
FY10 Total													7,093	
FY09 Total													6,402	
FY08 Total													5,229	
FY07 Total													2,373	

11. Matching Funds-

Georgia remains committed to serving individuals who have a serious mental illness and are homeless. The State PATH Contact participates in Georgia's Interagency Homeless Coordination Council to oversee the implementation of the State Action Plan to End Chronic Homelessness.

In 2011, Georgia received \$25.4 million from the HUD Continuum of Care grants program and \$3.5 million through the Emergency Shelter Grant (ESG) Program for local homeless projects. In metro Atlanta, the Regional Commission on Homelessness as led by United Way, continues to collaborate between providers, federal, state, local governments, and the business and faith communities to end homelessness in City of Atlanta, Fulton, DeKalb, Cobb, Douglas, Gwinnett, Rockdale, and Clayton counties.

The State of Georgia agrees to comply with the maintenance of effort by making available state contributions toward homeless services in an amount that is not less than \$1 for each \$3 of Federal PATH funds provided in the FY 2012 allocation, which are available at the beginning of this grant period. The State of Georgia will maintain state expenditures for services specified in Section 521 of the Public Health Service Act at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period proceeding this fiscal year.

12. Other Designated Funding-

- a. Mental Health Block Grant (MHBG) Funds: Georgia's MHBG funds are used to finance Peer Support Services and Supported Employment. No MHBG funds support PATH services.
- b. Substance Abuse, Prevention and Treatment Block Grant (SAPTBG) Funds: In 2003, MHBG funds were matched with SAPTBG funds to develop the first consumer-operated PEER Centers for consumers with co-occurring disorders. These services provide structured activities within a peer support model that promotes socialization, recovery, self advocacy, development of natural supports, and maintenance of community living skills. Activities are provided between and among individuals who have common issues and needs, and assist individuals in living as independently as possible. This service is available to assist and support any homeless person with co-occurring disorders with acquiring skills needed to manage their illness and access community resources.
- c. State General Revenue Funds: Any adult with a behavioral health diagnosis on Axis I or Axis II in accordance with the DSM IV with a significantly affected level of functioning due to mental illness and/or addictive diseases and financially unable to pay for all or part of the needed service and has no third party source of payment is deemed eligible to seek assistance and receive any service available within the public delivery system. Individuals who are homeless are identified in mental health provider contracts as a priority population to receive State funded mental health services, and shall be seen immediately in compliance with their needs.

Additional state funds are used to support residential programming for the homeless or formerly homeless. Self-help groups for those with co-occurring disorders, called Double

Trouble in Recovery are funded in multiple DBHDD regions and provide an excellent social network for homeless consumers with both mental health and substance use disorders.

13. HMIS Data Migration-

The Department of Community Affairs (DCA) funds Pathways Community Network to operate Georgia’s Homeless Information Management Information System (HMIS) known as PATHWAYS COMPASS. The current status on HMIS includes: Georgia has a single state HMIS system called PATHWAYS that includes the PATH HMIS Universal Data Elements. More than 343 agencies are members of PATHWAYS and enters client information into PATHWAYS to connect them to a homeless provider network. The majority of PATH agencies are members of PATHWAYS and many actively enter client data when enrolling a homeless individual into PATH supported services.

Beginning FY12, the State PATH Contact joined the HMIS Steering Committee led by DCA to develop a 2-4 year plan to migrate PATH data into PATHWAYS with 01.01.13 as the kick off date for PATH Programs to begin using PATHWAYS to enter client data and document treatment.

Activity	Activity Description	Target Date	Contact Person
Step 1: HMIS Membership	PATH Agency Membership in HMIS-PATHWAYS.	7.31.12	Joette Pollack-Pathways
Step 2: HMIS Initial Training	PATH Team staff complete HMIS New User Training.	9.30.12	Tommy Phillips-Pathways
Step 3: Identify PATH in HMIS	PATH Program set-up in HMIS	10.31.12	Joetta Pollack-Pathways
Step 4: HMIS PATH Set-Up	PATH Forms downloaded in HMIS	11.31.12	Joetta Pollack-Pathways
Step 5: HMIS PATH Set-Up Training	PATH Teams participate in HMIS documentation Training	12.31.12	Charley Bliss-DBHDD Tommy Phillips-Pathways
Step 6: HMIS Kick-Off	PATH Teams enter client information and document treatment in PATHWAYS.	01.01.13	Charley Bliss-DBHDD William Matson-Pathways David Trotten-DCA
Step 7: PATH Annual Data	DBHDD, DCA, and PATHWAYS will examine data capability	07.01.13	Charley Bliss-DBHDD William Matson-Pathways David Trotten-DCA

14. State Supported Training for PATH-funded Staff-

Georgia recognizes the importance and value of training. Multiple approaches offering technical assistance and programmatic improvement are in place through the use of the DBHDD held PATH funds. Training is made available on an individual basis through routine site visits, on a regional basis through local forums, and offered statewide. More and more training opportunities are coming available through technical advancement.

- a. **Individual PATH Provider Training:** The State PATH Contact visits each PATH Program annually, providing individualized training based upon program performance and assessed need. In addition to the annual visits, the State PATH Contact is readily available to all PATH funded staff throughout the year for telephone or email consultation. Information regarding national teleconferences, funding opportunities, and continuum of care information are relayed by listserv to all PATH providers and regional coordinators. Scholarships are made available to PATH funded staff to attend state and national training conferences. Providers may use PATH funds to send Peer Specialists to Certification training to build a competent consumer workforce. In previous years, PATH funds were used to send individuals to the 4-day SOAR Train-the-Trainer programs to build state training capacity. United Way PATH Team applied to participate in an 8 week training sponsored by Advocates for Human Potential called Effective Approaches to Case Management.

- b. **Regional PATH Provider Training:** In Region 3, the State PATH Contact conducts monthly Metro PATH Collaborative Meetings with the seven (7) PATH programs to discuss cases, share information, and organize outreach events. Training and local presentations is a part of the collaborative meetings. In FY2012, PATH funds were used to provide 6, 2-day SOAR Regional Trainings for 200 participants.

- c. **Statewide PATH Provider Training:** Each year, the State PATH Contact organizes a statewide PATH training.
 - In 2009, the PATH TA Center provided statewide technical assistance to Georgia PATH providers to increase access to housing for PATH enrolled consumers.
 - In 2010, PATH providers participated in the SAMHSA HRC & PATH Webcast Series “Motivational Interviewing in Action” and incorporated the PATH Street Outreach Video Series into their local training and team supervision.
 - In 2012, PATH sponsored a statewide training on conducting Vulnerability Index Surveys to identify and prioritize those homeless individuals most at risk.
 - In 2012, the State PATH Contact leads a statewide SOAR Steering Committee to implement SOAR strategies within each department. The SOAR Network provides statewide TA and training to providers assisting with SSA application.
 - In 2013, PATH Teams will participate in Trauma Training provided by Georgia’s Jail Diversion and Trauma Recovery (JDTR) Grant.

Section C. 2012 LOCAL PROVIDER INTENDED USE PLAN

**Serenity Behavioral Health Systems
 3421 Mike Padgett Hwy
 Augusta, GA 30906
 (706) 432-7923**

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and the amount of PATH funds the organization will receive.

Serenity Behavioral Health Systems (SBHS) is a public, nonprofit organization governed by the Community Service Board of East Central Georgia. We are a comprehensive provider of mental

health, addictive diseases and developmental disability services, accredited by CARF. We provide services under contract with the Department of Behavioral Health and Developmental Disabilities (DBHDD). Our service area covers 7 counties in east central Georgia: Richmond, Columbia, McDuffie, Wilkes, Lincoln, Warren and Taliaferro. We have clinics located in Augusta, Thomson and Washington.

Serenity BHS will provide PATH funded services in Augusta/Richmond County located in DBHDD Region 2.

This PATH program shall receive \$119,000 in PATH Federal funds and \$41,320 in State Match funds totaling \$160,320 to support PATH services. A detailed program budget is attached.

2. Participation in the HUD Continuum of Care program and any other local planning, coordinating or assessment activities.

PATH staff attend scheduled meetings of the Continuum of Care. This meeting allows us to network with other providers of service to the homeless in a formal manner. We, along with other member agencies, serve on the Mayor's Council on Homelessness. We also participate each year in the Department of Veterans Affairs annual "Stand Down" program for the homeless.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

The PATH team attends scheduled meetings of the Continuum of Care (CoC) where contact is made to strengthen partnerships with the supporting agencies that serve people who are homeless. PATH team members also participate in various housing and outreach committees.

PATH coordinates services with the following supporting agencies:

Augusta Task Force for the Homeless, Salvation Army, Garden City Rescue Mission, Augusta Rescue Mission, Lots Ministry, Mercy Ministry, Hale House, Augusta Urban Ministries, Augusta Housing Authority, Richmond Summit Apartments, Maxwell House Apartments, Bon Air Apartments, Glenwood Apartments, Augusta Area Ministries Council, Antioch Ministries, First Baptist Church of Augusta, Beulah Grove Baptist Church Community Center, Caring Together and More, Inc., Catholic Social Services, Church of the Good Shepherd, Serenity Behavioral Health Systems, Behavioral Health Link, Faith Outreach Christian Center, Georgia Legal Services, Golden Harvest Food Bank, Goodwill Industries, GAP Ministries, Interfaith Hospitality Network, Neighborhood Improvement Project, Saint Paul's Church, Saint Vincent DePaul Health Clinic, Department of Public Health, EDA, St. Stephen's Ministries of Augusta, United Way of the CSRA, Department of Veterans Affairs Homeless Service Program, Walton Community Service, Department of Family and Children Services, East Central Regional Hospital, Georgia Health Sciences Health Services, University Hospital, Augusta Richmond County Government, Georgia Department of Labor.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including.

a. Alignment with PATH goals to target adults who are literally homeless:

Georgia regards Outreach and Case Management as priority services and limits the use of PATH funds to these two (2) services in order to maximize the benefit of PATH funds with increased

access to housing. These services must be delivered in accordance with the Department's defined service guidelines.

OUTREACH:

The average number of outreach contacts per consumer, prior to enrollment, is 1-3 contacts. The contact time may range from 15 minutes up to an hour or more depending on the individual and presenting issues. Outreach is the beginning step of case management. Problems and needs are identified and initial linkages to resources to address those needs are made. Outreach is the first step in establishing trust and hope for engaging the individual in treatment to improve their physical and mental health. The Serenity PATH Team uses four (4) outreach approaches to maximize contact with individuals who are PATH eligible which include:

Mobile outreach, which includes face-to-face interactions with literally homeless people in the streets, under bridges, in shelters, and other nontraditional settings, is intended to identify individuals who are unable or unwilling to seek services on their own. The team as a whole will engage individuals with a personal connection that encourages a desire to change. The Team Lead will utilize motivational interviewing skills to stimulate readiness to change. This may be accomplished by identifying **current risks and problems related to homelessness and/or mental health issues**. The Housing Specialist will assist by focusing on what the individual identifies as their wants and needs, offering immediate housing options, obtaining emergency contact information and setting up another meeting with the individual, preferably the following day. The Peer Specialist will share her story of recovery, remain consumer-focused and address their requests, provide helpful resource information that can be easily accessed, and provide a program brochure with contact information.

Fixed outreach is provided by the team and includes having a routine schedule for visiting shelters, soup kitchens, day labor and other homeless services. The team is located at Master's Table, the soup kitchen, daily from 11:00 until 12:30. They are located at Garden City Rescue Mission every Monday, Wednesday, and Friday from 2:30-4:00.

Referred outreach is the availability of another agency to make a referral of a person experiencing homelessness by telephone. It consist of supporting agencies making contact with the PATH team on behalf of the consumer, or the consumer making contact with PATH because they were given information about the PATH program. All of the shelters, health clinics and hospitals have PATH program brochures with contact information.

Walk-in outreach provides assistance to those persons who self present at a fixed outreach location in the community. The individual is connected to the PATH team and outreach begins.

CASE MANAGEMENT:

The purpose of case management is to engage with individuals to develop a plan to end their homelessness and access mental health and/or substance abuse services, medical services and entitlement benefits. Case management services are designed to address directly the issues of consumer access to housing and service integration into mainstream mental health and substance abuse services. The team members, along with the individual, identify what is important to the individual and then develop a realistic plan for achieving the goals. The recovery plan identifies these needs and contains strategies that will be used to end the homeless cycle. The Team Lead will assist with financial planning, provide psycho-education, provide interventions for the development of interpersonal, community coping, and independent living skills. The Peer Specialist will assist with development of a Wellness Recovery Action Plan and development of

symptom monitoring and self-medication strategies. Supports provided by the Peer Specialist will include empowering the individual to have hope for and participate in her/his own recovery. The Housing Specialist will identify with the individual his/her preference for housing and assist with obtaining emergency shelter and utilizing homeless resources in the community. This may include subsidized off-the-street (motel) housing, Supportive Housing Programs and Shelter Plus Care housing. The Housing Specialist may also assist with family reunification if the individual is agreeable. Case management services are provided to eligible homeless individuals involved in PATH and their recovery plans are reviewed at least once every 3 months.

Discharge planning begins at enrollment via identifying specific goals the individual wants to achieve and the time frame needed to achieve these. Once the goals have been substantially reached, discharge can occur. Other reasons for discharge include transitioning to mainstream mental health services, such as Community Support Services, where the individual will receive ongoing case management services. Discharge can occur if the individual is unwilling to participate in the program, if he/she needs services not available with the PATH program, or if the individual asks to be discharged. Every effort is made to secure housing and mental health/substance abuse services prior to discharge.

Whether the service is outreach or case management, the team will assist the individual to access needed services by arranging transportation when possible, providing transportation, accompanying them to appointments, and assisting with completing applications for housing, benefits, food stamps, etc. The PATH program utilizes a dedicated van in order to have access to potential and current individuals involved with PATH. The team is able to use the van to locate potential consumers, transport to and from any appointments they may have, obtain emergency food, clothing, shelter, etc, until the individuals are able to access these resources on their own. Individuals who are being linked to community resources may or may not have knowledge of the location of the resources. Having available transportation can be used as a teaching tool for demonstrating where community resources are located. Being able to provide transportation to appointments also encourages adherence to prescribed treatments.

b. Gaps that exist in the current service system:

- Housing for homeless persons with sex offenses and/or felonies is very limited.
- Shelters for females (non-domestic violence) are limited.
- Employment opportunities suitable for those with disabilities still have gaps.
- Transportation services still have gaps.

c. Services available for individuals who have both a serious mental illness and substance use disorder:

Individuals who have both a serious mental illness and substance related disorder are referred to Serenity Behavioral Health Systems for treatment, as we operate an integrated, dual diagnosis-specific treatment program. Outpatient treatment (ASAM Level 1) is provided daily. Substance Abuse Intensive Outpatient (SAIOP ASAM Level II.1) is also available 5 days per week. In addition to outpatient services, the Crisis Stabilization Unit is also available for medical detoxification.

Veterans are referred to the Veterans Affairs Homeless Program.

In addition, the PATH program provides information to individuals about community based self-help recovery options such as Double Trouble, AA and NA.

d. Agency supported evidenced-based practices, trainings and HMIS activities:

The PATH team supports the following EBP practices:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to permanent housing with attached support services;
- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT) linkage for those discharged from PATH with intensive treatment needs.

PATH Staff have received training on how to use Georgia’s HMIS, known as PATHWAYS.

5. Data and Provider’s status on HMIS migration in the next 2 to 4 years.

This PATH provider is a user of HMIS. All individuals enrolled in Case Management are entered into HMIS and instantly connected to the homeless provider network. PATH team members participate in HMIS webcasts and training to learn how to facilitate migration of PATH data into HMIS within 2-4 years.

This agency will explore flexible uses of PATH administrative funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.

Those eligible for housing will be linked to the following housing programs:

EOA Transitional Housing, Bon Air Apartments, Augusta Housing Authority, Richmond Villa Apartments, Richmond Summit, Glenwood Apartments, Villa Marie Apartments, Mount Zion Apartments, Old Towne, Inc., and Trinity Manor. We will also utilize the Georgia Housing Voucher Program if the individual meets the requirements for participation in that program.

In addition, Maxwell House Apartments has 44 units allocated for individuals with mental health needs. Serenity currently provides ongoing support and case management to those individuals. We will also utilize the Georgia Housing Voucher Program if the individual meets their requirements for participation

7. Staff information: (a) demographics of the staff serving the clients; (b) how staff providing services to the target population will be sensitive to age, gender, and racial/ethnic differences of clients; and (c) the extent to which staff receive periodic training in cultural competence.

a. The agency employs a racial/ethnic diverse staff to serve homeless clients. Recognizing that the team is comprised of 3 females, the PATH administrator is male and provides male sensitivity to the outreach and case management process. The following is a representation of the PATH

Team:

Provider	# PATH Staff	# Females	# Males	# Caucasian	# Black African/Am.	# MH Consumers
Serenity BHS	3	3	0	1	2	1

- b. This agency uses staff training via Essential Learning; language services, program evaluation, and community representation to ensure that services are provided in a manner that are sensitive to the differences of those they serve. Serenity Behavioral Health Systems promotes cultural diversity and provides cultural competency training to all employees. Free interpreter services, as well as our language line, are available for those who do not speak English. This organization evaluates performance satisfaction using consumer and family satisfaction surveys, including the level of satisfaction with staff sensitivity to cultural background. This organization supports community representation in the program design with employed mental health consumers operating as direct care staff.
 - c. Serenity Behavioral Health Systems promotes cultural diversity and offers cultural competency training to all employees.
- 8. Client Information: (a) demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.**
- a. The homeless population served by the PATH program in FY 2011 in Augusta was 73% males and 27% females, who are 77% African American, 17% White and 6% other races, with 26% between the ages 18-34 and 45% between the ages of 35 and 49, and 73% were living in a short term shelter upon first contact. The principle mental illness diagnoses were schizophrenia and affective disorders, with 48% having co-occurring substance use disorders.
 - b. Projected Service Expectations for SFY 2013 - 7/01/12 through 6/30/13:
 - 1) Contractor shall identify and have contact with at least **285** individuals who are homeless and mentally ill in PATH funded Outreach services during the contract period.
 - 2) Contractor shall enroll at least **200** individuals who are homeless and mentally ill in PATH funded Case Management services and we shall transition enrollment of at least **150** individuals from PATH funded Case Management services into community mental health services during the contract period.
 - c. A minimum of 70% of the unduplicated total will be “literally” homeless (living outdoors or in an emergency shelter.).
- 9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and family members are involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.**
- It is the mission of this organization to promote self-sufficiency and to reflect the value of involving consumers and family members in order to improve the outcome. The Board of Directors includes family members of consumers and they help shape program policy and procedures. Serenity Behavioral Health Systems employ Certified Peer Specialists who actively participate in program planning and implementation of services. A Certified Peer Specialist is a member of the PATH funded Team. Two previous PATH recipients are currently employed with SBHS. This agency places a strong emphasis on consumer satisfaction and seeks ongoing program evaluation of services through the use of a consumer satisfaction survey. PATH consumers will continue to be involved in identifying and planning for services.

10. Proposed State FY 2013 Annual PATH Budget.

1. Personnel Costs

Positions	Annual Salary	PATH FTE	PATH Salary	Total
Mental Health Professional	\$52,000	1.0	\$52,000	
Housing Specialist	\$25,000	1.0	\$25,000	
Certified Peer Specialist	\$24,000	<u>1.0</u>	\$24,000	
		3.0 FTE		
				\$101,000
2. Fringe Benefit Costs @28%				\$28,280
3. Transportation Costs				
Vehicle Operation & Personal Mileage:		\$6,000		
Bus Passes:		\$400		\$6,400
4. Training Costs				\$800
5. Housing Coordination Costs				
Rental Assistance & Emergency Housing:		\$17,405		
Emergency Food Assistance:		\$300		
Security Deposits:		\$2,100		
Household Items:		\$300		\$20,105
6. Administrative Costs				\$3,735
			GRAND TOTAL:	\$160,320

Section C. 2012 LOCAL PROVIDER INTENDED USE PLAN....continued
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First Step Staffing, Inc.
203 Auburn Avenue NE, Suite 203
Atlanta, GA 30303
404.577.3392

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and the amount of PATH funds the organization will receive.

First Step Staffing, Inc. is a 501 (c) 3, registered in the State of Georgia as a non-profit organization. First Step's mission is to end homelessness by assisting people to secure income sufficient to maintain housing. For persons able to work, we operate an employment agency that places people in contract and permanent jobs. For persons with a disability that prevents employment, we use the SOAR method to expedite access to Social Security disability benefits (SSI/SSDI) and Medicaid. Over 90% of clients who are approved for SSI/SSDI are placed in housing within 60 days of the decision.

First Step Staffing currently serves homeless men and women in metro Atlanta area/Fulton and DeKalb Counties, North Georgia/Cobb and Douglas Counties, Augusta/Richmond County, Columbus/Muscogee County, and Savannah/Chatham County. PATH services are provided by this agency in DBHDD Regions 1, 2, 3, 5, and 6.

First Step will receive \$180,000 in Federal PATH funds and \$61,285 in State match funds totaling \$241,285 annualized to provide assistance with applying for SSI/SSDI for eligible individuals enrolled in Georgia's PATH services. A detailed budget is attached.

2. Participation in the HUD Continuum of Care program and any other local planning, coordinating or assessment activities.

First Step has a strong partnership with metro Atlanta's Regional Commission on Homelessness led by United Way. First Step management actively works on several committees dedicated to mental health, substance abuse, and employment. Additionally, we participate in the metro Atlanta Tri-Jurisdiction Continuum of Care that includes the City of Atlanta, Fulton and DeKalb Counties. Strong collaboration with providers in the HUD Continuum of Care program is a necessity for successful outcomes. First Step's partners with CoC agencies to support health care, housing and supportive service providers by offering services focused on obtaining income and insurance coverage through employment and SSA entitlement benefits.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

First Step maintains partnerships with key agencies as a homeless provider network to serve PATH clients which include:

Atlanta- St Joseph's Mercy Care, Grady Hospital, Georgia Regional Hospital, Community Friendship, Hope Atlanta/Travelers Aid, Gateway, Regional Commission, CaringWorks, Georgia Rehabilitation Outreach, Atlanta Outreach, PCCI, Crossroads Community Ministries, the Atlanta Children's Shelter, New Hope Enterprises, Georgia Justice Project, MUST Ministries, Intown Collaborative Ministries, the Atlanta Center for Self-Sufficiency, City of Refuge, Decatur Cooperative Ministries, Rainbow Village, and Trinity Community Ministries.

Augusta-Serenity Behavioral Health Systems, Action Ministries, Garden City Rescue Mission, Friendship Community Center, Augusta Rescue Mission, Lot's Ministry, Mercy Ministry, Hale House, Augusta Housing Authority, Augusta Area Ministries Council, Catholic Social Services, Goodwill Industries, University Hospital, and Augusta Task Force for the Homeless.

Columbus -Columbus Alliance for Battered Women, Columbus Regional Healthcare System, Goodwill, Open Door Community House, New Horizons, The Salvation Army, the United Way of Chattahoochee Valley, and the Valley Healthcare System.

Savannah: First Step's PATH SOAR Benefit Specialist is located at the Chatham Savannah Authority for the Homeless and has developed relationships with key agencies including: Georgia Regional Hospital, University Medical Center, Union Mission, Hope House, Inner City Night Shelter, Old Savannah City Mission, J.C. Lewis Health Care Center, and Sojourner of Savannah Women's Shelter.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients including:

a. Alignment with PATH goals to target adults who are literally homeless:

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illnesses or co-occurring disorders to permanent housing opportunities. PATH funds support Case Management services to assist PATH eligible individuals to obtain income support by applying for Supplemental Security Income (SSI) and/or Social Security Disability Insurance (SSDI) to help meet their basic housing and treatment needs as a foundation on which to build their recovery. Three Benefit Specialists will be dedicated to file SSI/SSDI applications for PATH eligible consumers in Atlanta and Savannah prior to linking consumers to mainstream mental health services. Additional Benefit Specialists will be available to file SSI/SSDI application for PATH eligible individuals in Augusta and Columbus on a referral basis. A Program Coordinator will be the primary contact between First Step management, staff contractors and the State. They will be responsible for the oversight of the program, reporting, and quality control. An Administrative Coordinator will be responsible for gathering medical evidence, arranging consultative exams, and for following up with partner agencies.

Consultative exams will be used to expedite approvals for SSI. First Step will arrange and pay for exams when appropriate. In addition, First Step will transport and accompany consumers to appointments. Engagement tools will be used to ensure that consumers remain engaged in the process of securing SSI. Consumers must be present for and adhere to the requests by the Social Security Administration. Tools such as snacks and food coupons keep them in touch with their Benefits Specialist. Bus tokens are provided for consumers to provide access to transportation for appointments and access to service locations.

b. Gaps that exist in the current service system:

- A primary gap in the current service system is the shortage of trained and dedicated SOAR staff and a significant backlog of disability cases in Georgia. First Step fills this gap by dedicating a trained workforce of SOAR Benefit Specialists to actively work with the Social Security Administration (SSA) and Disability Adjudication Services (DAS) to ensure that consumers move expeditiously through the application process. In Atlanta, they are fast-tracked in DAS' homeless unit.
- A second gap in the service system is a time lag with accessing substance abuse and mental health treatment. First Step addresses this gap by maintaining a partnership with local PATH providers to coordinate the care of consumers while linking to mainstream services.
- A third gap is not reaching SSI/SSDI-eligible individuals prior to release from jails or prisons. Compared to other states, Georgia has the highest percentage of its population under the supervision of the criminal justice system. Nearly 22,000 prisoners are released back to the community every year. The statistics for CY 2010 are as follows: more than 6,900 in metro Atlanta; 1,012 in Chatham County; and 586 in Richmond County. The Georgia Department of Corrections reports that about 16% of inmates have a mental disability and another 1% a physical impairment, which means that there is a potential SOAR pool of some 1,200 just among released inmates in metro Atlanta, Savannah, Augusta, and Columbus. While First Step does not have an active process in place to coordinate with the criminal justice system, we will continue to try to build a deeper partnership with jails and prisons throughout the State.

c. Services available for individuals who have both a serious mental illness and substance use disorder:

A close working relationship between First Step and the PATH team will enable clients to access treatment for both serious mental illness and substance use disorder during the application process for Disability benefits. Access to Disability benefits, and the accompanying approval for Medicaid, opens additional doors for treatment and medication. Upon approval for benefits, providers are reimbursed by Medicaid for retroactive expenses incurred by the consumer. When providers realize the high rate of approval for clients represented using SOAR techniques, they are encouraged to serve those clients even prior to approval.

d. Agency supported evidence-based practices, trainings, and HMIS activities:

First Step uses SOAR strategies to file SSI/SSDI applications that include:

1. Meet with consumer to complete SSA application and all related assessments.
2. File 1696 to assume consumer representation.
3. Obtain collateral information and medical evidence to support disability determination.
4. File on-line applications and provide additional paper documents to SSA as needed.
5. Attend scheduled SSA appointment with consumer, if required.
6. Contact DAS and follow each application to determination.
7. Complete medical summaries (when needed).
8. Schedule and/or attend Consultative Exams (when needed).
9. Link to Payee Service (when needed).
10. Partner with Path teams and participate in outreach initiatives as appropriate.

In March 2012, the developers of the SOAR curriculum released a database designed to track SOAR data nationally. First Step has been trained and will begin inputting data in April 2012. In addition, First Step will lead the effort to train other members of the Georgia SOAR Coalition to learn how to use the SOAR national data tracking system.

All PATH funded Benefit Specialists have been trained to use Georgia's HMIS, called PATHWAYS.

First Step dedicates PATH funds to provide 4, 2-day SOAR Seminars to train direct care case managers on how to expedite the application process and reduce the disability determination period. Two trainings will be conducted in the metropolitan-Atlanta area and two in locations to be determined.

5. Data and Provider's status on HMIS migration in the next 2 to 4 years:

First Step is an active user of Pathways, a widely accepted HMIS system utilized by the network of homeless service providers. Pathways is designed to help providers share information to ensure that the services that consumers obtain are appropriate and effective. It also is used to generate data that can be used to monitor the long term impact of these services. First Step uses Pathways primarily to maintain records and to coordinate services. PATH team members participate in HMIS webcasts and training to learn how to facilitate migration of PATH data into MHIS within 2-4 years.

6. Access to housing and strategies to make suitable housing available to PATH clients:

The Georgia Department of Community Affairs estimates that there is a need for housing for 2000+ chronically homeless individuals in Atlanta; 220 in Augusta; and 100 in Savannah. Despite the shortage, First Step has been highly successful in locating housing for clients once they have income.

Generally, housing is in supportive units. In Atlanta, we work with partners such as CaringWorks and GRO who provide stability for clients. Over 90% of First Step clients who are approved for disability benefits are placed in housing within 60 days. Given the high rate of approval of First Step clients, some housing providers are willing to house clients prior to approval.

Solid housing partnerships currently exist in metro-Atlanta. We have developed good housing partners in Augusta and Savannah. We will need to develop housing partners in Columbus. We will work closely with the PATH teams in each of the areas to help coordinate this effort. In addition, to establish relationships, we will approach the local United Way, Regional Commission, or other organizations with access to housing. We would expect the same results we experienced in Atlanta - once the likelihood of approval for income is known, numerous doors to housing open up.

Potential housing partners in each location are included in item 3 above.

7. **Staff Information: (a) demographics of the staff serving the clients; (b) how staff providing services to the target population will be sensitive to age, gender, and racial/ethnic differences of clients; and (c) the extent to which staff receive periodic training on cultural competence.**
 - a. The agency employs staff that represent the gender and racial/ethnic diversity of the homeless clients served. First Step's staff is currently 81% female; 65% African American; 35% White; ages range from 20s – 60s. Additionally, we have three AmeriCorps members who work in Benefits.
 - b. All of the staff are either social workers or have extensive experience working with this population. In addition, First Step staff is organized into teams so that they continue to learn from each other.
 - c. Staff attends a weekly clinical meeting to talk about specific cases. It is led by an MSW and insights into culturally-appropriate practices are shared. In addition, First Step employs several formerly-homeless people. Their experience, plus ongoing agency training, keeps staff sensitive to age, gender, racial/ethnic differences, and ability differences.

8. **Client Information: (a) demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.**
 - a. First Step's Benefits' clientele is currently 66% male; 98% African American; 100% with severe disabilities.

 - b. Projected number of clients to be served in SFY2013 from 7/01/12 to 6/30/13:
 - (1) Provider shall file SSI/SSDI applications for at least **250** individuals who are homeless and mentally ill and/or in PATH funded Case Management.
 - (2) Provider shall receive an SSI/SSDI approval determination for **150** individuals within 120 days who are homeless and mentally ill and in PATH funded Case Management.

(3) Provider shall train at least 100 case managers to use SOAR strategies to expedite access to SSI/SSDI for homeless individuals with disabilities.

c. This Provider projects that 60% of the total clients served with PATH funds will be “literally homeless” and 40% will be at imminent risk of homelessness.

9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and family members are involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.

Several staff members are formerly homeless. One Board member was also homeless and had a substance use disorder. He serves on our Program Committee to ensure that services address the needs of our clients. We also provide a consumer satisfaction survey that helps us determine how we can improve our service delivery.

10. Proposed Annual State FY 2013 Budget

I. Personnel Costs

Positions	Annual Salary	PATH FTE	PATH Salary	Total
Benefit Specialist-Atlanta	\$38,000	2.0	\$76,000	
Benefit Specialist-Savannah	\$38,000	1.0	\$38,000	
Benefit Specialist-Contracted	\$36,000	1.0	\$36,000	
Program Coordinator	\$45,000	0.5	\$22,500	
Administrative Coordinator	\$35,000	<u>0.25</u>	<u>\$ 8,750</u>	
		4.75		\$181,250

II. Fringe Benefit Costs @ 20%

(No fringe for contracted Benefit Specialists)

\$29,050

III. Staff Transportation Costs

Vehicle Operation & Personal Mileage: \$3,670
 Parking \$540

\$4,210

IV. Supervisory Costs

Vehicle Operation & Personal Mileage: \$1,260
 Hotel for Supervisor (6 nights @ \$100/night): \$600
 Per Diem (18 days @ \$40/day): \$720

\$2,580

V. SOAR 2-Day Workshops

Vehicle Operation & Personal Mileage: \$670
 Hotel for Trainers (6 nights X 2 @ \$100/night): \$1,200
 Per Diem (4 days X 2 people @ \$40/day): \$320
 SOAR Training Supplies \$280

\$2,470

VI. Consumer Coordination Funds

Consultative Exams (15 exams @ \$250): \$3,750
 Engagement Tools (food coupons) \$1,000

\$6,625

Bus Tokens (125 consumers X \$5 X 3)	\$1,875	
VII. Program Supply & Equipment Costs		\$8,100
Office Supplies:	\$2,000	
Equipment:	\$3,600	
3 Blackberries & Service Plans:	\$2,500	
VIII. Administrative Costs (3%)		<u>\$7,000</u>
GRAND TOTAL		\$241,285

Section C.	2012 LOCAL PROVIDER INTENDED USE PLAN....continued
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Community Friendship, Incorporated
85 Renaissance Parkway, NE
Atlanta, GA. 30308
(404) 875-0381

1. Description of the provider by organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and the amount of PATH funds the organization will receive.

Community Friendship, Inc. (CFI) is a comprehensive provider of recovery-based services assisting adults in metropolitan Atlanta. Incorporated in 1971, CFI is a non-profit organization that has been nationally accredited by CARF (Commission on Accreditation of Rehabilitation Facilities) International for over 30 years. Our mission is to provide a supportive community for people whose mental illness prevents them from participating in community life, employment and relationships. Services provided include intensive case management, homeless outreach, skill teaching services, vocational services, supported employment as well as a broad range of residential options to persons with psychiatric disabilities, many of whom have been homeless.

CFI will provide PATH services in metro Atlanta serving Fulton and DeKalb Counties which are located in DBHDD Region 3.

CFI will receive \$89,000 in Federal PATH funds and \$31,300 in State Match funds totaling \$120,250 to support PATH services. A detailed budget is included with this application.

2. Participation in the HUD Continuum of Care program and any other local planning coordinating or assessment activities.

The Homeless Mental Health Team coordinates services within a network of regional providers by utilizing their services to stabilize and maintain the physical health, mental health and substance abuse issues of the consumer served. By working closely with these and other agencies, consumers are assisted in reaching their maximum level of successful community living. The team plays an intricate part of Atlanta's continuum of care by providing emergency housing and case management services to consumers who are referred by jails, shelters, and area hospitals.

The case managers of the HMHT participate in planning and coordinating services with local agencies to assist PATH consumers in obtaining needed services. For instance, the case managers might assist a consumer in obtaining mental health treatment services from Grady Health System

and medical services from St. Joseph's Mercy Care Services while working with the Regional Commission on Homelessness to secure housing resources.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

The Team works in coordination with other providers of community services, such as Grady ACT Team, Auburn Recovery Center, Open Door Community, First Presbyterian Church, Women's Day Shelter, Lady of Lourdes Catholic Church, Veterans Empowerment Organization (VEO), Central Presbyterian, First Step Staffing, Inc. and the Homeless Outreach Collaboration Committee. The PATH case managers communicate and coordinate as needed with the above agencies to assist PATH consumers in obtaining needed services. For instance, the case manager might assist a consumer in obtaining mental health treatment services from Grady Health System, Fulton County Mental and other private providers. In addition, the PATH case managers collaborate with Welcome House, VEO, Seven Bridges for housing.

Other collaborating agencies include: Fulton County Community Mental Health Centers, Grady Health System, Northside Community Mental Health and Substance Abuse Center, St. Joseph's Mercy Care Services (healthcare), AUM (My Sisters House), Georgia's Mental Health Consumer Network (consumer support), Traveler's Aid and area shelters, hospitals, and jails.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including.

a. Alignment with PATH goals to target adults who are literally homeless:

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness or co-occurring disorders to permanent housing opportunities. Therefore, 100% of PATH funds are used for Outreach and Case-Management services. Both services must be delivered in accordance with the Department's service guidelines. This PATH team includes two (2) Case Managers and one (1) full-time Peer Support Case Manager (mental health consumer) to provide street outreach and visits various shelters located in downtown Atlanta. The Team targets those homeless individuals whose mental illness has remained untreated. Typically this population has a multitude of complex needs including food, clothing, housing, mental health services, health services, and income to name a few. Some clients are best served through Outreach. This service focuses on establishing a trusting relationship, building rapport, assessing immediate need, providing referral information, and coordinating linkages to resources. CFI's Homeless Mental Health Team has adjusted its schedule to do morning outreach starting at 6:00am. The team has also participated in the early morning outreach with the Atlanta Homeless Outreach Collaborative. Moreover, when consumers have early morning or late afternoon appointments or emergencies, the team can address this need. Due to the variety of consumer needs, services range from only needing the coordination of mental health services to full array of bio-psycho-social needs. One PATH staff has completed the SOAR training to learn strategies to expedite disability benefit applications. Assisting homeless individuals with filing claims will be a major focus for the PATH Team this year. It is the goal of PATH Case Management team to successfully transition clients into mainstream mental health services. For some, the enrollment process takes an extended period of time and is considered an important first step as the individual begins the recovery process.

b. Gaps that exist in the current service system:

Gaps in service to PATH eligible clients continue to be a lack of affordable housing, lack of supported housing, lack of available housing for individuals with mental illness who are elderly (geriatric needs), a lack of specialized services for adults aged 18 to 21, limited case management services, poor access to quality medical care/treatment and limited transportation support. Limited affordable housing with support makes it difficult for individuals to maintain successful community integration. Case Management is important and significant to properly assess and link consumers to mental health, medical and community services. Case Management will ensure that the needs of consumers are addressed from a holistic perspective and can provide needed support in making and keeping appointments. Although public transportation is available, many individuals need help in utilizing the MARTA system and/or need financial assistance to purchase Breeze cards. Physical health issues for this population are often ignored or go untreated.

c. Services available for individuals who have both a serious mental illness and co-occurring substance use disorder:

Consumers are provided support and encouragement to maintain sobriety and are supported in treatment participation, self-help programs and compliance with mental health service recommendations. Consumers are referred to dual diagnosis programs such as Auburn Recovery Center. The Georgia Mental Health Consumer Network provides Double Trouble peer support self-help groups to individuals with co-occurring mental illness and substance abuse.

d. Agency supported Evidence-Based Practices, training, and HMIS activities:

The PATH team supports and incorporates into practice the following EBP practices:

- 1) Motivational Interviewing techniques to move individuals through stages of change;
- 2) Peer Supports to develop a wellness recovery action plan (WRAP);
- 3) Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- 4) Supportive Housing by linking individuals to permanent housing with attached support services;
- 5) SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- 6) Assertive Community Treatment (ACT) linkage for those discharged from PATH with intensive treatment needs. The PATH Team co-case manages for a 30 day period to ensure a successful transition.
- 7) Integration of health care services via partnership with St. Joseph's Mercy Care mobile medical coach.

The Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) Division of Mental Health offers a Minimum Standard Training Requirement courses for Paraprofessionals online titled Georgia's Essential Learning. The subject areas consist of Case Management, Cultural Competence, Documentation, Mental Illness – Addictive Disorders, Professional Relationships, Safety/Crisis De-escalation, and Service Coordination. A total of 29 hours of online training is necessary to fulfill the training requirements. All CFI's Homeless Mental Health Team members are required to complete the curriculum. The Peer Case Manager has completed the Department's Peer Specialist training and certification process.

5. Data and Provider's status on HMIS migration in the next 2 to 4 years.

This agency is a member of Georgia’s HMIS known as PATHWAYS, but is not an active user. This provider plans to participate in HMIS training activities to learn more about becoming an active user of HMIS and learn how to migrate PATH data into HMIS within 3-5 years. Also, this agency plans to explore the use of PATH funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.

CFI’s Homeless Mental Health Team (HMHT) has access to the residential services using the Ponce Hotel for 30 – 90 days (dependent on available resources and client’s situations) as short-term alternatives until more permanent options become available. The Ponce Hotel is utilized often due to the good working relationship that we have with management staff there. Management staff is able to provide a report of how a client functions and interacting with other hotel guests and staff while staying at the hotel. The HMHT also initiates housing referrals to CFI’s own residential programs. CFI’s residential programs includes, supervised group homes, HUD supervised-apartments, semi-independent apartments, O’Hern House and Phoenix House. In addition, the HMHT refers clients to Welcome House Shelter Plus Program, Positive Outlook, Living Room (if they are HIV positive), Atlanta Housing Authority, Georgia Rehabilitative Outreach, Travelers Aid, and boarding houses. All referrals are dependent on client’s income. For clients that have SSI, all the above options are available to them. As for clients who have only General Assistance and Food Stamps, they would qualify for Phoenix House, Welcome House, Atlanta Housing Authority, and HUD apartments. Clients who do not have an income, their only options are O’Hern House, Positive Outlook, and Seven Bridges.

7. Staff Information: (a) the demographics of the staff serving the clients; (b) how staff providing services to the target population will be sensitive to age, gender, and racial/ethnic differences of clients; and (c) the extent to which staff receive periodic training in cultural competence.

a. The agency employs a staff that is representative of the gender and racial/ethnic diversity of homeless clients served. The following is a representation of the PATH Team:

Provider	# PATH Staff	# Females	# Males	# Caucasian	# Asian	# Black African/Am	# MH Consumers
CFI	3	2	1	0	0	3	1

b. This agency uses staff training, language services, program evaluation, and community representation to ensure that services are provided in a manner that are sensitive to the differences of those they serve. CFI promotes cultural diversity and provides cultural competence training to all employees. Free interpreter services are available for those who do not speak English. This organization evaluates performance satisfaction using consumer and family satisfaction surveys, including the level of satisfaction with staff sensitivity to cultural background. This organization supports community representation with employed mental health consumers operating as direct care staff.

c. Cultural sensitivity is a critical part of the CFI new hire orientation training. All employees receive annual diversity training in order to reiterate the importance of respecting individual differences. DBHDD includes cultural competence performance standards in all service contracts and requires that provider staff match the population served.

8. Client Information: (a) the demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

a. CFI is located in downtown Atlanta which is the largest city in the most densely populated county in the State. The client population is 55% male and 45% female, 85% African American, with 48% between the ages of 35-49 and literally homeless upon initial contact. The primary diagnoses include schizophrenia and affective disorders, with 33% reporting co-occurring substance use disorders.

b. Projected Service Expectations for SFY 2012- 7/01/12 to 6/30/13:

- 1) Contractor shall identify and have contact with at least **215** individuals who are homeless and mentally ill in PATH funded Outreach.
- 2) Contractor shall enroll at least **150** individuals who are homeless and mentally ill in PATH funded Case Management.

c. This provider projects that 90% of the unduplicated total will self-report as “literally” homeless.

9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and family members are involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.

A Board of Directors requires consumers and family membership to participate in program planning decisions. CFI’s Board includes both consumer and family representation. Consumer participation is a vital part of the planning, implementation and evaluation of the quality of service programming. Consumer Satisfaction Surveys are used to obtain PATH client feedback related to the provision of PATH services, seeking input, feedback, and suggestions for improvement. Agency wide, approximately 20% of the employees are consumers and a member of the PATH Homeless Mental Health Team is a Peer Specialist with homeless experience.

10. Proposed Annual State FY 2013 PATH Budget

1. Personnel Costs

Positions	Annual Salary	PATH FTE	PATH Salary	Total
Program Director	70,400	0.1	7,040	
Asst Program Director	40,000	0.5	20,000	
Case Manager	35,000	1.0	35,000	
Peer Outreach	18,320	<u>1.0</u>	18,320	
		2.6 FTE		
				\$80,360

2. Fringe Benefit Costs (@ 20%) **\$16,072**

3. Transportation Costs **\$5,175**
 -Vehicle Operation & Personal Mileage:

4. Housing Coordination Costs **\$15,143**
 -Rental Assistance & Emergency Housing

5. Administrative Costs

\$3,500

GRAND TOTAL: \$120,250

Section C.	2012 LOCAL PROVIDER INTENDED USE PLAN...continued
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Travelers Aid of Metropolitan Atlanta
75 Marietta Street, Suite 400
Atlanta, GA 30303
(404) 817-7070

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and amount of PATH funds the organization will receive.

In 1917, Atlanta Travelers Aid assisted traveling servicemen and their families with displacement caused by war as well as national migration caused by the Great Depression of 1930's. Since that time, Travelers Aid has adapted its services to include not only assisting stranded travelers but also to assist those in Atlanta who experience homelessness. Travelers Aid has played a significant role in the Metro Atlanta response to major crises such as September 11, 2001 and hurricanes Katrina and Rita. This non-profit agency provides multiple services which include housing, outreach, homeless prevention, and emergency assistance to victims of domestic violence, HIV/AIDS, and families experiencing homelessness.

Travelers Aid will provide PATH funded services in metro Atlanta serving Fulton and DeKalb Counties located in DBHDD Region 3.

Travelers Aid will receive \$118,000 Federal PATH funds and \$40,900 State Match funds totaling \$158,900 annualized to support PATH services. A detailed budget including direct and indirect costs is included with this application.

2. Participation in the HUD Continuum of Care program and any other local planning, coordinating or assessment activities.

Travelers Aid is actively involved in the Atlanta Tri-Jurisdiction Continuum of Care, and receives HUD funding for supportive housing. Travelers Aid is also an active member of the Regional Commission on Homelessness and participates in the planning and coordination of housing for organized Street-to-Home outreach initiatives.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

The Homeless Mental Health Team collaborates with other key service organizations to increase access to an array of needed services and resources for enrolled clients. These key organizations include:

Community Friendship for access to supportive housing resources;
Behavioral Health Link for access to crisis and emergency services;
St. Joseph Mercy Cares for access to healthcare;
Grady Health Systems for access to mental health and ACT services;
Regional Commission on Homelessness as leading Metro Atlanta's Blueprint to End Homelessness;

Gateway 24/7 Homeless Service Center for providing programs and services for chronically homeless individuals.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including:

a. Alignment with PATH goals to target adults who are literally homeless:

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness or co-occurring disorders to permanent housing opportunities. These two services must be delivered in accordance with the Department's service guidelines and available to homeless individuals and families living in places not meant for human habitation in both Fulton and DeKalb counties. The target population may be referred by the general population, police, community courts, or upon discharge from jail. A Homeless Mental Health Team consisting of three full-time staff includes an Outreach Coordinator, licensed Mental Health Professional (LCSW), and Certified Peer Specialist.

The Outreach Coordinator oversees outreach activities including establishing daily performance targets, site locations, engagement tactics, and identify resources for homeless consumers. Types of resources used for engagement include food coupons and MARTA tokens to assist with transportation. The team uses the HUD definition of homelessness and is trained to recognize mental illness and co-occurring substance use disorders in order to determine if an individual is PATH eligible. Outreach contacts are entered into the HMIS system (Pathways).

Case Management provides intensive support to assist clients enrolled through Outreach to access housing and transition into mainstream mental health treatment. Each new client enrollment receives an eligibility screening and a needs assessment by the licensed Mental Health Professional (LCSW) that includes housing, SSI/SSDI, employment, veteran status, substance abuse, mental health, and medical. An Individualized Service Plan is developed in partnership with the consumer to identify goals and strategies to promote change and end homelessness. The Certified Peer Specialist assists by helping the consumer articulate personal goals for recovery and setting objectives for achieving goals. The Peer Specialist models recovery, teaches illness self-management, and connects the consumer to self-help groups including NA, CA, and DTR.

b. Gaps that exist in the current service system:

The Homeless Mental Health Team is responsible for filling gaps in services or bringing any gaps to the attention of the Regional Commission on Homelessness. The main gap in the system is the need for case managers to support clients as they transition from homeless to "being housed". The Regional Commission has great success in creating new supportive housing in metro Atlanta. The PATH funding provides the attached supports needed to successfully transition clients into housing and access ongoing services and entitlement benefits to ensure self-sufficiency.

c. Services available for individuals who have both a serious mental illness and substance use disorder:

Each person enrolled in case management is evaluated for co-occurring mental illness and substance use disorders and through Georgia's Access Line, the individual is linked to local

providers of addictive and mental health services. PATH consumers are also linked to self-help groups including Double Trouble in Recovery (DTR) meetings which occur 7 days a week at various sites throughout Atlanta.

d. Agency supported Evidence-Based Practices, training, and HMIS activities:

The PATH team supports and implements the following EBP practices into practice:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to a continuum of emergency, transitional and permanent housing with attached support services;
- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT) linkage for those discharged from PATH with intensive treatment needs.

Each member of the PATH Team attends a Case Management Training Academy and receives HMIS training.

5. Data and Provider’s status on HMIS migration in the next 2 to 4 years.

This PATH agency is an active user of Georgia’s HMIS known as PATHWAYS. All individuals enrolled in Case Management are entered into HMIS and instantly connected to the homeless provider network. PATH team members plan to participate in HMIS webcasts and training in order to learn how to facilitate migration of PATH data into HMIS within 2-4 years. This agency will explore the flexible use of PATH administrative funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.

Travelers Aid receives HUD funding and project based vouchers through the Atlanta Housing Authority to operate a “housing first” program in metro Atlanta for homeless men, women, and children. Using scattered apartment communities, each client receives on-site case management support while enrolled in the program. These housing programs include:

- Sylvan Hills Apartments;
- The Pavilion Place Apartments;
- Woods at Glenn Rose Apartments;
- Columbia Tower Apartments; and
- Park Commons.

PATH clients also receive assistance locating appropriate housing using the Department of Community Affairs’ (DCA) affordable housing database at www.georgiahousingsearch.com.

7. Staff Information: (a) the demographics of the staff serving the clients; (b) how staff providing services to the target population will be sensitive to age, gender, and racial/ethnic difference of clients; and (c) the extent to which staff receive periodic training in cultural competence.

a. The agency supports staff diversity. The following represents the PATH Team:

Provider	# PATH Staff	# Females	# Males	#Caucasian	# Black African/Am	# MH Consumers
Travelers Aid	4	1	3	0	4	1

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- b. Staff is experienced in this field and has participated in diversity training.
- c. Staff must participate in the Regional Commission on Homelessness Case Management Training Academy through a series of monthly 3 to 6 hour workshops based on specific curricula to improve skills to engage consumers and impact their homelessness. This includes routine sessions on cultural competence.

8. Client Information: (a) demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

- a. A description of the client target population includes:
 - individuals with serious mental illness who are literally homeless;
 - individuals located in Fulton and DeKalb counties; and
 - individuals who do not readily access traditional services.
- b. Projected Service Expectations for SFY 2013 - 7/01/12 to 6/30/13:
 - 1) Contractor shall identify and have contact with at least **130** individuals who are homeless and mentally ill in PATH funded **Outreach**.
 - 2) Contractor shall enroll at least **114** individuals who are homeless and mentally ill in PATH funded **Case Management**.
- c. This provider projects that 70 % of the unduplicated total will self-report as “literally” homeless.

9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and family members are involved at the organizational level in the planning, implementation, and evaluation of PATH funded services.

A Board of Directors includes consumers and family members to participate in programming decisions and implementation. Travelers Aid hires consumer practitioners. One member of the PATH Homeless Mental Health Team is a consumer in recovery with homeless experience. Consumer Satisfaction Surveys are used to obtain PATH client feedback related to the provision of PATH services, seeking input, feedback, and suggestions for improvement.

10. Proposed Annual State FY 2013 PATH Budget:

1. Personnel Costs

Positions	Annual Salary	PATH FTE	PATH Salary	PATH Total
Team Lead (LCSW)	43,860	1.00	\$43,860	
Case Manager	37,500	1.00	\$37,500	
Peer Specialist	28,000	<u>1.00</u>	<u>\$28,000</u>	
		3.00 FTE		\$109,360

2. Fringe Benefit Costs (@ 20%)

\$21,872

3. Transportation Costs

\$8,120

Vehicle Operation & Personal Mileage:

4. Supplies	\$1,565
Cell Phones 2@ \$120/mo	
Office Supplies	
5. Housing Coordination Costs	\$14,473
Emergency Rental Assistance	
Emergency Food Assistance	
Security Deposits	
Household Items	
6. Administrative Costs	\$3,500
GRAND TOTAL:	\$158,900

Section C. 2012 LOCAL PROVIDER INTENDED USE PLAN...continued
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United Way of Metropolitan Atlanta
100 Edgewood Avenue, NE
Atlanta, GA 30303
(404) 527-7237

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and amount of PATH funds the organization will receive.

United Way of Metropolitan Atlanta is a non-profit organization that provides support and funding for community-based programs and services in a thirteen-county Atlanta metropolitan area.. It acts as convener and fiscal agent for the work of the Regional Commission on Homelessness. United Way will use the monies generated by this contract to fund a Collaborative PATH Team which will accomplish two goals: 1) Provide active, face-to-face outreach to homeless persons who have mental illnesses; and 2) Provide short-term case-management and community linkages for these persons. The goal of the Collaborative PATH Team will be to target and engage homeless persons who are not receiving needed services to improve their mental and physical health and to create linkages to community resources in order to continue and maintain services as needed. More information is provided in #3 below.

United Way PATH Team will provide PATH funded services in Atlanta/Fulton and DeKalb Counties located in DBHDD Region 3.

United Way will receive \$185,000 in PATH Funds and \$64,000 in PATH State Match Funds totaling \$249,000 in annualized PATH funding. A detailed budget including direct and indirect costs is enclosed.

2. Participation in the HUD Continuum of Care program and any other local planning, coordinating or assessment activities.

The United Way Regional Commission on Homelessness, Hope Atlanta/Travelers Aid, the Gateway 24/7 Center, City of Refuge, and First Step all coordinate closely with Atlanta's Tri-Jurisdiction Continuum of Care. All three programs that comprise the HUD CoC are utilized by the Collaborative PATH Team for housing clients: Supportive Housing Program; Shelter Plus Care; and Single Room Occupancy apartments.

Key CoC leaders participate in the Regional Commission on Homelessness quarterly meetings including Directors from: Cobb/Douglas Community Service Board; DeKalb Community Service Board; Gateway Center; City of Refuge; Caring Works; First Step; Hope Atlanta/Traveler's Aid; and numerous others.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

Numerous community organizations will be engaged as partners with this Collaborative PATH Team. The following is a partial list of community partners:

- Primary **shelters** from which clients will be identified include: City of Refuge, Gateway 24/7 Center, and Atlanta Mission (Shepherd's Inn and My Sister's House).
- Primary **jail/prison re-entry partnerships** which will assist in identifying clients include: DeKalb Diversion Treatment Court, Gwinnett Re-Entry Intervention Program, Fulton County Probation, and Fulton County Public Defender.
- Primary **health care providers** include: St. Joseph's Mercy Care, Grady Healthcare System, Atlanta Medical Center, DeKalb Medical Center, and Emory University Hospitals
- Primary **mental health care providers** include: Grady Healthcare System, Atlanta Medical Center, County Community Service Boards, Behavioral Health Link, and Metro Atlanta Assertive Community Treatment Teams.
- Primary **substance abuse assistance providers** include: Recovery Consultants of Atlanta, St. Jude's Addiction Services; Hope House, County Community Service Boards, and Café 458.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including:

a. Alignment with PATH goals to target adults who are literally homeless:

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness to permanent housing. The Georgia State PATH Contact limits the use of PATH funds to these two (2) services which must be delivered in accordance with the service guidelines and utilization criteria set forth in the PATH Program. The contractors comprising the PATH team are experienced in identifying and engaging individuals who are literally homeless with mental health issues.

Outreach activities: The PATH team will identify individuals in the Atlanta area who are homeless and who have mental illness and who are not currently receiving sufficient care and support services; establish trusting relationships with these clients; accompany clients to and facilitate relationships with care providers for these clients' immediate and basic needs; and reach agreements with these clients to accept supportive case management services. The PATH team will engage in outreach via face-to-face interaction with homeless people primarily in shelters but also in other non-traditional settings such as in streets and under bridges.

Case management activities: The PATH team will provide intensive, time-limited (under 90 days) support to assist PATH clients to end their homelessness through direct intervention and transition into services including housing, mental health and substance abuse services, medical services, entitlement benefits assistance, and supported employment services. PATH case

managers will assist clients to develop an Individualized Recovery Plan (IRP), which identifies client needs and strategies for meeting these needs. Case Managers will also assist clients in accessing needed services by arranging transportation, accompanying clients to appointments, and assisting with applications. Case Managers will provide direct assistance with and/or linkage to services and resources available in the community, which may include healthcare, housing, employment, mental health and substance abuse treatment, independent living skills, medications, payee services, psycho-education, and others as needed for individual clients.

b. Gaps that exist in the current service system:

The PATH team members will fill gaps in services or bring identified needs to the attention of the Regional Commission. The funding for the PATH team fills many existing gaps including:

- Outreach to homeless consumers suffering from untreated mental illnesses;
- Case management services not only to provide referrals but also to accompany consumers to their appointments for services, which will result in linkage to services such as medical care, housing, mental health treatment, and income streams.
- Monies for client benefits including MARTA cards, client medications, and client household supplies.

Additional gaps that continue to exist in the service system include: 1) lengthy wait for community mental health and substance abuse services for individuals without medical insurance; 2) lack of housing options for individuals without income; and 3) lack of transitional and supportive housing resources to meet existing housing needs.

c. Services for clients who have both a serious mental illness and substance use disorder (strategy for meeting the treatment needs of co-occurring)

Each person enrolled via the Collaborative PATH Team will be evaluated for co-occurring disorders. All evaluations will be done by a mental health case management professional. These clients will be enrolled in both addictive and mental health programs available in the community. Case Managers will assist PATH clients to identify local mental health and substance abuse service providers using the Georgia Crisis & Access Line. PATH consumers are also provided information on local peer led self-help groups including Double Trouble in Recovery (DTR) meetings which occur 7 days a week at various sites throughout Atlanta.

d. Agency supported Evidence-Based Practices, training, and HMIS activities:

The PATH team supports and implements the following EBP practices:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to permanent housing with attached support services;
- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT), Intensive Case Management (ICM), Community Support Individual (CSI), and/or Core Mental Health Service linkages for those discharged from PATH with varying levels of mental health treatment needs.

United Way provides a Case Management Training Academy for PATH staff using a series of monthly 3 to 6 hour workshops to teach outreach skills that engage homeless individuals and impact their homelessness. In addition, each member of the PATH team receives HMIS training.

5. Data and Provider’s status on HMIS migration in the next 2 to 4 years.

This PATH agency is an member and active user of Georgia HMIS called PATHWAYS. All individuals enrolled in Case Management are entered into HMIS and instantly connected to the homeless provider network. PATH team members plan to participate in HMIS webcasts and trainings in order to learn how to facilitate migration of PATH data into HMIS within 2-4 years. This organization will explore the flexible use of PATH administrative funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.

The Collaborative PATH Team implements two “housing first” strategies called “street –to-home” and “shelter-to-home”. These strategies move literally homeless individuals directly into permanent housing first and then link them to services and resources needed to remain housed.

- Housing options for PATH Clients **without income** include: Sound Landing, URDC, County Community Service Boards, Caring Works, Georgia Housing Voucher Program, and Anticipation Project (Clients agree to reimburse for funds expended on their behalf when they begin to receive income).
- Housing options for PATH Clients **with income** include: Caring Works, URDC, Georgia Housing Voucher Program, Baptist Towers, County Community Service Boards, and affordable apartment/duplex housing options identified using DCA’s housing data base at www.georgiahousingsearch.com
- Housing options for PATH Clients with **HIV** include: The Living Room, AID Atlanta, and HOPWA housing providers

7. Staff Information: (a) demographics of staff serving the clients; (b) how staff providing services to the target population will remain sensitive to age, gender, and racial/ethnic differences; and (c) the extent to which staff receive periodic training on cultural competence.

a. The Collaborative PATH Team will comprise both males and females, and at least half of the team members will be African-American. The team will utilize the services of peer support individuals who have experienced homelessness and mental illness. Nearly all the service providers expected to participate in this program have minorities in upper level positions and substantial minority representation throughout their staff. The following is a representation of the PATH Team:

Provider	# PATH Staff	# Females	# Males	#Caucasian	# Black	#MH Consumers
United Way-Atlanta	6	3	3	2	4	2

- b. All team members and most of our community partners are experienced in the field of diversity/cultural competency.
- c. PATH team members will receive training in cultural competency at least annually, and partner agency staff members are expected to receive cultural competency training at least annually as well.

8. Client Information: (a) demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

a. According to <http://www.nationalhomeless.org/factsheets/who.html>, 68% of the single homeless population is male. As to ethnicity, 42% of homeless persons are African-American; 38% are white; and 20% are Hispanic. The precise make-up depends partly on geographic region. Veterans comprise 13% of homeless persons. In addition, 26% of the homeless struggle with severe and persistent mental illness, and estimates of substance abuse among the mentally ill are as much as 65%.

b. Projected Service Expectations for SFY 2013 - 7/01/12 through 6/30/13:

- 1) Contractor shall identify and have **Outreach** contact with at least **180** unduplicated individuals who are homeless and suspected of having a serious mental illness during the contract period.
- 2) Contractor shall enroll in PATH funded **Case Management** at least **180** unduplicated individuals who are homeless and mentally ill during the contract period. At least **135** (75%) enrolled PATH clients will link to housing and/or community mental health services upon discharge from PATH funded Case Management.

c. This provider projects that 100% of the unduplicated total will self-report as “literally” homeless, noted as living outdoors or in an emergency shelter.

9. Consumer Involvement, how persons who are homeless consumers and have serious mental illnesses and family members are involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.

The PATH team will include at least two peer support individuals who have experienced homelessness and serious mental illness. Persons who are PATH-eligible are expected to participate in advisory boards for the various providers of services. Consumer Satisfaction Surveys are used to obtain PATH client feedback related to the provision of PATH services, seeking input, feedback, and suggestions for improvement.

10. Proposed SFY13 PATH Annual Budget

1. Personnel	Function	FTE Salary	PATH Salary	PATH Total
MHP SW	Team Lead	1.0	\$43,260	
Case Manager	Outreach Coordinator	1.0	\$43,260	
Case Manager	BS or BA	1.0	\$35,020	
Case Manager	BS or BA	1.0	\$35,020	
CPS	BS or BA or CPS	0.5	\$13,000	
CPS	BS or BA or CPS	<u>0.5</u>	<u>\$13,000</u>	
		5.0 FTEs		\$182,560
2. Fringe Benefits @25% (except part-time CPS employees)				\$39,140
3. Transportation Costs -Vehicle maintenance & Staff mileage				\$5,000

4. Training Costs	\$2,300
-Staff Training costs (local and out of state)	
5. Client Benefit Funds	\$12,000
-Household Items	
-Marta Cards	
6. Supplies & Equipment	\$3,000
-Office Supplies	
-Staff Cell Phones	
7. Administrative Costs	<u>\$5,000</u>
GRAND TOTAL:	\$249,000

Section C.	2012 LOCAL PROVIDER INTENDED USE PLAN...continued
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Fulton DeKalb Hospital Authority
250 Auburn Avenue
Atlanta, Georgia 30303
(404) 616-9239

1. Description of the provider by organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and amount of PATH funds the organization will receive.

Fulton DeKalb Hospital Authority (aka Grady Health Systems) is a public, non-profit organization contracted by the Department of Behavioral Health & Developmental Disabilities (DBHDD), Division of Mental Health to deliver comprehensive community mental health and addictive disease services to individuals and families. The professional team of psychiatrists, clinical psychologists, psychiatric nurses, mental health specialists, substance abuse specialists, counselors and specialty consultants provide such services as mental health and substance use interventions including emergency, intensive inpatient/outpatient, adult and child mental health counseling, medication, day treatment, and specialized outreach services.

Grady Health Systems will provide PATH funded services in Atlanta serving Fulton and DeKalb Counties located in DBHDD Region 3.

This provider will receive \$59,000 in PATH Federal funds and \$66,400 in PATH State funds, totaling \$125,400 annually to support PATH services. A detailed budget is enclosed with this application.

2. Participation in the HUD Continuum of Care program as well as any other local planning, coordinating or assessment activities.

Grady Health Systems is a participating organization in the Atlanta Tri-Jurisdiction Continuum of Care Planning Process. The PATH Coordinator attends the quarterly CoC meetings in an effort to develop strong working relationships with HUD funded grantees. As a major medical and

behavioral health organization in metro Atlanta, Grady health Systems continues to enter into strategic partnerships that support the state's plan to end homelessness.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

A PATH funded Mental Health Clinician, Mental Health Associate and Certified Peer Specialist will collaborate with other agencies, organizations, and sites using a “front door” and “back door” approach. The team travels to multiple agencies identifying those homeless individuals with mental health and/or substance use needs. Using a fixed outreach approach, they visit local homeless shelters, service centers, jails, hospitals, and known homeless gathering sites on a routine and scheduled basis. Their presence is anticipated and planned both by the agency and the homeless population. The team receives referrals from other agencies, including jails and works closely with local homeless coalitions. The team provides on-site mental health and/or substance use assessments and evaluations. With the majority of needed resources and services remaining outside the PATH service, the team must collaborate with a multitude of organizations and providers in order to access those resource needed to address the complex and extensive needs of those identified as homeless. Those local agencies and organizations that work in collaboration with this PATH funded team include the following:

Atlanta Day Shelter for Women and Children, Crossroads Ministries Shelter, Atlanta Union Mission, Jefferson Place Shelter, The ROCK (homeless drop-in center), Community Concerns (safe haven) Central Fulton Auburn Renaissance Day Treatment Center, Central Fulton Mental Health and Intake for Substance Abuse, Grady Health System's psychiatric emergency, crisis stabilization, and inpatient services, Northside Mental Health Center, Community Friendship, Fulton County Drug and Alcohol Treatment Center, Georgia Regional Hospital at Atlanta, Bright Beginnings Residential Services, Welcome House (shelter + care), O'Hern House, St. Joseph's Mercy Care Health Clinic at Central Presbyterian Church, the Fulton County Jail (conflict and public defender's offices), Atlanta City Jail, Atlanta Community Court, Mental Health America, and the Task Force for the Homeless. Grady Health Systems also partners with First Step, Inc., a SOAR provider to assist consumers with SSI/SSDI benefits enrollment. Claims are now processed within 3 months and clients are going without benefits for a much shorter period of time.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including:

a. Alignment with PATH goals to target adults who are literally homeless:

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness to permanent housing resources. The PATH State Contact limits the use of PATH funds to these two (2) services which must be delivered in accordance with the Department's approved service guidelines and specifications.

A three person team will identify those individuals who are homeless and mentally ill through fixed and mobile Outreach efforts and once engaged, will enroll in client-centered Case Management, which will include access to housing and linkage to mainstream services and resources needed to remain housed.

b. Gaps that exist in current service system:

There are several gaps in services for the homeless population in metro Atlanta. Some of these gaps include the screening for mental health and substance abuse issues, case management services available on-site. The PATH team addresses these gaps by conducting mental health and substance abuse screenings at local homeless sites including shelters, jails, streets, and hospitals while providing service coordination to address financial, transportation, vocational, and housing needs.

c. Services available for clients who have both a serious mental illness and substance use disorder:

Eligible PATH enrollments are screened for mental health and substance use disorders by the PATH Team who is cross trained in both disability areas. This ensures the identification of and service planning for co-occurring issues. The PATH Team refers and links consumers to those programs that combine mental health and substance use services including Auburn Renaissance Center, Fulton CARES Network, Integrated Life Center, and others. PATH consumers are also linked to local self-help groups including Double Trouble in Recovery (DTR) meetings which occur 7 days a week at various sites throughout Atlanta.

d. Agency supported and implemented Evidence-Based Practices, training, and HMIS activities:

The PATH team supports the following EBP practices:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to permanent housing with attached support services;
- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT) linkage for those discharged from PATH with intensive treatment needs.

Grady Health Systems provides extensive staff training which includes cultural diversity training. PATH Team Lead participated in the Regional Commission on Homelessness (RCOH) Case Management Academy and PATH staff are in the process of receiving HMIS training through PATHWAYS.

5. Data and Provider's status on HMIS migration in the next 2 to 4 years.

Grady Health Systems is a member of Georgia's HMIS, called PATHWAYS but not an active user. This provider plans to participate in HMIS training and then enter PATH data on those homeless clients served with PATH funds. All individuals enrolled in Case Management will be entered into HMIS and instantly connected to the homeless provider network. PATH team members plan to participate in HMIS webcasts and trainings in order to learn how to facilitate migration of PATH data into HMIS within 2-4 years. This organization will explore the flexible use of PATH administrative funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.

The array of housing options that exist for PATH enrolled clients includes emergency shelter, subsidized group home placement, safe haven, shelter plus care, and permanent supportive housing.

The Grady health Systems PATH Team continues to utilize an array of housing options which include:

- Crisis and Temporary Housing: Crossroads Ministries Shelter, Peachtree & Pine Shelter, Jefferson Street Shelter, and the Atlanta Union Mission.
- Low Demand Housing: Community Concern.
- Permanent Housing: Community Friendship, Welcome House, Integrated Life, and Georgia Rehabilitation Outreach.

Beginning FY12, The Grady PATH Team developed a local partnership with a housing provider to utilize a 3 bedroom apartment as temporary housing for PATH consumers while assisting with more permanent housing options.

7. Staff Information: (a) the demographics of the staff serving the clients; (b) how staff providing services to the target population will be sensitive to age, gender, and racial/ethnic differences of clients; and (c) the extent to which staff receive periodic training in cultural competence.

a. The agency employs a diverse racial/ethnic staff to serve homeless individuals. Recognizing that this is an all male PATH team, the PATH agency administrator is female and provides female perspective to the planning and implementation of Outreach and Case Management services.

The following is a representation of the PATH Team:

Provider	Total PATH Staff	# Female	# Male	# White	# Black	# MH Consumers
Grady	3	0	3	0	3	1

b. This agency uses staff training, language services, program evaluation, and community representation to ensure that services are provided in a manner that is sensitive to the differences of those they serve. FDMHC promotes cultural diversity and provides cultural competence training to all employees. Free interpreter services are available for those who do not speak English. This organization evaluates performance satisfaction using consumer and satisfaction surveys. This organization supports community representation with employed mental health consumers operating as direct care staff.

c. Cultural diversity training is a routine part of the new hiring orientation training with on-going sensitivity training supported by supervisory monitoring. DBHDD includes cultural competence performance standards in all service contracts and requires that provider staff match the populations served.

8. Client Information: (a) demographics of client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

a. Grady Health System is located in downtown Atlanta in Fulton County which is considered the most densely populated county in all of Georgia. As a culturally diverse area, metro inhabitants speak twenty-seven languages, with even more cultures represented. When compared to the rest of the state, African-American, Hispanic/Latino, and Asian Pacific-island communities are heavily represented. The latter two of these communities have outstripped the rate of growth of other cultural minorities. The demographics of those served using PATH funds include 43% males, 57% females, 84% African American with 55% between the ages of 35-49 years. 68%

were literally homeless upon initial contact with schizophrenia being the most frequent mental health diagnoses. 33% reported co-occurring substance use disorders.

- b. Projected Service Expectations for SFY 2013 - 7/01/12 through 6/30/13:
 - 1) Contractor shall identify and have contact with at least 224 individuals who are homeless and mentally ill in PATH funded Outreach.
 - 2) Contractor shall enroll at least 157 individuals who are homeless and mentally ill in PATH funded Case Management.
- c. This provider projects that 90% of the unduplicated total will self-report as “literally” homeless.

9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and any family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.

This agency places a strong emphasis on consumer satisfaction and family involvement in treatment. A sampling of consumers receiving adult mental health services delivered by Grady Health Systems participate in Consumer Satisfaction Surveys. Results from the consumer satisfaction surveys are routinely reviewed in order to identify any area of service dissatisfaction, thereby triggering a plan of correction. For those PATH clients not formally linked to Grady Health Systems, the PATH program administers a PATH specific satisfaction survey to enrolled clients. Program staff receives training in consumer and family related issues, including consumer rights, principles of recovery, and peer led services. Staff consults with consumer organizations such as NAMI for assistance in involving family members and assessment of procedures to increase constructive involvement. A consumer is employed full-time as a certified peer specialist to deliver direct service to PATH clients. Their involvement ensures the presence of a consumer perspective during treatment planning.

10. State FY 2013 Proposed Annualized PATH Budget:

1. Personnel	Annual Salary	PATH FTE	PATH Salary	PATH Total
Mental Health Associate II/CPS	\$32,510	1.0	\$32,510	
Mental Health Clinician	\$44,553	1.0	\$44,553	
Mental Health Associate	\$29,432	<u>0.4</u>	<u>\$11,774</u>	
		2.4		\$88,837
2. Fringe Benefit Costs (20.7%)				\$18,389
3. Housing Coordination Funds				<u>\$18,174</u>
-Rental Assistance				
-Security Deposits				
-Transportation				
-Household Assistance				
			GRAND TOTAL:	\$125,400

Section C.	2012 LOCAL PROVIDER INTENDED USE PLAN...continued
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**24/7 Gateway Center
275 Pryor Street SW
Atlanta, GA 30303
(404) 215-6601**

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and amount of PATH funds the organization will receive.

The Gateway Center (GWC) is a non-profit organization designed to serve as a “gateway” to the community continuum of care that helps individuals move out of homelessness. The Gateway Center works to end homelessness, and particularly chronic homelessness, by providing the programs support and framework people need to achieve self-sufficiency. GWC is a homeless programs and services center in which individuals and families in regional Atlanta can come for short term support with basic human needs such as showers, storage, and clothing to more long term supportive guidance in the areas of housing, employment, health, and stabilization. On the premises we house individuals from two weeks up to two years depending on the specifics of each program. GWC utilizes 265 male specific beds to address mental/physical health, the displaced employed, persons in school/training, Veterans, and individuals with addiction issues. In the area of Women and Children services there are 43 beds designed to stabilize individuals and families (women with children) in an effort to establish a more long term housing solution.

The Gateway Center will provide PATH funded services in Atlanta serving Fulton and DeKalb Counties located in DBHDD Region 3.

Gateway will receive \$144,000 in Federal PATH Funds and \$50,000 in State PATH Match, totaling \$194,000 in PATH Program Funding to provide Homeless Outreach and Case Management services to identify, engage, and link PATH eligible consumers to housing and community mental health services. A detailed budget including direct and indirect costs is enclosed in this application.

2. Participation in the HUD Continuum of Care program as well as any other local planning, coordinating or assessment activities.

The Gateway Center is an active member of the Atlanta Tri-Jurisdiction Continuum of Care and receives HUD funds for emergency shelter and transitional housing. Prior to becoming a non-profit agency, the Gateway Center was created by the United Way to serve as the hub of the Regional Commission on Homelessness (RCOH). While the Gateway Center is not the only entry point to homeless services we take pride in our active engagement in RCOH planning as well as Metropolitan Atlanta Tri-Jurisdictional Collaborative on Homelessness.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

The Gateway Center has been noted as a “Best Practice” agency in collaboration. A number of the key service-providing agencies that will work with the Gateway PATH Team are:

Mental/Physical Health Care Services: Saint Joseph’s Mercy Care Services, Grady Health Systems, Veterans Administration, DBHDD Behavioral Health Link, and AID Atlanta.

Substance Abuse/Recovery Support Services: Recovery Consultants of Atlanta, Atlanta Center for Self Sufficiency, and Saint Jude’s Recovery Center.

Career Development Services: Georgia Department of Labor, Atlanta Center for Self-sufficiency, and First Step Staffing.

Legal & Benefit Application Support: Georgia Law Center for the Homeless, and First Step Staffing (SOAR Project).

Partners in Homeless Outreach: United Way of Metropolitan Atlanta, Hope Atlanta Programs of Travelers Aid, Saint Joseph's Mercy Care Services, and Veterans Administration Homeless Veterans Program.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including:

a. Alignment with PATH goals to target adults who are literally homeless:

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness to permanent housing resources. The Gateway will use PATH funding to provide Outreach and Case Management services to identify, engage, and link homeless mentally ill persons sleeping in places not meant for habitation or shelters (literally homeless) to housing and community services. The Gateway's four-person PATH team will consist of a Masters Level Team Lead, two Case Managers (Bachelors Level), and one PATH eligible Peer Specialist. All will have experience working with the severely mentally ill and/or populations diagnosed with co-occurring disorders.

The Gateway PATH Team will utilize motivational interviewing techniques to engage contacts in dialogue, affirm the client, establish a positive rapport, and ultimately elicit a willingness to change. The Gateway PATH Team will make face to face contacts, provide general resource information, and offer Marta transportation and food assistance. Outreach will use both a fixed and mobile approach to meet clients "where they are" and begin moving them towards a "readiness to change." As an incentive the Gateway PATH Team will provide various forms of life skills supportive tools to assist potential clients in outreach. The team will provide hygiene items, clothing, and blankets. In addition, the team will provide assist with identification related purchases, including copies of birth certificates, and medication purchase assistance. A primary Outreach site is the Client Engagement Center located at the Gateway. However, the Gateway PATH Team will also accept referrals for outreach from law enforcement personnel and the community at large.

Once a client demonstrates a willingness to work with the Gateway PATH Team, they are enrolled in Case Management. Their information is entered into HMIS, and a client record is opened. The Case Manager will offer an immediate safe place to stay while a suitable housing placement is identified.

Case Managers will develop Individual Service Plans (ISP), *link to* mainstream mental health and substance abuse services; *link to* healthcare providers for medical services; *link to* self-help groups (NA, AA, CA, DTR), *link to* income resources including employment or benefits entitlements, access temporary and permanent housing resources (reunification, transitional housing, permanent or permanent supported housing); and provide direct care services including transportation assistance.

Case Managers will partner with clients to develop discharge plans to transition them into mainstream services. For those seeking recovery-based services, the Case Manager will link to core mental health services. For those more chronically homeless individuals with more

intensive community integration needs, the PATH Team will link directly to Assertive Community Treatment (ACT) services.

b. Gaps that exist in current service system:

Recent data released by the Metropolitan Atlanta Tri-Jurisdictional Collaborative on Homelessness indicates that the Atlanta metropolitan area has seen an increase in the number of homeless in the area. Much of this rise can be attributed to the increasing number of individuals with chronic conditions that often hinder the ability to make sound judgments. The Gateway Center is proud to partner with the Department of Behavioral Health and Developmental Diseases (DBHDD) to answer the call to bridge the gap between homeless transition and on-going stability. The Gateway PATH team will provide directed outreach and intensive case management that will ensure that these individuals are connected to permanent/supportive housing and community mental health providers and equipped with the tools needed to successfully end homelessness and address potentially lifelong challenges.

c. Services available for clients who have both a serious mental illness and substance use disorder:

A PATH Team Case Manager is a certified addictions counselor with specific training and certification in addressing co-occurring disorders. Enrolled clients will receive a screening for both mental health and substance abuse issues to determine service needs. Clients will be referred to partnering agencies within the facility and throughout the community for support groups and SA meeting participation. The internal options for participation include: Double Trouble which is specifically designed to support clients with co-occurring disorders (Tuesdays, 6:30 pm – 7:30 pm); Peer-led NA/AA meeting (Fridays, 6:45 pm-7:45pm); Step Study groups that focus on the fundamentals of the 12 Step recovery model (Saturdays, 3:00 pm-4:00 pm); We Do Recovery AA meeting (Mon, Wed, Sat 6:30 pm -8:00 pm); Gateway Group of Narcotics Anonymous (Thursday, 6:45 pm-7:45pm). There are also addiction education and thought processing groups in the Gateway Pre-treatment Programs.

The Gateway PATH team will access mainstream mental health and substance abuse services through the Georgia Crisis and Access Line operated by Behavioral Health Link. The Gateway also partners with National Alliance on Mental Illness, Atlanta Center for Self-sufficiency and Recovery Consultants of Atlanta for advocacy support, peer-to-peer support training, and programming for choice in recovery. The Gateway PATH team includes a Peer Specialist that will model appropriate mental health and addiction recovery behavior and provide mentoring support by sharing testimony of challenge and triumph throughout the transitioning process.

d. Agency supported and implemented Evidence-Based Practices, training, and HMIS activities:

The PATH team supports and implements the following EBP practices:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to permanent housing with attached support services;

- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT) linkage for those discharged from PATH with intensive treatment needs.

All PATH clients are entered into Georgia’s HMIS called PATHWAYS upon enrollment.

5. Data and provider’s status on HMIS migration in the next 2-4 years.

This PATH provider is a member and active user of the state supported Homeless Management Information System (HMIS) called Pathways Community Network. All individuals enrolled in Case Management are entered into HMIS and instantly connected to the homeless provider network. PATH team members will participate in HMIS webcasts and training in order to learn how to facilitate migration of PATH data into HMIS within 2-4 years.

6. Access to housing and strategies to make suitable housing available to PATH clients.

For those enrolled in Case Management, the PATH Team will offer temporary housing at the 24/7 Gateway Center while identifying more integrated housing options within the community. The PATH team will utilize Housing Coordination Funds to move individuals into community housing through in partnership with the following housing providers:

- HPRP Funding (permanent housing assistance)
- Georgia Rehabilitation Outreach (permanent supportive)
- Community Friendship (permanent supportive)
- United Way of Metropolitan Atlanta (Quest 35, VEO, Shelter plus care)
- Caring Works (Hope House, Welcome House, Seven Courts , Donnelly Courts, Imperial)
- Atlanta: Programs of Travelers Aid (HIV+, permanent, and permanent supportive)
- City of Refuge (Transitional)
- Trinity (Transitional and Permanent)
- The Living Room.(HIV+, transitional and permanent supportive)
- Santa Fe Villa
- Other tools utilized by the team are Georgia Housing Search, HUD Affordable Apartment Search, and the Furniture Bank.

7. Staff Information: (a) demographics of the staff serving the clients; (b) how providing services to the target population will be sensitive to age, gender, and racial/ethnic difference of clients; and (c) the extent to which staff receives periodic training in cultural competence.

a. The agency employs a staff that represents the age, gender, and racial/ethnic diversity of the homeless clients served. Demographics of the staff serving the clients:

Provider	Total PATH Staff	#Females	#Males	#White	#Black	#MH Consumers
Gateway Center	4	2	2	0	4	1

b. Team members are experienced in the field and receive training in cultural diversity. The organization evaluates quality performance by using satisfaction surveys to gather consumer input and recommendations for improvement.

c. Team will participate in the Regional Commission on Homelessness Case Management Training which includes modules in cultural competence. Social Service Coordinator will take bi-annual CEU's to maintain certification as an addiction counselor. Peer Specialist will participate in peer certification training both of which require training in cultural competence.

8. Client Information: (a) demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

a. Male and female homeless individuals located in downtown Atlanta, Georgia diagnosed with severe mental illnesses and/or co-occurring disorders.

b. Projected Service Expectations for SFY2013-7/01/12 through 6/30/13:

- 1) Contractor shall identify and have contact with at least **350** individuals who are homeless and mentally ill in PATH funded Outreach.
- 2) Contractor shall enroll at least **240** individuals who are homeless and mentally ill into PATH funded Case Management.

c. This provider projects that 80% of the unduplicated total will self-report as "literally" homeless.

9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and any family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH funded services.

Formerly homeless clients are often hired as staff members filling both full-time and part-time positions. These individuals as with all staff members are given the opportunity to share in staff meetings and submit to suggestion box ideas regarding strategic planning, program development, and operations. Current and former clients are invited to give feedback regarding program and service implementation in a special one-on-one meeting with the Director. All current clients are given the opportunity to participate in community meetings in which they are able to communicate concerns and provide general assessment of service delivery, community guidelines, and agency structure. Several programs maintain a Dorm Monitor and/or Council that gives input and suggestions on means to improve client services. Eleven exemplary clients are chosen to participate in the Resident Assistant program which serves as a Programs Advisory Board that contributes to strategic planning and visioning. The PATH team Peer Specialist is a member of this elite group.

10. Proposed State FY 2013 Annual PATH Budget:

1. Personnel	Annualized Salary	PATH FTE	PATH Salary	Total
Coordinator/Team Lead	\$39,900	1.0	\$39,900	
Case Manager	\$27,300	1.0	\$27,300	
Case Manager	\$29,400	1.0	\$29,400	
Peer Specialist	\$20,000	<u>1.0</u>	<u>\$20,000</u>	
		4.0FTEs		\$116,600
Fringe Benefits (@25%)				\$29,150
Transportation Costs				\$1,950
-Vehicle operation and personal mileage				
-GWC Bus				
Program Supply Costs				\$6,890

- Office Supplies
- Equipment (Cell Phones, Computer, File Cabinets)
- Hygiene Kits, Clothing, Blankets
- Identification

Training Costs **\$450**

Housing Coordination Fund **\$33,140**

- Rental Assistance/Emergency Housing
- Emergency Food
- Security Deposits
- Household Items
- Transportation MARTA cards

Administrative Costs **\$5,820**

GRAND TOTAL: \$194,000

Section C.	2012 LOCAL PROVIDER INTENDED USE PLAN...continued
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Saint Joseph's Mercy Care Services, Inc.
424 Decatur Street, SE
Atlanta, GA 30312
(678) 843-8500

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and amount of PATH funds the organization will receive.

Saint Joseph's Mercy Care Services, Inc. (SJMCS) is also a non-profit organization that provides an integrated system of primary health care, education and social services to Atlanta's homeless, new immigrants, uninsured and underinsured, becoming the medical home for thousands throughout the metropolitan area. With a fleet of vans, two fully equipped mobile medical coaches, eleven clinic sites and an experienced team of medical/dental providers and supportive services staff, SJMCS provides a comprehensive continuum of care that includes primary and preventive health care, oral health care, vision screenings, mental health case management, culturally appropriate programs targeting the Hispanic population, health education, and a broad range of HIV prevention, primary care and supportive services. SJMCS' mental health case management program follows a patient-centered model that provides intensive case management to homeless men and women with behavioral health and other complex issues. Case management services are provided onsite at several SJMCS primary care clinic sites as well as other community-based locations. In 2009, following an extensive review by the Commission for the Accreditation of Rehabilitation Facilities (CARF), the program received its second consecutive three-year accreditation.

SJMCS will provide PATH funded services in Atlanta serving Fulton and DeKalb Counties located in DBHDD Region 3.

SJMCS will receive \$249,000 in PATH Federal funds and \$83,000 in PATH State Funds for Outreach and Case Management, totaling \$332,000 for PATH services. A detailed program budget is included.

2. Participation in the HUD Continuum of Care program as well as any other local planning, coordinating or assessment activities.

SJMCS Mental Health Specialists regularly attend Metro Atlanta Tri-Jurisdictional CoC meetings and the agency receives HUD supportive services funding specifically for its St. Luke's site. SJMCS staff members also participate in the Tri-J's biennial Point-in-Time Census Count of homeless persons in the metro area. Other coalitions and task forces in which agency staff participate include the following: the Homeless Action Group (including its Continuum of Care Committee), the Fulton County Collaboration to Reduce Homelessness, the Supportive Living Coalition, the Atlanta Community Access Coalition, the Pathways User Group, quarterly provider meetings sponsored by DBHDD, and the Regional Commission on Homelessness (including subcommittees on health care services for the homeless).

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible.

For services beyond its scope, the PATH team refers clients to other agencies using formal and informal agreements. These include, but are not limited to Grady Health System, the Living Room, First Step, Fulton County Department of Health and Wellness, Samaritan House, Georgia Law Center, Georgia Department of Family and Children Services, Legal Clinic for the Homeless, HOPE Atlanta (Travelers Aid of Metropolitan Atlanta), Quest 35, Inc., and the Georgia Crisis and Access Line.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including:

a. Alignment with PATH goals to target adults who are literally homeless.

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness to permanent housing resources. SJMCS will use PATH funds to provide Outreach and Case Management services.

OUTREACH

Outreach services are provided to the chronically homeless in the places where they are known to congregate including the streets, parks, shelters, soup kitchens, as well as near other provider agencies. To maximize efforts, staff works closely with numerous local agencies in regular contact with the homeless and knowledgeable of their patterns and locations, including: Georgia Department of Transportation; City of Atlanta Police Department; Fulton County Police and Fire Departments; Atlanta's Ambassador Force; and the City of Atlanta Community Court.

Outreach activities include providing information and referrals to community services and resources including Mercy Clinic Downtown for health needs and Core Mental Health providers for mental health needs. Additional referral sources include food, shelter and clothing. To facilitate engagement, Mental Health Specialists hand out printed information about SJMC programs and provide hygiene kits, gift cards for McDonald's and MARTA Breeze cards to meet basic daily needs of Outreached individuals. The Mental Health Specialists makes repeated

visits to individuals who refuse or resist assistance in hopes of building trust and rapport through consistent contact. Once the individual agrees to participate in services, the Mental Health Specialist enters identifying information into the state homeless management information system (HMIS) known as PATHWAYS.

CASE MANAGEMENT

Case Management services take place at six community-based sites easily accessible to the homeless: Atlanta Enterprise Center, St. Luke's Episcopal Church, 24/7 Gateway Homeless Services Center, City of Refuge/Eden Village and Intown Ministries, and Atlanta City Court/Fulton County Mental Health Court.

Enrollment into Case Management begins with the opening of a client record which includes consent for treatment, Eligibility Screening and Needs Assessment, and the Individualized Recovery Plan (IRP). Included in the IRP are goals and objectives developed jointly by the Mental Health Specialist and the client that focus on linkage to mental health services and housing. The IRP promotes self-sufficiency by building on client strengths.

Case Management activities include linking individuals to services (medical, mental health, substance abuse, employment, etc.), arranging transportation and accompanying the client to appointments, assisting with applications for housing, financial planning, teaching independent living skills, and monitoring client progress. Eligible individuals are referred to a SOAR Benefit Specialist to assist with filing SSI/SSDI applications. The PATH Team accesses temporary housing and makes referrals to permanent housing for PATH enrolled individuals prior to discharge.

Linking individuals to community mental health services is a primary focus of Case Management. The PATH Team uses the Georgia Crisis and Access Line to identify and establish appointments with local Core Mental Health Service Providers. For individuals needing more intensive community services, the PATH Team will link directly to Intensive Case Management (ICM) and Assertive Community Treatment (ACT) teams.

The PATH team also maintains contracts with the University of Georgia, Georgia State University, Kennesaw State University, and Clark Atlanta University's Social Work programs. Each of these programs refers interns during the school year to assist with both outreach and case management duties. Approximately 2-3 Bachelor or Masters level interns are available to the PATH team for a total of 16-24 hours per week.

The Case Management Coordinator operates as the Team Lead whose functions include, participating in outreach activities, maintaining a caseload, supervising the team and interns, and monitoring overall client progress towards achieving IRP goals.

b. Gaps that exist in current service systems.

To access and navigate the mental health system in the State of Georgia is challenging for individuals with cognitive disorders and may result in treatment delay. The PATH team assists clients with accessing Core Services. The team will not only help to establish appointments but

also provide transportation and encourage follow up to ensure the client is getting the required assistance to maintain their mental health.

Substance abuse treatment is also difficult to access within the state's system of care. The PATH team includes cross trained staff experience with addressing substance use disorders. Using motivational interviewing techniques, the PATH Team assists individuals as they move through the stages of change. Once the client identifies readiness to participate in treatment, the PATH team facilitates a "warm" referral to a service agency.

c. Services available for clients who have both a serious mental illness and substance abuse disorders.

Substance abuse assessments are conducted by the PATH team, and when appropriate, referrals are made for counseling and/or treatment. The PATH team currently has agreements with ten local substance abuse providers to provide residential treatment services to its patients upon referral. Individuals with dual diagnosis concerns are connected to the Atlanta Recovery Center and the Auburn Avenue Recovery Center, as part of Grady Health System. At both sites, individuals participate in dual diagnosis groups to gain a better understanding of their illness and to master coping strategies. In addition, the PATH team refers clients to Double Trouble Recovery groups within the area to assist the client in establishing strategies to cope with both their mental illness and substance abuse concerns.

d. Agency supported and implemented Evidence-Based Practices, training, and HMIS activities.

The PATH team supports and implements the following EBP practices:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to permanent housing with attached support services;
- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT) linkage for those discharged from PATH with intensive treatment needs.

All individuals enrolled in PATH funded Case Management are entered into HMIS and instantly connected to the homeless provider network. Various continuing education sessions are routinely coordinated and offered by SJMCS' marketing department as well as by SJMCS partners and vendors.

5. Data and provider's status on HMIS migration in the next 2-4 years.

This PATH provider agency is a member and active user of Georgia's HMIS called PATHWAYS. Upon enrollment, client information is entered into PATHWAYS. PATH team members plan to participate in HMIS webcasts and trainings in order to learn how to facilitate migration of PATH data into HMIS within 2 to 4 years. This agency will explore the flexible use of PATH administrative funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.
 The PATH team has established Memoranda of Understanding with Quest35 (8 beds), United Methodist Children’s Home, Gateway 24/7 (22 beds), and HOPE Atlanta (16 beds) to assist with clients’ housing needs. Each housing agency has set aside beds for SJMCS clients in exchange for providing case management services specifically for these clients. PATH team members place clients in these beds after client has been enrolled into PATH services. PATH team members consistently meet with the client to ensure they are linked to appropriate resources to assist them in remaining housed and meeting the established goals. Team members also assist clients apply for permanent housing. The PATH team hopes to establish additional MOUs with housing agencies by utilizing SJMCS’ mobile clinic services as leverage for housing with other agencies.

7. Staff Information: (a) demographics of the staff serving the clients; (b) how providing Services to the target population will be sensitive to age, gender, and racial-ethnic difference of clients; and © the extent to which staff receives periodic training in cultural competence.

a. Demographics of the PATH Team staff serving the clients

Provider	# PATH Staff	# Females	# Males	# Caucasian	# African-American	# MH Consumers
SJMCS	7	5	2	0	7	0

b. SJMCS has a 25-year track record of serving the homeless, the medically indigent and recent immigrants – individuals representing a broad cross-section of the cultural spectrum, i.e. race, ethnicity, and gender. In reaching out to these individuals through numerous programs and services, SJMCS staff continually maintains a clear understanding of the unique issues, barriers and/or risk factors that may contribute to cultural and/or linguistic isolation. The agency is deeply committed to eliminating that isolation through respect for the individual, knowledge and appreciation of the culture, cultivation of trust and rapport between staff and clients, and access to comprehensive services that are responsive to their needs while respectful of their traditions and norms.

c. All staff members are required to participate in an annual cultural competency training sponsored by Saint Joseph’s Health System. SJMCS is also working with Kaiser Permanente to develop a cultural sensitivity program specific to the issues of homelessness. The program will be a customized version of Kaiser’s existing employee program and will enhance SJMCS’ employees’ (particularly new employees) understanding of the uniqueness of the homeless individual.

8. Client Information: (a) demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

a. In January 2009, the Tri-J completed its fourth “Point-in-Time Census Count”, and documented 7,019 homeless persons. Based on the point-in-time data collected during the count, it was estimated that approximately 21,441 persons would experience homelessness in the Tri-J sometime during 2009. In conjunction with the census count, the Tri-J also performed a survey of nearly 500 homeless persons. The survey results included the following client demographics: 79% Men, 87% African-American, 64% between ages 35 and 54, 95% single, 35% first episode of homelessness in the past three years, and 23% chronically homeless.

- b. Projected Service Expectations for SFY 2013 – 7/1/12 through 6/30/13
 1) SJMCS shall identify and have contact with at least **590** individuals who are homeless and have a mental illness in PATH-funded Outreach Services throughout the contract period.
 2) SJMCS shall enroll at least **415 (70%)** individuals who are homeless and have a mental illness in PATH-funded Case Management Services throughout the contract period. Contractor shall also transition enrollment of at least **310 (75%)** individuals from PATH-funded Case Management services into community mental health services during the contract period.
- c. This provider projects that **75%** of the unduplicated total served will self-report as “literally homeless”.

9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and any family members will be involved at the organizational level in the planning, implementation and evaluation of PATH-funded services.

SJMCS maintains an agency-wide Client Advisory Committee comprised of client volunteers. The Committee’s purpose is to receive, assess and make recommendations based on client feedback. The Committee reports its recommendations at SJMCS Board meetings. In turn, the Board uses this input to improve upon and/or implement needed services.

Patient satisfaction surveys are another valuable source of client input. The Outreach Team gives surveys to each client who is assessed as being PATH-eligible and who is willing to complete the survey. Once enrolled, the surveys are also given monthly to each client by his/her Mental Health Specialist. In all instances, the client is instructed to place the survey in a confidential box for subsequent retrieval by the SJMCS Quality Assurance Manager, who in turn compiles the data and provides monthly performance reports to staff.

10. Proposed State FY 2013 Annual PATH Budget

1. Personnel	Annualized Salary	PATH FTE	PATH Salary	Total
Team Lead/Coordinator	\$69,843	0.5	\$34,922	
MH Specialist	\$33,161	1.0	\$33,161	
MH Specialist	\$39,780	1.0	\$39,780	
MH Specialist	\$34,370	1.0	\$34,370	
MH Specialist	\$43,663	1.0	\$43,663	
MH Specialist	\$36,535	1.0	\$36,535	
MH Specialist	\$43,832	<u>0.7</u>	<u>\$31,689</u>	
		6.2FTE’s		\$254,120
2. Fringe Benefit Costs @ 25%				\$63,529
3. Transportation				\$1,538
-Parking	\$800			
-Mileage Reimbursement	\$50			
-Van Maintenance and Fuel	\$688			

4.	Training		\$450
5.	Program Supplies		\$1,350
	-Office Supplies	\$250	
	-Computer Maintenance	\$500	
	-Cell Phones	\$600	
6.	Housing Coordination		\$1,053
7.	Administrative @ 3%		<u>\$9,960</u>
		GRAND TOTAL:	\$332,000

Section C.	2012 LOCAL PROVIDER INTENDED USE PLAN.....continued
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United Way of Metropolitan Atlanta
100 Edgewood Avenue, NE
Atlanta, GA 30303
(404) 527-7237

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and amount of PATH funds the organization will receive.

United Way of Metropolitan Atlanta is a non-profit organization that provides support and funding for community-based programs and services in a thirteen-county Atlanta metropolitan area.. It acts as convener and fiscal agent for the work of the Regional Commission on Homelessness. United Way will use the monies generated by this contract to fund a Collaborative PATH Team which will accomplish two goals: 1) Provide active, face-to-face outreach to homeless persons who have mental illnesses; and 2) Provide short-term case-management and community linkages for these persons. The goal of the Collaborative PATH Team will be to target and engage homeless persons who are not receiving needed services to improve their mental and physical health and to create linkages to community resources in order to continue and maintain services as needed. More information is provided in #3 below.

United Way PATH Team will provide PATH funded services in North Georgia serving Cobb and Douglas Counties located in DBHDD Region 1.

United Way will receive \$85,000 in PATH Funds and \$33,395 in PATH State Match Funds totaling \$118,395 in annualized PATH funding. A detailed budget including direct and indirect costs is enclosed.

2. Participation in the HUD Continuum of Care program and any other local planning, coordinating or assessment activities.

The United Way Regional Commission on Homelessness, Hope Atlanta/Travelers Aid, the Gateway 24/7 Center, City of Refuge, and First Step all coordinate closely with Atlanta’s Tri-Jurisdiction Continuum of Care. All three programs that comprise the HUD CoC are utilized by the Collaborative PATH Team for housing clients: Supportive Housing Program; Shelter Plus Care; and Single Room Occupancy apartments.

Key CoC leaders participate in the Regional Commission on Homelessness quarterly meetings including Directors from: Cobb/Douglas Community Service Board; DeKalb Community Service Board; Gateway Center; City of Refuge; Caring Works; First Step; Hope Atlanta/Travelers Aid; and numerous others.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

Numerous community organizations will be engaged as partners with this Collaborative PATH Team. The following is a partial list of community partners:

- Primary **shelters** from which clients will be identified include: MUST Ministries, Douglas County Men's Assessment Center, Douglas Homeless Shelter, The Door Shelter, and Center for Family Resources.
- Primary **health care providers** include: Wellstar Kennestone, Wellstar Cobb, Wellstar Douglas, Tanner Medical Center, and Emory Adventist Hospital.
- Primary **mental health care providers** include: Cobb-Douglas Community Service Board, Willowbrooke at Tanner Behavioral Health, Ridgeview Institute, Brownstone Project, and Anka Assertive Community Treatment Teams.
- Primary **substance abuse assistance providers** include: The Extension, St. Jude's Addiction Services, Hope House, and Cobb-Douglas Community Service Board.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including:

a. Alignment with PATH goals to target adults who are literally homeless:

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness to permanent housing. The Georgia State PATH Contact limits the use of PATH funds to these two (2) services which must be delivered in accordance with the service guidelines and utilization criteria set forth in the PATH Program. The contractors comprising the PATH team are experienced in identifying and engaging individuals who are literally homeless with mental health issues.

Outreach activities: The PATH team will identify individuals in north Georgia's Cobb and Douglas Counties who are homeless and who have mental illness and who are not currently receiving sufficient care and support services; establish trusting relationships with these clients; accompany clients to and facilitate relationships with care providers for these clients' immediate and basic needs; and reach agreements with these clients to accept supportive case management services. The PATH team will engage in outreach via face-to-face interaction with homeless people primarily in shelters but also in other non-traditional settings such as in streets and under bridges.

Case management activities: The PATH team will provide intensive, time-limited (under 90 days) support to assist PATH clients to end their homelessness through direct intervention and transition into services including housing, mental health and substance abuse services, medical services, entitlement benefits assistance, and supported employment services. PATH case managers will assist clients to develop an Individualized Recovery Plan (IRP), which identifies client needs and strategies for meeting these needs. Case managers will also assist clients in

accessing needed services by arranging transportation, accompanying clients to appointments, and assisting with applications. Case managers will provide direct assistance with and/or linkage to services and resources available in the community, which may include healthcare, housing, employment, mental health and substance abuse treatment, independent living skills, medications, payee services, psycho-education, and others as needed for individual clients.

b. Gaps that exist in the current service system:

The PATH team members will fill gaps in services or bring identified needs to the attention of the Regional Commission. The funding for the PATH team fills many existing gaps including:

- Outreach to homeless consumers suffering from untreated mental illnesses;
- Case management services not only to provide referrals but also to accompany consumers to their appointments for services, which will result in linkage to services such as medical care, housing, mental health treatment, and income streams.
- Monies to assist homeless individuals with transportation, medications, and household items.

Additional gaps that continue to exist in the service system include: 1) lengthy wait for community mental health and substance abuse services for individuals without medical insurance; 2) lack of housing options for individuals without income; and 3) lack of transitional and supportive housing resources to meet existing housing needs.

c. Services for clients who have both a serious mental illness and substance use disorder (strategy for meeting the treatment needs of co-occurring)

Each person enrolled via the Collaborative PATH Team will be evaluated for co-occurring disorders. All evaluations will be done by a mental health case management professional. These clients will be enrolled in both addictive and mental health programs available in the community. Case Managers will assist PATH clients to identify local mental health and substance abuse service providers using the Georgia Crisis & Access Line. PATH consumers are also provided information on local peer led self-help groups including Double Trouble in Recovery (DTR) meetings which occur 7 days a week at various sites throughout Atlanta.

d. Agency supported Evidence-Based Practices, training, and HMIS activities:

The PATH team supports and implements the following EBP practices:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to permanent housing with attached support services;
- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT), Intensive Case Management (ICM), Community Support Individual (CSI), and/or Core Mental Health Service linkages for those discharged from PATH with varying levels of mental health treatment needs.

United Way provides a Case Management Training Academy for PATH staff using a series of monthly 3 to 6 hour workshops to teach outreach skills that engage homeless individuals and impact their homelessness. In addition, each member of the PATH team receives HMIS training.

5. Data and Provider’s status on HMIS migration in the next 2 to 4 years.

This PATH agency is a member and active user of Georgia’s HMIS called PATHWAYS. All individuals enrolled in Case Management are entered into HMIS and instantly connected to the homeless provider network. PATH team members plan to participate in HMIS webcasts and trainings in order to learn how to facilitate migration of PATH data into HMIS within 2-4 years. This organization will explore the flexible use of PATH administrative funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.

The Collaborative PATH Team implements two “housing first” strategies called “street –to-home” and “shelter-to-home”. These strategies move literally homeless individuals directly into permanent housing first and then link them to services and resources needed to remain housed.

Housing options available to PATH clients in north Georgia’s Cobb and Douglas Counties include the DBHDD Georgia Housing Voucher Program, Cobb-Douglas Shelter Plus Care Program, Hope Atlanta/Travelers Aide Valley Brook Apartments, MUST Ministries, and other housing options listed on DCA’s affordable housing database located at www.georgiahousingsearch.com

7. Staff Information: (a) demographics of staff serving the clients; (b) how staff providing services to the target population will remain sensitive to age, gender, and racial/ethnic differences; and (c) the extent to which staff receive periodic training on cultural competence.

a. The Collaborative PATH Team will comprise both males and females, and at least half of the team members will be African-American. The team will utilize the services of peer support individuals who have experienced homelessness and mental illness. Nearly all the service providers expected to participate in this program have minorities in upper level positions and substantial minority representation throughout their staff. The following is a representation of the PATH Team:

Provider	# PATH Staff	# Females	# Males	#Caucasian	# Black	#MH Consumers
United Way-Cobb	3	1	2	1	2	1

b. All team members and most of our community partners are experienced in the field of diversity/cultural competency.

c. PATH team members will receive training in cultural competency at least annually, and partner agency staff members are expected to receive cultural competency training at least annually as well.

8. Client Information: (a) demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

a. According to <http://www.nationalhomeless.org/factsheets/who.html>, 68% of the single homeless population is male. As to ethnicity, 42% of homeless persons are African–American; 38% are

white; and 20% are Hispanic. The precise make-up depends partly on geographic region. Veterans comprise 13% of homeless persons. In addition, 26% of the homeless struggle with severe and persistent mental illness, and estimates of substance abuse among the mentally ill are as much as 65%.

- b. Projected Service Expectations for SFY 2013 - 7/01/12 through 6/30/13:
 - 1) Contractor shall identify and have **Outreach** contact with at least **120** unduplicated individuals who are homeless and suspected of having a serious mental illness during the contract period.
 - 2) Contractor shall enroll in PATH funded **Case Management** at least **96** unduplicated individuals who are homeless and mentally ill during the contract period. At least **72** (75%) enrolled PATH clients will link to housing and/or community mental health services upon discharge from PATH funded Case Management.
- c. This provider projects that 100% of the unduplicated total will self-report as “literally” homeless, noted as living outdoors or in an emergency shelter.

9. Consumer Involvement, how persons who are homeless consumers and have serious mental illnesses and family members are involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.

The PATH team will include one peer support individual who have experienced homelessness and serious mental illness. Persons who are PATH-eligible are expected to participate in advisory boards for the various providers of services. Consumer Satisfaction Surveys are used to obtain PATH client feedback related to the provision of PATH services, seeking input, feedback, and suggestions for improvement.

10. Proposed SFY13 PATH Annual Budget

1. Personnel	Function	PATH FTE	PATH Salary	PATH Total
MHP SW	BSW or MSW	1.0	\$34,000	
MHP SW	BSW or MSW	1.0	\$34,000	
CPS	BS or BA or CPS	<u>1.0</u>	<u>\$18,000</u>	
		3.0 FTEs		\$86,000
2. Fringe Benefits @21%				\$18,060
3. Transportation Costs				\$3,000
-Cost to maintain transportation vehicle				
-Staff mileage				
4. Training Costs				\$1,000
-Staff Training costs (local and out of state)				
5. Client Benefit Funds				\$6,035
-Household Items				
-Marta Cards				

-Client Meds

6. Supplies & Equipment **\$2,000**

-Office Supplies

-Staff Cell Phones

7. Administrative Costs **\$2,300**

PATH GRAND TOTAL: \$118,395

Section C. 2012 LOCAL PROVIDER INTENDED USE PLAN.....continued

**New Horizons Community Service Board
2100 Comer Avenue
Columbus, GA 31906
(706) 596-5717**

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and amount of PATH funds the organization will receive.

New Horizons is a Community Service Board (CSB), a public, non-profit organization contracted by the Department of Behavioral Health and Developmental Disabilities (DBHDD) to deliver comprehensive community mental health and substance use disorder services through an interdisciplinary treatment team process. New Horizons has a thirty year history of providing community mental health services. The array of services provided by New Horizons CSB includes: Screening, Crisis & Outreach, Outpatient, Day & Employment, Residential, and Service Entry and Linkage Services.

New Horizons CSB will provide PATH funded services primarily to the city of Columbus serving Muscogee County located in DBHDD Region 2.

New Horizons will receive \$147,000 Federal PATH funds and \$51,900 State Match funds totaling \$198,900 annualized to support PATH services. A detailed budget including direct and indirect program costs is enclosed with this application.

2. Participation in the HUD Continuum of Care program as well as any other local planning, coordinating or assessment activities.

David Wallace (LPC, M.S., SAM, MHP, and NBCC) is the PATH Project Coordinator and serves as an active member of the local HUD Continuum of Care program. Arlena Shaw (M.S. Degree in Counseling Psychology) is the Program Director and serves as a representative on the CoC Planning Committee as well as community liaison to other area service providers. New Horizons currently has a diverse array of HUD funded housing options through the CoC including Shelter Plus Care and Permanent Supportive Housing Program. New Horizons also participates in both Client track and Pathways HMIS Community Information Networks.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients.

New Horizons currently provides an array of outpatient mental health and substance use disorder treatment services, including psychiatric and nursing services, psychosocial rehabilitation, intensive outpatient, ambulatory detoxification, and residential support services. New Horizons regularly links consumers to medical services, employment services and mainstream housing services through case management. New Horizons has many contacts with agencies providing these services. New Horizons will work closely with the local ACT and Mobile Crisis Teams to connect consumers to mainstream community resources in a coordinated effort to end the consumer's episode of homelessness.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including:

a. Alignment with PATH goals to target adults who are literally homeless.

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness to permanent housing resources. State PATH Contact limits the use of PATH funds to these two (2) services which must be delivered in accordance with the Department's approved service specifications. The New Horizons Homeless Team implements street and shelter Outreach services to identify and engage literally homeless individuals in Muscogee County and move them towards readiness to change. Once enrolled in Case Management services, individuals are assisted with access to housing and linked to mainstream services and resources.

After Hours Response: The PATH Team will provide 24/7 response to the Mobile Crisis Team using an afterhours on-call schedule when identifying literally homeless individuals with mental illness after hours, who are not linked to a Core Provider and unable or unwilling to access mainstream mental health services without assistance. When the Mobile Crisis Team encounters a homeless individual who reports receiving services at a mental health center, then the PATH Team will recommend that the Mobile Crisis Team contact that Core Provider and seek crisis intervention services. When the Mobile Crisis Team encounters a homeless individual who is able to access services on their own, then Mobile Crisis can simply provide them with GCAL information.

The on-call PATH Team Member and the Mobile Crisis Team will determine via telephone the type of response necessary to assist the homeless individual with accessing immediate shelter and linking them to mental health services. When possible, the on-call PATH Team Member will provide the Mobile Crisis Team with an immediate shelter option and plan to meet the individual at that shelter in the morning. When the Mobile Crisis Team determines the homeless individual requires more intensive support and assistance to divert a crisis, then the on-call PATH Team Member will be dispatched within 2 hours, meeting the Mobile Crisis Team and the homeless individual to provide face-to-face assistance with accessing shelter and linking to mental health services.

The PATH Team will initiate referrals directly to ACT Services for those who meet the ACT admission criteria. PATH and ACT Team members will establish a standing weekly meeting time and date to discuss referrals and develop a transition plan while continuing to co-manage for 30 days to ensure continuity of care for the consumer.

b. Gaps that exist in current service system.

Few non-traditional mental health services exist for those consumers who resist accessing the traditional service system. New Horizons will utilize the PATH funds to enhance the provision of outreach and case management services that can be accessed through local shelters, emergency rooms, clinics, hospitals, jails, places not meant for human habitation, and soup kitchens. An aggressive Outreach Service will utilize one full-time peer-to-peer specialist with personal homeless experience who will go into shelters and soup kitchens on a regular weekly schedule. People living on the street are more likely to trust someone who can reflect first hand knowledge of the homeless experience. Because of their street smarts, systems knowledge, and flexibility, survivors of homelessness are in a unique position to serve individuals who are both homeless and have a mental illness. New Horizons has implemented a Mental Health Court program to help divert non-violent mentally ill persons from jail into treatment. Individuals referred to the Mental Health Court program and verified as homeless prior to arrest may receive PATH funded services. This will ensure Mental Health Court participants do not immediately return to homelessness from jail.

c. Services available for clients who have both a serious mental illness and substance use disorder.

PATH consumers with co-occurring substance use disorders access local peer led self-help groups. Agape meets in downtown Columbus on a weekly basis and provides support and education to those with co-occurring issues. Double Trouble in Recovery (DTR) meets twice a week using the 12-step approach to discuss mental health and addictive disease issues without shame or stigma. In addition, any PATH enrollee may participate in any program provided by New Horizons, including a psychosocial rehabilitation program specifically designed for the dually diagnosed as well as gender-specific programming for women. The PATH Team will work closely with the local ACT and Mobile Crisis Teams to ensure continuity of care for PATH eligible consumers.

d. Agency supported and implemented Evidence-Based Practices, training, and HMIS activities.

The PATH team supports the following EBP practices:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to permanent housing with attached support services;
- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT) linkage for those discharged from PATH with intensive treatment needs.
- 24/7 delivery of services via the use of an after hours on-call schedule.

All individuals enrolled in Case Management are entered into HMIS and instantly connected to the homeless provider network. All staff members receive agency-based training upon hire and annually thereafter.

5. Data and provider’s status on HMIS migration in the next 2-4 years.

All CoC organizations are linked to the state supported Homeless Management Information System (HMIS) called Pathways Community Network. This agency is a member and active user of Pathways, entering client information for all those enrolled in Case Management. PATH team members will participate in HMIS webcasts and trainings to learn how to facilitate migration of PATH data into HMIS within 3-5 years. This agency will explore the flexible use of PATH administrative funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.

A Housing Resource Specialist works collaboratively with the local housing authority, Shelter Plus Care (S+C) providers (including New Horizons), other local housing programs (i.e., the Ralston, Stewart Community Home, and Open Door Community Home), Continuum of Care agencies, the Columbus Homeless Resource Network and the Georgia Department of Community Affairs Rental Access Network (which provides an update of available, affordable apartments across Georgia) to identify an appropriate and accessible array of housing options. The Housing Resource Specialist will then match the enrolled PATH client to the appropriate and available housing resource. A portion of the PATH budget is allocated to pay security deposits, cover the cost associated with coordinating housing, costs associated with matching eligible homeless individuals with appropriate housing situations, and one-time rent payments to prevent eviction. A “home establishment” fund will be used to purchase essential items, without which the individual would not remain in the home. The PATH Team will also receive referrals from the local Mobile Crisis Teams and will utilize the same strategies to end the identified consumer’s episode of homelessness. When appropriate, PATH will make referrals to the local ACT Team.

7. Staff Information: (a) demographics of the staff serving the clients; (b) how staff providing services to the target population will be sensitive to age, gender, and racial/ethnic differences of clients; and (c) the extent to which staff receive periodic training in cultural competence.

a. The agency employs a staff that is representative of the gender and racial/ethnic diversity of homeless clients served. The following is a representation of the PATH Team:

Provider	Total PATH Staff	# Female	# Male	# Caucasian	# African American	# MH Consumers
New Horizons	6	5	1	3	3	3

b. This agency uses staff training, language services, program evaluation, and community representation to ensure that services are provided in a manner sensitive to the differences of those they serve. New Horizons promotes cultural diversity by providing cultural competence training to all employees. Free interpreter services are available for those who do not speak English. This organization evaluates performance satisfaction using consumer and family satisfaction surveys, including the level of satisfaction with staff sensitivity to cultural background. This organization supports community representation with employed mental health consumers operating as direct care staff.

c. All staff members receive agency based training regarding cultural sensitivity upon hire and annually thereafter. Every employee is required by this agency to attend training on consumer rights and consumer protection issues.

8. Client Information: (a) demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

- a. New Horizon’s Community Service Board is located in the city of Columbus, which is the third largest city in the state with a 3.9% population growth in the last ten years. The population demographics of those served by PATH services were predominately African American males (69%) between the ages of 35-49 with co-occurring mental illness and substance use disorders and literally homeless upon initial contact.
- b. Projected Service Expectations for SFY 2013 -7/01/12 through 6/30/13:
 - 1) Contractor shall Outreach at least **350** individuals who are homeless and mentally ill.
 - 2) Contractor shall enroll in PATH funded Case Management at least **244** individuals who are homeless and mentally ill.
- c. This provider projects that 60% of the unduplicated individuals receiving PATH services will self-report as “literally” homeless.

9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.

New Horizons has a Board of Directors that includes consumers of disabilities and family members who are actively involved in the planning and implementation of services. New Horizons participates in Georgia’s Performance Measurement and Evaluation System. Guided by a steering committee of consumers, advocates and professionals, satisfaction surveys are administered. A Consumer Satisfaction Survey specifically for PATH recipients is used to gather input on PATH funded services. Input from these surveys is used to improve the planning and implementation of PATH funded services. New Horizons employs two full-time Peer Specialists who are mental health consumers with homeless experience to provide Peer Outreach.

10. Proposed State FY 2013 Annual PATH Budget:

1. Personnel Positions	Annualized Salary	PATH FTE	PATH Salary	PATH Total
SSC – Team Lead	\$31,000	1.0	\$31,000	
Social Service Provider	\$29,000	1.0	\$29,000	
Social Service Technician	\$23,000	1.0	\$23,000	
Social Service Technician	\$23,000	1.0	\$23,000	
Peer Specialist	\$29,000	<u>1.0</u>	<u>\$29,000</u>	
		5.0		\$135,000
2. Fringe Benefits @ 36%				\$47,250
3. Travel				\$3,680
Local travel – 200miles/wk @\$0.45 mile		\$1,680		
Training/Conferences for PATH Staff		\$2,000		
4. Supplies				\$2,000
Quarterly Newsletter Supplies, copies, postage, brochures				

5. Housing Coordination	\$8,970
Security Deposits;	
One-Time Rental Payments	
House Establishment Supplies	

6. Administrative Costs	<u>\$2,000</u>
Office Space, Utilities	Grand Total: \$198,900

Section C.	2012 LOCAL PROVIDER INTENDED USE PLAN.....continued
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Chatham-Savannah Homeless Authority
2301 Bull Street
Savannah, Georgia 31401
(912) 790-3400

1. Description of the provider organization receiving PATH funds including name, type of organization, services provided by the organization, region served, and amount of PATH funds the organization will receive.

Established by the Georgia State Legislature more than 18 years ago, the Chatham-Savannah Authority for the Homeless (Homeless Authority) is a non-profit 501C3 organization created to provide a central planning and coordinating effort to address homeless needs and services. The Homeless Authority, in conjunction with the City of Savannah, coordinates all activities called for in the community Continuum of Care. Beginning with the writing of the homeless section of the Housing and Community Development Plan, the Homeless Authority is charged with all aspects of planning, service delivery coordination, and certain other roles such as evaluation and monitoring, advocacy, education, and resource development. PATH funded services will focus on the behavioral health issues of families and individuals experiencing homelessness.

The Homeless Authority will provide PATH funded services in Savannah/Chatham County located in DBHDD Region 5. Savannah has the state's second largest concentrations of individuals experiencing homelessness outside of Metro Atlanta.

This provider will receive \$136,000 in Federal PATH funds and \$47,500 in State Match funds, totaling \$183,500 annualized to support PATH services for families and individuals experiencing homelessness with behavioral health issues. A detailed budget is included with this application.

2. Participation in the HUD Continuum of Care program as well as any other local planning, coordinating or assessment activities.

The Chatham-Savannah Homeless Authority is a State Legislated organization designated to coordinate all activities in the local Continuum of Care plan, including planning, collaborating, identifying gaps in services, and addressing ways to close those gaps. The agency collaborates with the agencies that are the providers of behavioral health services and provides transportation for clients enrolled in behavioral health programs. The Homeless Authority administers the PATH funds, and all hired employees are out-stationed at predetermined Continuum of Care organizations. This five-person PATH team will also be out-stationed at predetermined Continuum of Care sites

including Emmaus House, Inner City, and the Social Apostolate. All Continuum of Care organizations are linked to a Homeless Management Information System called Pathways.

3. Community partnerships with local organizations that provide key services (e.g., primary health, mental health, substance abuse, housing, employment) to PATH eligible clients:

The PATH Team collaborates with multiple key agencies in Savannah to provide key services to PATH enrolled clients. Each of these agencies work cooperatively and collaboratively to ensure that those experiencing homelessness can attain and maintain self-sufficiency:

- Recovery Place Community Services for substance abuse services;
- Savannah Counseling Services for ongoing mental health services;
- J.C. Lewis Health Center of Union Mission for medical and dental needs;
- Union Mission, Inc. and the Savannah Housing Authority for permanent supportive housing;
- Savannah Regional Hospital for access into Assertive Community Treatment for those with the most intensive needs.

Additionally, the Homeless Authority has an excellent relationship with the Savannah Police Department, and meets regularly with the police department to coordinate services. Training for the Police Department's CIT (Crisis Intervention Team) is provided on a recurring basis by an employee of American Work, Inc.

4. Service provision plan for coordinated and comprehensive services to eligible PATH clients, including:

a. Alignment with PATH goals to target adults who are literally homeless.

Georgia regards Outreach and Case Management as priority services to link literally homeless individuals with serious mental illness to permanent housing resources. The State PATH Contact limits the use of PATH funds to these two (2) services which must be delivered in accordance with the Department's approved service specifications.

The Homeless Authority operates an integrated Unified Case Management (UCM) system that combines the resources of the homeless continuum of care with behavioral health services to provide one coordinated effort for those in need of housing and other support services. With interconnected Case Managers dropped into various shelter settings, the Unified Case Management system serves as "gatekeeper" by verifying consumer eligibility and organizing the utilization of housing and behavioral health services through weekly case conference meetings. PATH funds a five-person UCM team composed of a full-time Mental Health Professional (MHP) team leader (with blended HUD and PATH funding) and four full-time peer-to-peer specialists to provide Outreach and Case Management services.

OUTREACH

The PATH Team locates the hardest-to-reach individuals through mobile and fixed Outreach sites which include the Salvation Army and Inner Center Night Shelters, the Social Apostolate and Emmaus House-two local congregate feeding sites shelters, and local parks. Outreach identifies PATH eligible clients, establishes a personal connection, and helps them believe that change is possible. Once the consumer expresses willingness to accept services, they are then enrolled in PATH funded Case Management .

CASE MANAGEMENT

Case Management services assist with meeting basic needs, accessing housing, and linking to ongoing mental health and substance abuse treatment. For those individuals with intensive mental health needs, the PATH Teams links them directly to Assertive Community Treatment (ACT) services. A key function of PATH funded Case Management is actively assisting clients to apply for entitlement benefits such as Social Security Disability (SSDI) and Supplemental Security Income (SSI).

b. Gaps that exist in the current service system.

Gaps in services include crisis services for those experiencing behavioral health issues, short-term respite care, the availability of resources on the weekends, and the shortage of affordable, adequate, permanent supportive housing for women and families. In FY09, the State expanded crisis services in Savannah to include a new Crisis Stabilization Program, Mobile Crisis, and Assertive Community Treatment to address the crisis needs in Savannah. The PATH team is actively collaborating with these services to reduce service gaps.

c. Services available for clients who have both a serious mental illness and substance use disorder.

Those PATH enrolled clients with co-occurring issues are referred to the appropriate service provider. In addition to counseling, consumers are provided Psychosocial Rehabilitation Program based on the Boston University Model, which is considered a “Best Practice” model. It addresses the level of community functioning needs for those with mental health and substance use disorders.

To complement these clinic-based services, PATH consumers also link to local Double Trouble in Recovery (DTR) 12-step self-help groups, which are free and readily available. These two-hour groups provide a safe environment for these consumers to support each other while addressing medication issues without shame or stigma. Chatham-Savannah Homeless Authority combines counseling, rehabilitation, self-help and ongoing support as a treatment strategy for PATH clients with co-occurring disorders.

d. Agency supported and implemented Use of Evidence-Based Practices, training, and HMIS activities.

The PATH team supports and implements the following EBP practices:

- Motivational Interviewing techniques to move individuals through stages of change;
- Peer Supports to develop a wellness recovery action plan (WRAP);
- Double Trouble to Recovery self-help groups for individuals with co-occurring mental illness and substance use disorders;
- Supportive Housing by linking individuals to permanent housing with attached support services;
- SOAR Trained Benefit Specialists to expedite access to entitlement benefits;
- Assertive Community Treatment (ACT) linkage for those discharged from PATH with intensive treatment needs;
- HMIS Training to C of C agencies.

5. Data and provider’s status on HMIS migration in the next 2-4 years.

This agency is a member and active user of Georgia’s HMIS called Pathways Community Network. All individuals enrolled in Case Management are entered into HMIS and connected with the homeless provider network. The PATH team Case Manager will be required to maintain data on consumers through Pathways Communication Network, the statewide Homeless Management Information System. PATH team members plan to participate in HMIS webcasts and training to learn how to facilitate migration of PATH data into HMIS within 3-5 years. This agency will explore the flexible use of PATH administrative funds to support HMIS activities.

6. Access to housing and strategies to make suitable housing available to PATH clients.

The PATH team meets weekly with the Housing Team of Union Mission (the largest provider of housing in the community) and the Unified Community Support Team to determine service and housing needs, including available bed openings. There are over 600 beds available in the Homeless Continuum of Care in the Savannah region. Approximately 300 are dedicated to behavioral health needs. Memorandums of Agreement exist between the Chatham-Savannah Authority for the Homeless and the majority of homeless service providers in the community, including those who provide housing to PATH consumers. Because of these relationships and agreements, PATH team members are knowledgeable of space availability in the Continuum, and can immediately make referrals and reserve space, if required to do so. Team members assist consumers in completing the necessary applications and acquiring any documentation required. PATH team members also ensure that consumers make and keep appointments necessary, including assisting with transportation to those appointments. There are several housing programs that most frequently serve PATH consumers, including emergency and transitional facilities, and several Shelter + Care programs. Emergency facilities include the Salvation Army and Magdalene Project of UMI and transitional facilities include the Economic Opportunity Authority’s Thomas Austin House, and Recovery Place’s Men’s & Women’s Residential programs. In addition, there are a number of Shelter + Care programs that are most successful in housing PATH consumers, and they include: Genesis, New Beginnings, Serenity, and Dutchtown. Through the weekly meetings and contacts, the PATH team is kept abreast of any and all vacancies and able to make referrals on a timely basis. This allows PATH consumers to be placed on a “fast track” in their quest for stability and housing placement. This process allows PATH consumers to gain direct and immediate access to these housing resources, and the process will continue to be employed.

Sometimes, PATH enrolled clients can access stable housing, but lack the financial resources to do so. An increase in case management funds will be utilized to provide direct assistance to clients including emergency rental assistance and bus passes.

7. Staff Information: (a) the demographics of the staff serving the clients; (b) how staff providing services to the target population will be sensitive to age, gender, and racial/ethnic differences of clients; and (c) the extent to which staff receive periodic training in cultural competence.

- a. DBHDD includes cultural competence performance standards in all service contracts and requires that provider staff match the population served. Staffing represents the racial/ethnic diversity of the clients served as follows:

Provider	Total PATH Staff	# Female	# Male	# White	# Black	# MH Consumers
Savannah -Authority for the Homeless	5	1	4	1	4	4

- b. This agency uses staff training, language services, program evaluation, and community representation to ensure that services are provided in a manner that are sensitive to the differences of those they serve. The Savannah Chatham-Savannah Authority for the Homeless promotes cultural diversity and provides cultural competence training to all employees. Free interpreter services are available for those who do not speak English. This organization evaluates performance satisfaction using consumer and family satisfaction surveys, including the level of satisfaction with staff sensitivity to cultural background. This organization supports community representation with employed mental health consumers operating as direct care staff.
- c. The Homeless Authority, J.C. Lewis Health Center, and Recovery Place routinely provide clinical training for case managers and behavioral health staff which include a mandatory diversity workshop to heighten awareness and increase staff effectiveness.

8. Client Information: (a) the demographics of the client population; (b) projected number of adults to be outreached and enrolled; and (c) percentage of adults served that are literally homeless.

- a. Chatham-Savannah Homeless Authority is located in Savannah, which is the fourth-largest city and the sixth largest county in the state. The demographics of those enrolled in PATH services include: 58% male; 42% female; 48% between the ages 35-49 years; 44% African American; 40% White; 69% with “other psychotic disorders; 54% with co-occurring substance use disorders; and 59% literally homeless upon initial contact.
- b. Projected Service Expectations for SFY 2013 - 7/01/12 to 6/30/13:
 - 1) Outreach Contacts: Contractor shall identify and have contact with at least 328 Individuals who are homeless and mentally ill in PATH funded Outreach.
 - 2) Case Management Enrollments: Contractor shall enroll at least 229 clients who are homeless and mentally ill in PATH funded Case Management.
- c. This provider projects that 90% of the unduplicated individuals served by PATH services will self-report as “literally” homeless.

9. Consumer Involvement, how persons who are homeless and have serious mental illnesses and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services.

The Homeless Authority Board of directors is constructed to include local and state government, as well as advocates, providers of service, and homeless or formerly homeless consumers. Hired consumers provide peer support services after successfully completing and passing the training and certification process. Consumers through the Community Consumer Advocacy Board on Homelessness, (CCABoH), are actively involved as part of the planning and implementation process of homeless services. Peer Specialists also serve on the Board of Directors of the Social Apostolate and Emmaus House, congregate feeding sites, which also provide food and other assistance to those experiencing homelessness. A certified peer specialist serves as peer mentor at Georgia Regional Hospital, the region’s mental health facility. Additionally, a select group of board members, service providers, consumers, and family members meet directly with direct care staff biannually to evaluate the progress of PATH services. Members of NAMI are invited to participate in the review of

services twice yearly. Additionally, the CCABoH reviews consumer satisfaction surveys for services rendered in the Savannah Continuum of Care.

10. Proposed Annual State FY 2013 PATH Budget

I. Personnel Costs	Annualized Salary	PATH FTE	PATH Salary	PATH Total
Positions				
Mental Health Professional	\$42,000	1.0 FTE	\$42,000	
Certified Peer Specialist	\$26,000	1.0 FTE	\$26,000	
Peer to Peer Specialist	\$26,000	1.0 FTE	\$26,000	
Certified Peer Specialist	\$25,000	1.0 FTE	\$25,000	
Peer to Peer Specialist	\$22,900	<u>0.5 FTE</u>	<u>\$11,450</u>	
		4.5 FTE		\$130,450
II. Fringe Benefit Costs (@25%)				\$32,800
III. Transportation Costs Vehicle Operation & Personal Mileage				\$ 6,500
IV. Training Costs				\$ 2,200
V. Program Supply Costs				\$4,000
Cell phones @ \$300/month		\$ 3,600		
Office Supplies (folders, paper, ink)		\$ 400		
VII. HMIS Data Collection/Management				\$750
1) ¼ of annual Pathways HMIS User Fee		\$ 250		
2) ¼ of estimated internet fees		\$ 500		
VII. Direct Assistance				\$1,300
-Emergency Rental Assistance				
-Bus Passes				
VIII. Administrative Costs				<u>\$ 5,500</u>
		GRAND TOTAL:		\$ 183,500

Section C.	2012 LOCAL PROVIDER INTENDED USE PLAN.....continued
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DBHDD, Division Mental Health
2 Peachtree Street, NW
Suite 23.202
Atlanta, GA 30303
(404) 657-2141

Proposed State FY 2013 Annual PATH Administrative Budget

1. Travel/Training	\$2,500
2. Supplies	<u>\$500</u>

(books, videos, printing costs)

GRAND TOTAL: \$3,000