

I. State Information

State Information

Plan Year

Federal Fiscal Year 2015

State Identification Numbers

DUNS Number 965736635

EIN/TIN 94-3473160

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

Agency Name Department of Behavioral Health and Developmental Disabilities

Organizational Unit Division of Behavioral Health

Mailing Address 2 Peachtree Street NW Floor 24

City Atlanta

Zip Code 30303

II. Authorized Representative for the PATH Grant

First Name Dawne

Last Name Morgan

Agency Name GA Department of Behavioral Health & Developmental Disabilities

Mailing Address 2 Peachtree Street NW Floor 23

City Atlanta

Zip Code 30303

Telephone 404-657-5681

Fax

Email Address dawne.morgan@dbhdd.ga.gov

III. State Expenditure Period

From 9/1/2015

To 8/31/2016

IV. Date Submitted

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

Submission Date 5/28/2015 11:47:44 PM

Revision Date

V. Contact Person Responsible for Application Submission

Title AMH Program Coordinator

Organizational Unit Name GA Department of Behavioral Health & Developmental Disabilities

First Name Jill

Last Name Mays

Telephone 404-657-2140

Fax

Email Address jill.mays@dbhdd.ga.gov

Footnotes:

I. State Information

Funding Agreement

FISCAL YEAR 2015

PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) AGREEMENT

I hereby certify that the State of Georgia agrees to the following:

Section 522(a)

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

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

Section 522(b)

Entities receiving grants under the PATH Formula Grant Program will expend funds for the following services:

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

Section 522(c)

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

Section 522(d)

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

Section 522(e)

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

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

Section 522(f)

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

Section 522(g)

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

Section 522(h)

The State agrees that:

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

Section 523(a)

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

Section 523(c)

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

Section 526

The State has attached hereto a Statement

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

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

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

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

Section 527(a)(4)

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

Section 527(b)

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

Section 527(c)(1)(2)

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

Section 528(a)

The State will, by January 31, 2016, prepare and submit a report providing such information as is necessary for:

- Securing a record and description of the purposes for which amounts received under the PATH Formula Grant Program were expended during fiscal year 2015 and of the recipients of such amounts; and
- Determining whether such amounts were expended in accordance with the provisions of Part C- PATH.

Section 528(b)

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

Appendix D – Agreements

FISCAL YEAR 2015

PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)

AGREEMENT

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needs of eligible homeless individuals who are both mentally ill and suffering from a substance abuse disorder.

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

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Section 522(f). Not more than 4 percent of the payments received under the PATH Formula Grant Program will be expended for administrative expenses regarding the payments.

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

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Section 527(a) (1), (2), and (3). The State has attached hereto a description of the intended use of PATH Formula grant amounts for which the State is applying. This description

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

Section 527(a) (4). The description of intended use for the fiscal year of the amounts for which the State is applying will be revised throughout the year as may be necessary

to reflect substantial changes in the programs and activities assisted by the State pursuant to the PATH Formula Grant Program.

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

Section 527(c) (1) (2). The services to be provided pursuant to the description of the intended use required in Section 527(a), have been considered in the preparation of, have been included in, and are consistent with the State Plan for Comprehensive Community Mental Health Services under P.L. 102-321.

Section 528(a). The State will, by January 31, 2016, prepare and submit a report providing such information as is necessary for:

- Securing a record and description of the purposes for which amounts received under the PATH Formula Grant Program were expended during fiscal year 2015 and of the recipients of such amounts; and
- Determining whether such amounts were expended in accordance with the provisions of Part C – PATH.

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

Section 529. Payments may not be made unless the State agreements are made through certification from the chief executive officer of the State.

Charitable Choice Provisions:

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

Nathan Deal

Governor

8-25-15

Date

Section 529

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

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Name	<input type="text" value="Nathan Deal"/>
Title	<input type="text" value="Governor"/>
Organization	<input type="text" value="State of Georgia"/>

Signature: Nathan Deal Date: 8-25-15

Footnotes:



STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Nathan Deal
GOVERNOR

May 12, 2014

Virginia Simmons
Attn: PATH Formula Grant (SM 12-F2)
Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health Services Administration
One Choke Cherry Road, Room 7-1091

Dear Ms. Simmons:

The Georgia Department of Behavioral Health and Development Disabilities (DBHDD), through its Division of Mental Health, has applied for the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant for federal fiscal year 2014. It is my understanding that DBHDD is Georgia's leading agency for the administration of these funds.

Georgia will continue to utilize the PATH funding as required in the Public Health Service Act as authorized under Section 521 through 535; to provide assertive outreach for individuals with serious mental illnesses designed to end homelessness. Staff at the Department's Division of Mental Health will continue to monitor fund utilization to assure maximum benefit to the citizens of Georgia impacted by homelessness and mental illness.

We appreciate the opportunity to submit this application, and look forward to continuing a cooperative relationship with SAMHSA and the Center for Mental Health Services.

Sincerely,

A handwritten signature in black ink that reads "Nathan Deal".

Nathan Deal

I. State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §92131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name

Frank Berry

Title

Commissioner

Organization

GA Department of Behavioral Health & Developmental Dis

Signature: _____

Date: _____

Footnotes:

I. State Information

Certifications

1. Certification Regarding Debarment and Suspension

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

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

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

Office of Grants and Acquisition Management
Office of Grants Management

3. Certifications Regarding Lobbying

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name	Frank Berry
Title	Commissioner
Organization	GA Department of Behavioral Health & Developmental Dis

Signature: _____ Date: _____

Footnotes:

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I. State Information

Disclosure of Lobbying Activities

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

Yes

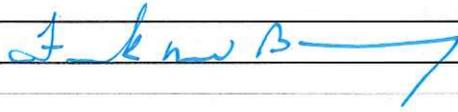
No

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

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

Name	Frank Berry
Title	Commissioner
Organization	GA Department of Behavioral Health & Developmental Disa

Signature:



Date:

2/19/2015

Footnotes:

I. State Information

State PATH Regions

Name	Description	Actions
Region 1	The Region One DBHDD Office plans and oversees a network of public mental health, developmental disabilities, addictive disease and prevention services for 31 counties. Counties in this region include: Banks, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fanin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Hart, Lumpkin, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, White, and Whitfield.	
Region 2	The Region Two DBHDD Office plans and oversees a network of public mental health, developmental disabilities, addictive disease and prevention services for 33 counties. Counties in this region include Baldwin, Barrow, Bibb, Burke, Clarke, Columbia, Elbert, Emanuel, Glascock, Greene, Hancock, Jackson, Jasper, Jefferson, Jenkins, Jones, Lincoln, Madison, McDuffie, Monroe, Morgan, Oconee, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Twiggs, Walton, Warren, Washington, Wilkes, and Wilkinson	
Region 3	The Region Three DBHDD Office plans and oversees a network of public mental health, developmental disabilities, addictive disease and prevention services for six counties. Counties in this region include Clayton, DeKalb, Fulton, Gwinnett, Newton and Rockdale.	
Region 4	The Region Four DBHDD Office plans and oversees a network of public mental health, developmental disabilities, addictive disease and prevention services for 24 counties. Counties in this region include Baker, Ben Hill, Berrien, Brooks, Calhoun, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Seminole, Terrell, Thomas, Tift, Turner, and Worth.	
Region 5	The Region Five DBHDD Office plans and oversees a network of public mental health, developmental disabilities, addictive disease and prevention services for 34 counties. Counties in the region include Appling, Atkinson, Bacon, Bleckley, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Clinch, Coffee, Dodge, Effingham, Evans, Glynn, Jeff Davis, Johnson, Laurens, Liberty, Long, McIntosh, Montgomery, Pierce, Pulaski, Tattnall, Telfair, Toombs, Treutlen, Ware, Wayne, Wheeler & Wilcox	
Region 6	The Region Six DBHDD Office plans and oversees a network of public mental health, developmental disabilities, addictive disease and prevention services for 31 counties. Counties in this region include Butts, Carroll, Chattahoochee, Clay, Coweta, Crawford, Crisp, Dooly, Fayette, Harris, Heard, Henry, Houston, Lamar, Macon, Marion, Meriwether, Muscogee, Peach, Pike, Quitman, Randolph, Schley, Spalding, Stewart, Sumter, Talbot, Taylor, Troup, Upson and Webster.	

Footnotes:

II. Executive Summary

1. State Summary Narrative

Narrative Question:

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

Footnotes:

II. Executive Summary

1. State Summary Narrative

The Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD), through its Division of Behavioral Health (formerly Division of Community Mental Health), Office of Adult Mental Health is submitting the annual application for the Projects for Assistance in Transition from Homeless (PATH) Program for federal fiscal year 2015. This application is made on behalf of Georgia to the Director of the Center for Mental Health Services, within the Substance Abuse and Mental Health Services Administration (SAMHSA) requesting the award of \$1,669,000 in federal funds, with a state match of \$556,333, for a total overall budget of \$2,225,333.

In Georgia, as many as 72,000 persons with mental illness may experience homelessness, and as many as 15,000 may experience chronic homelessness. DBHDD records show that 4,015 homeless persons accessed mental health services in FY2013. Of these, 3,902 were adults. In FY14, a total of 2,853 homeless adults received benefits from PATH funded services. Of those enrolled, 1,489 adults with serious mental illness or co-occurring disorders received ongoing community mental health services.

Contained within this application is an overview of the activities that the State proposes to support through the PATH Formula Grant Program. In addition, an Intended Use Plan for each PATH-funded organization is included. DBHDD uses these funds to contract with providers for the provision of outreach and case management services in those areas across the state that present the greatest need for homeless supports.

Georgia will continue to use these PATH federal funds to support assertive outreach for homeless individuals with serious mental illness who need assistance and are not pursuing mental health treatment and other entitlements on their own. The State PATH Contact and the staff in the DBHDD, Office of Adult Mental Health will continue to monitor fund utilization to assure maximum benefit to the citizens of Georgia impacted by homelessness and mental illnesses.

II. Executive Summary

2. State Budget

Planning Period From 9/1/2015 to 8/31/2016

* Indicates a required field

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

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

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

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

f1. Contractual (IUPs)	\$ 1,666,756	\$ 555,580	\$ 2,222,336	
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f2. Contractual (State)	\$ 1,666,000	\$ 556,333	\$ 2,222,333	
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Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	\$ 1,666,000	\$ 556,333	\$ 2,222,333	Provider IUPs

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

i. Total Direct Charges (Sum of e-h)	\$ 3,332,756	\$ 1,111,913	\$ 4,444,669	
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Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
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j. Indirect Costs (Administrative Costs)	\$ 3,000	\$ 0	\$ 3,000	
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k. Grand Total (Sum of i and j)	\$ 3,335,756	\$ 1,111,913	\$ 4,447,669	
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Allocation of Federal PATH Funds	\$ 1,669,000	\$ 556,333	\$ 2,225,333	
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Source(s) of Match Dollars for State Funds:

II. Executive Summary
2. Budget

Organization Name:	Organization Type:	PATH Federal Funding Amount	PATH State Match Funding Amount	PATH Total Funding Amount	Service Area Counties:	PATH Funded Service(s)	# Proposed Outreached # literally homeless	# Proposed Enrolled
1. Serenity Behavioral Health Services	Public, non-profit, mental health agency	\$ 149,800	\$41,681.70	\$191,481.70	Richmond	-Outreach -Case Mgt	285 271	216
2. Behavioral Health Services of South Georgia.	Public, non-profit, mental health agency	\$ 150,800	\$40,361.70	\$191,161.70	Lowndes, Tift, Cook	- Outreach -Case Mgt	120 60	60
3. Community Friendship, Inc.	Private non-profit, mental health agency	\$156,800	\$59,659.70	\$216,459.70	Fulton/ DeKalb	-Outreach -Case Mgt	240	120
4. Hope Atlanta **	Public, non-profit	\$305,716.05	\$101,905.35	\$407,621.40	Fulton /DeKalb, Cobb/ Douglas	-Outreach -Case Mgt	475 356	300
5. Community Advanced Practice Nurses, Inc.	Public, non-profit, mental health agency	\$166,800	\$64,361.70	\$231,161.70	Fulton/ DeKalb	-Outreach -Case Mgt	170 170	156
6. Fulton-DeKalb Hospital Authority (Grady Health Systems)	Public, non-profit, health care agency	\$130,800	\$45,761.70	\$176,561.70	Fulton/ DeKalb	-Outreach -Case Mgt	260 230	182
7. St. Joseph Mercy Care	Private, non-profit, health care agency	\$255,800	\$107,361.70	\$363,161.70	Fulton/ DeKalb	-Outreach -Case Mgt	590	180
8. New Horizons Community Service Board	Public, non-profit, mental health agency	\$177,800	\$52,261.70	\$230,061.70	Muscogee	-Outreach -Case Mgt	350 280	244
9. Chatham-Savannah Authority for the Homeless	Public, non-profit local governing authority	\$166,800	\$47,861.70	\$214,661.70	Chatham	-Outreach -Case Mgt	328 295	229
GA DBHDD,	State Gvt	\$3,000	\$0	\$3,000	Statewide	-Admin.	NA	NA

Division of Behavioral Health								
2013 PATH Funding	Public/ Private & Non-Profit	\$1,669,000	\$556,333	\$2,225,333	10 Counties	-Outreach -Case Mgt	3,358 2,650 (79%)	2,290

** Hope Atlanta (formerly known as Traveler's Aid) numbers for budget, proposed outreach, # literally homeless and # proposed enrolled reflect numbers for two teams, Region 3 Team serving Fulton and Dekalb counties and Region 1 Team serving Cobb and Douglas Counties.

Footnotes:



WebBGAS Offline

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Thank you for your patience.

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Help Desk Number: 1-888-301-BGAS(2427) | Help Desk Email: BGASHelpDesk@samhsa.hhs.gov



Community Friendship, Incorporated
85 Renaissance Parkway, NE
Atlanta, GA. 30308
(404) 875-0381

1. Local Provider Description.

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 \$156,800 in Federal PATH funds and \$59,659.70 in State Match funds totaling \$216,459.70 to support PATH services. A detailed budget is included with this application.

2. Collaboration with HUD Continuum of Care (CoC) Program.

Community Friendship Inc. PATH team is an active member and participant in the City of Atlanta Continuum of Care (CoC) Program. Community Friendship Inc. Executive Director has been a City of Atlanta CoC Rank and Review committee member for the past 2 years. Community Friendship Inc. current active involvement includes: participation in bi-monthly CoC meetings, participated in the annual homeless census count, coordinated outreach with the Interim Executive Director of Atlanta Homeless Continuum of Care, participated in several planning sessions with Regina Cannon Senior Program Manager, CSH. Future participation will also include Dekalb and Fulton County CoC meetings. CFI homeless outreach team will conduct street outreach weekly in Fulton County, Dekalb County and the city of Atlanta.

The Homeless Mental Health Team (HMHT) 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, Atlanta Police Department, shelters, and area hospitals. Street outreach will take place in Dekalb and Fulton County.

3. Collaboration with Local Community Organizations.

The HMHT works in coordination with other providers of community services, such as Grady ACT Team, First Presbyterian Church, Atlanta's Women's Day Shelter, Central Presbyterian, 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.

CFI'S HMHT links PATH clients to St. Joseph's Mercy Care mobile coach van to "obtain on the spot" health care services every other Wednesday. For instance, the case manager might assist a consumer in obtaining mental health treatment services from Grady Health System, Fulton County Mental Health, Northside Community Mental Health, Serene Reflections and the Georgia's Mental Health Consumer Network (consumer support). In addition, the PATH case managers collaborate with Welcome House, Adams House, Caring Works, Quest Communities and identified apartment complexes throughout metro Atlanta for housing.

Substance abuse treatment partners include: St Judes Recovery Center and Dekalb Crisis Center.

Employment partners to assist clients with job training and placement include CFI Work Opportunity Department and Georgia Works.

4. Service Provision.

- 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 currently includes (1) Case Manager and one (1) full-time Certified Peer Support Case Manager to provide street outreach and visits various shelters located in downtown Atlanta. We currently have 1.5 case management positions open for hire. 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 conduct early morning outreach starting at 6:00am. The team also participates in early morning outreach with our collaborating PATH team partners.

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 not only needing the coordination of mental health services to full array of bio-psycho-social needs. PATH staff will assist homeless individuals with filing claims by linking them to dedicated DBHDD Medicaid Eligibility Specialists. It is the goal of PATH Case Management team to successfully transition clients into mainstream mental health services.

CFI's PATH Case Management Director and Assistant Director play an intricate part with planning and coordinating several Region 3 Outreach functions to include: weekly

scheduling of Region 3 PATH collaboration meetings, locating space for meetings, locating guest speakers, liaison between Region 3 PATH teams and BH Regional Service Administrator, Organizers for communication amongst the Region 3 PATH teams, 5am early outreach and 11:00 pm airport outreaches for all metro PATH teams, HOPE Officers and the Atlanta Police Department inside the Hartsfield Jackson Airport on a bi monthly basis. Collected/calculated/submitted outreach statistical data to Hartsfield-Jackson Airport police Captain Shepherd and Planning and Development Specialist with DBHDD. In addition, played a key role in supporting the new Interim Executive Director of the City of Atlanta CoC by providing an introduction to all Metro Atlanta PATH teams and assisted with Atlanta homeless count work sessions.

- 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 long term 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. 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 Positive Impact and Serene Reflections. The Georgia Mental Health Consumer Network provides Double Trouble peer support self-help groups to individuals with co-occurring mental illness and substance abuse.

- 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) Intensive Case Management (ICM) and 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.
 - 6) 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 Whole Health Action Management (WHAM) and Peer Specialist training certification process.

5. Data.

CFI is an active member of Georgia's HMIS known as Pathways. CFI participates in HMIS training activities and conference calls. CFI also has an agency Pathways administrator.

- All services and case notes are maintained in CFI's Pathways HMIS system.
- Clinical services are not provided within the Pathways HMIS system.
- CFI uses Pathways HMIS system only at this time.
- All new staff are required to attend Pathways trainings that include: confidentiality, new user training and data compliance.

6. SSI/SSDI Outreach, Access, Recovery (SOAR).

CFI's Homeless Mental Health Team (HMHT) did not have any trained SOAR staff during 2013-2014. However, staff successfully connected homeless individuals to receive benefit through Peter Ward and Sherry McGlowin who are the Medicaid Eligibility Specialists with DBHDD.

7. Access to Housing.

CFI's Homeless Mental Health Team (HMHT) has access to the residential services using various hotels and assessment beds for 30 – 90 days (dependent on available resources and client's situations) as short-term alternatives until more permanent options become available. The Savannah Suite is often used and in close proximity to CFI which provide PATH staff the opportunity to encounter PATH clients on a daily basis to assess their immediate needs. 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, Phoenix House, and Presley Woods Apartments. In addition, the HMHT refers clients to Welcome House Shelter Plus Program, Living Room (if they are HIV positive), Atlanta Housing Authority, Georgia Housing Voucher Program, and Hope Atlanta. 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 and Georgia Housing Voucher Program.

8. Staff Information.

- 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	4	2	2	0	0	4	1

***Note: CFI PATH is in the process of hiring a part time and full time staff.**

- 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 to include age, gender, disability, lesbian, gay, bi sexual, transgender, racial/ethnic. . 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.

9. Client Information.

- 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 65% male and 35% female; 86% African American; 67% between the ages of 35-49; 87% living on the streets or short-term shelter upon initial contact; primary diagnoses including 29% schizophrenia, 28% affective disorders, 35% other SMI; and 29% reporting co-occurring substance use disorders.
- b. Projected Service Expectations for SFY 2015 - 7/01/15 to 6/30/16:
 - 1) Contractor shall identify and have contact with at least **240** individuals who are homeless and mentally ill in PATH funded Outreach. (Previous Fiscal Year was 100).
 - 2) Contractor shall enroll at least **120** individuals who are homeless and mentally ill in PATH funded Case Management. (Previous Fiscal Year was 96).

10. Consumer Involvement.

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 Certified Peer Specialist and Whole Health Action Management who has experienced homelessness. The team’s CPS is also a Certified Addiction Recovery Empowerment Specialist. (CARES)

DBHDD Region 5
CHATHAM-SAVANNAH HOMELESS AUTHORITY
761 Wheaton Street
SAVANNAH, GEORGIA 31401
PH: (912) 790-3400 FAX: (912) 790-3403

- 1. Local Provider Description-**Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.

Established by the Georgia State Legislature more than 25 years ago, the Chatham-Savannah Authority for the Homeless (Homeless Authority) is a private, non-profit 501C3 organization created to provide a central planning and coordinating effort to address homeless needs and services. This particular PATH program is designed to encompass a sixteen-county area and is served by the DBHDD Region 5 Office. However, the focus of service will be on the behavioral health issues of families and individuals experiencing homelessness within Chatham County (Region 5), since Savannah has one of the largest concentrations of individuals experiencing homelessness outside of Metro Atlanta. CSAH will receive \$228,225 in PATH funds.

- 2. Collaboration with HUD Continuum of Care Program-**Describe the organization's participation in the HUD Continuum of Care program and 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 to address the needs of the homeless, including planning, collaborating, identifying gaps in services, and addressing ways to close those gaps. CSAH, 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 City's Housing and Community Development Plan, the agency is charged with all aspects of planning, service delivery coordination, and certain other roles such as evaluation and monitoring, advocacy, education, and resource development. CSAH is the Continuum of Care lead agency; it collaborates with the agencies that are the providers of behavioral health services and provides some transportation for clients enrolled in behavioral health programs. CSAH administers the PATH grant, and all case management staff of the agency is out-stationed at predetermined Continuum of Care organizations. The five peer specialists on the PATH team are also out-stationed at predetermined Continuum of Care sites including Emmaus House, Inner City, Savannah Baptist, Old Savannah City Mission, and the Social Apostolate. Since 2004, all Continuum of Care organizations were linked to a Homeless Management Information System called Pathways. The PATH team is required to maintain data on consumers through the Pathways Communication Network, the statewide Homeless Management Information System.

3. **Collaboration with Local Community Organizations**-Provide a brief description of partnerships with local community organizations that provide key services (i.e., primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients and describe coordination of activities and policies with those organizations.

The PATH Team collaborates with multiple agencies in Savannah to provide key services to PATH enrolled clients. Each of these agencies works 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 (ICM);
- J.C. Lewis Health Center of Union Mission for medical and dental needs;
- Union Mission, Inc. (No Wrong Door and permanent supportive housing)
- Housing Authority of Savannah and Union Mission, Inc. for permanent supportive housing;
- Georgia Regional Hospital for access into Assertive Community Treatment for those with the most intensive needs.
- Coastal Harbor for crisis stabilization and discharge planning for homeless consumers
- Memorial Health University (Clark Center) for behavioral health
- AmericanWork (ACT I and Chatham ACT)
- Savannah Justice Law Center (SJLC) which assists in acquiring birth certificates so that consumers can obtain proper identification, i.e., Georgia ID card
- Union Mission, Department of Labor, and Goodwill for employment services

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

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

PATH utilizes an outreach team to go into the streets and homeless shelters to identify individuals experiencing homelessness with mental illness, engage them in treatment, and connect them to mental health services and mainstream resources needed to end their homeless cycle. In order to maximize the use of PATH funds to serve adults who are literally and chronically homeless as a priority population, PATH funds a six-person team composed of a full-time Mental Health Professional (MHP) team leader (with blended HUD and PATH funding) and five peer-to-peer specialists to provide **Outreach** and **Case Management** services. This team locates the hardest-to-reach individuals with a primary diagnosis of Mental Illness through mobile and fixed Outreach sites which

include the Salvation Army and Inner City Night Shelters, the Social Apostolate, Emmaus House, Savannah Baptist Center and Old Savannah City Mission-four 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 a willingness to accept services, they are then enrolled in PATH funded *Case Management* which assists with meeting basic needs, accessing housing, and linking to ongoing mental health and substance abuse treatment. 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).

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

Gaps in services include crisis services for those 1) experiencing behavioral health issues, 2) short-term respite care, 3) the availability of resources on the weekends, and the 4) shortage of affordable, safe, permanent supportive housing for women and families. Additionally, housing for homeless persons with sex offenses and/or felonies is limited. In May, FY'14, the State expanded crisis services in Savannah to include a new 16-bed Crisis Stabilization Program and a 6-bed respite at Gateway Community Services that provides 30 day respite for stabilization to assist in addressing the crisis needs in Savannah. The PATH team is actively collaborating with these services to reduce service gaps.

- Provide a brief description of the current services available to clients who have both a serious mental illness and a 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 and Peer 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. CSAH combines counseling, rehabilitation, self-help and ongoing support as a treatment strategy for PATH clients with co-occurring disorders.

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

Yes, the provider provides, pays for, or otherwise supports evidence-based practices and other training for local PATH-funded staff including:

- Double Trouble in Recovery (DTR) self-help groups for individuals with co-occurring mental illness and substance use disorders.

- Psychosocial Rehabilitation (PSR) which addresses the level of community functioning needs for those with mental health and substance use disorders.
- SOAR training to expedite access to mainstream benefits.
- Assertive Community Treatment (ACT)
- Peer Support

The PATH team is required to maintain data on consumers through the Pathways Communication Network, the statewide Homeless Management Information System. Since 2004, the local Continuum of Care has been linked to the Homeless Management Information System (PATHWAYS) and PATH team members have been entering the data in Pathways since 2011. Each week, PATH team members are required to enter their client level data into Pathways, including number of persons contacted, number of times persons were contacted, number of persons engaged and the engagement rate. The PATH team lead is required to review and maintain data on consumers in the system. The agency HMIS specialist regularly runs reports and reviews the data to ensure that any errors, etc. are corrected. This ensures that quality data is in the system to adequately assess the effectiveness of the program.

- 5. Data-**Describe the provider's status on HMIS (Pathways) transition plan with accompanying timeline, to collect PATH data by fiscal year 2016. If providers are fully utilizing HMIS (Pathways) for PATH services, please describe plans for continued training and how providers will support new staff.

Activities to facilitate the use of Georgia's HMIS system PATHWAYS are already in place. Since 2004, the local Continuum of Care has been linked to the Homeless Management Information System (PATHWAYS) and PATH team members have been entering the data in Pathways since 2011. Each week, PATH team members are required to enter their client level data into Pathways, including number of persons contacted, number of times persons were contacted, number of persons engaged and the engagement rate. The PATH team lead is required to review and maintain data on consumers in the system. The agency HMIS specialist regularly runs reports and reviews the data to ensure that any errors, etc. are corrected. This ensures that quality data is in the system to adequately assess the effectiveness of the program. The PATH team participates in the mandated annual trainings for the HMIS system and any other training offered by the HMIS provider. When hired, new staff is immediately trained on the system and completes New User and Confidentiality training right away. Their usage of the system is carefully monitored, and they also follow the normal HMIS training schedule throughout the year.

- 6. SSI/SSDI Outreach, Access, Recovery (SOAR)-**Describe the provider's plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR during the grant year ended in 2014 (2013-2014), and the number of PATH funded consumers assisted through SOAR.

CSAH already has a number of staff trained on SOAR, including both regular case management and PATH peer specialists. Two PATH staff were trained in SOAR during the grant year ended 2013, the PATH team lead and one certified peer specialist. Five PATH

funded consumers were assisted through SOAR. SOAR on-line training is now available and CSAH will take advantage of it. Also, a community collaborative partner plans to train additional staff on SOAR and provide those services locally.

7. **Housing**-Indicate what strategies are used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).

The PATH team now meets and will continue to meet 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 necessary appointments, 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. **Dutchtown** is a permanent supportive housing project. **Georgia Housing Voucher Program (GHVP)** vouchers are also utilized to provide housing for program participants. 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.

Frequently, PATH enrolled clients would be able to access stable housing, but they lack the financial resources to do so. An increase in case management funds will be utilized to provide direct assistance to clients; these funds will be designated to provide security deposits for utilities, rental assistance, and motel nights for crisis situations. Based on assistance criteria, PATH enrolled clients will be able to tap these funds in order to access and/or maintain stable housing.

8. **Staff Information**-Describe the demographics of staff serving the clients; how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients; and the extent to which staff receive periodic training in cultural competence and health disparities. A strategy for addressing

health disparities is use of the recently revised national Culturally and Linguistically Appropriate Services (CLAS) standards: (<http://www.ThinkCulturalHEALTH.hhs.gov>).

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	#Hisp	# MH Consumers
Savannah	6	1	5	1	4	1	4

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. CSAH promotes cultural diversity and provides cultural competence training to all employees. Free interpreter services are available for those who do not speak English. CSAH evaluates performance satisfaction using consumer and family satisfaction surveys, including the level of satisfaction with staff sensitivity to cultural background. The organization supports community representation with employed mental health consumers operating as direct care staff.

CSAH and the J.C. Lewis Health Center routinely provide clinical training for case managers and behavioral health staff, which includes a mandatory diversity workshop to heighten awareness and increase staff effectiveness as it relates to service to protected classes. J.C. Lewis Health Center and Curtis V. Cooper Community Care, collaborative community partners, address health disparities by using the recently revised CLAS standards.

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

Chatham-Savannah Authority for the Homeless is located in Savannah, GA, which is the fourth-largest city and the sixth largest county in the state. The demographics of those enrolled in PATH services(client population) 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.

- a. **Projected number of adult clients to be Contacted:**
 - Outreach Contacts: Contractor shall identify and have contact with at least 328 individuals who are homeless and mentally ill in PATH funded Outreach.
- b. **Projected number of adult clients to be enrolled in PATH Case Management:**
 - Contractor shall enroll at least 229 clients who are homeless and mentally ill in PATH funded Case Management.
- c. **Percentage of adult clients served with PATH funds projected to be “literally” homeless (i.e., living outdoors or in an emergency shelter rather than imminent risk of homelessness):**

- This provider projects that 90% of the annual, unduplicated total will self-report or will be certified as “literally” homeless.

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

The Homeless Authority Board of Directors is constructed to include representatives of local and state government, as well as advocates, providers of service, and homeless or formerly homeless consumers. Consumers have been hired to provide peer support services after participating in an extensive training program; two have passed a certification process.

11. Budget narrative-Provide a budget narrative that includes the local-area provider’s use of PATH funds.

**Proposed PATH Annual Budget
State FY 2016**

CHATHAM-SAVANNAH AUTHORITY FOR THE HOMELESS

1. Personnel Costs	Annualized	PATH	PATH
Positions	Salary	FTE	Salary
Mental Health Professional	\$45,000	1.0 FTE	\$45,000
Certified Peer Specialist	\$26,800	1.0 FTE	\$26,800
Peer to Peer Specialist	\$26,400	1.0 FTE	\$26,400
Certified Peer Specialist	\$26,000	1.0 FTE	\$26,000
Peer to Peer Specialist	\$25,000	1.0 FTE	\$25,000
Peer to Peer Specialist	\$23,900	<u>0.5 FTE</u>	<u>\$ 5,416</u>
		5.5 FTE	
			\$154,616
2. Fringe Benefit Costs (@25%)			\$38,654
3. Transportation Costs			
Vehicle Operation & Personal Mileage			\$ 6,500
4. Training Costs			\$ 2,402
5. Program Supply Costs			\$4,000
Cell phones @ \$300/month		\$ 3,600	
Office Supplies (folders, paper, ink)		\$ 400	
6. HMIS Data Collection/Management			\$750
1) ¼ of annual Pathways HMIS User Fee		\$ 250	

2) ¼ of estimated internet fees	\$ 500	
7. Housing Coordination Funds		\$1,300
-Emergency Rental Assistance	\$800	
-Bus Passes	\$500	
8. Administrative Costs		<u>\$6,440</u>
	GRAND TOTAL:	\$214,662

2016 Local Provider Intended Use Plan

Mercy Care
424 Decatur Street, SE
Atlanta, GA 30312
(678) 843-8500

Local Provider Description:

Since 1985, Mercy Care has provided 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, Mercy Care 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. Mercy Care serves DBHDD's Region 3 (Fulton, DeKalb, Gwinnett, Clayton, Rockdale, and Newton counties).

Mercy Care 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 Mercy Care 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.

Mercy Care will receive \$366,544.00 in PATH funds for Case Management and Outreach. A detailed program budget is included.

Collaboration with HUD Continuum of Care Program

There is attendance and participation in the new Atlanta Continuum of Care. Mercy Care staff members also participate in the Metro Atlanta Homeless Census Count of homeless persons in the metro area. Other coalitions and task forces in which agency staff participate include the following: weekly PATH Collaborative meetings, the Homeless Provider Network, the Pathways User Group, quarterly provider meetings sponsored by DBHDD, and the Georgia School of Addiction Studies (also holds a position on the board).

Collaboration with Local Community Organizations

For services beyond its scope, Mercy Care refers clients to other agencies with which it has formal and informal agreements. These include, but are not limited to Grady Health System, the Living Room, Fulton County Department of Health and Wellness, Georgia Law Center, Georgia Department of Family and Children Services, Legal Clinic for the Homeless, HOPE Atlanta (Traveler's Aid of Metropolitan Atlanta), QUEST

Development Organization, and the Georgia Crisis and Access Line. Participation also in community events; Arts in the Garden, Substance Abuse/ Mental Health Awareness events, and Healthcare for the Homeless activities. Mercy Care works in concert with several agencies in early morning collaborative outreach events and other impactful activities to reach PATH targeted populations.

Service Provision

(A.) PATH funds will be used to provide outreach and case management services that will have a meaningful impact on the consumers we service. Case Managers will utilize their relationships developed in key community areas/programs that service PATH appropriate consumers. Providing outreach and case management inside and outside the traditional four walls to the chronically homeless in the places where they are known to congregate including the streets, parks, shelters, soup kitchens, drop in centers, as well as near other provider agencies. To maximize efforts, staff will work closely with numerous local organizations including PATH Collaborative, the City of Atlanta Police Department, the Fulton County Police and Fire Departments, and others – all agencies which are also in regular contact with the homeless and are knowledgeable of their patterns and locations.

Staff will educate clients about Mercy Care resources and provide referrals to various sources for immediate care including Mercy clinic sites for health needs. Other referrals may include available sources for behavior health, food, shelter and clothing. Staff will also help address basic needs by providing hygiene kits, incentives (socks, blankets, coats, bottled water, etc.) and/or MARTA Breeze cards. Individuals will also receive “easy to carry” cards with printed information about Mercy Care programs, services and contact information.

Any individual who has a suspected mental illness that is either self-reported or observed, and is currently homeless or at immediate risk of homelessness, will be considered appropriate for enrollment into PATH services. The Outreach team will utilize behavior modification and motivational interviewing techniques including the distribution of incentive items, to encourage individuals to complete required tasks such as following up with an assigned Mental Health Specialist.

A referral will then be given to the Mental Health Specialist for further follow-up. The Mental Health Specialist will obtain authorization, social security and birth date information, input the data into the Pathways HMIS, and will determine if the client has been seen previously at Mercy Care for other services.

Case Management - Within seven days of receiving the referral, the Mental Health Specialist will begin the intake process into PATH services. The Mental Health Specialist will complete the Eligibility Screening and Needs Assessment form while interviewing the client during the initial intake visit. Also during this visit, the Mental Health Specialist will develop the client’s Individualized Recovery Plan (IRP). Included in the IRP are goals and objectives developed jointly by the Mental Health Specialist and the client, with the focus on achieving self-sufficiency by building on the client’s

strengths within a timeframe of 3 to 6 months. The goals will normally be listed as a direct quote from the client to indicate the clients' level of participation in their development. The objectives will typically be built on the client's strengths in an effort to complete tasks that are within the client's abilities. Mental Health Specialists will help focus the client's goals on areas such as obtaining affordable housing, following up consistently with mental health/substance abuse needs, and increasing income. Mental Health Specialists will also utilize behavior modification through a reward system whereby when a client achieves a goal or steps toward goal achievement, he/she will receive a reward, i.e. a gift card to purchase housing supplies, assistance with rent or tickets to a local cultural event, as possible.

The Mental Health Specialist will assess the client for any medical concerns, and refer the client into the Mercy Care system of care as appropriate. The Mental Health Specialist will also refer the client to other organizations when it cannot directly meet an individual's needs. The Mental Health Specialist will support the client in following up on referrals by arranging transportation, accompanying the client to appointments, and assisting the client with required applications as needed. The Mental Health Specialist may also assist the client with financial planning, developing independent living skills, and monitoring the client's symptoms around mental illness/substance abuse to ensure that the client is remaining healthy and consistent.

The Mental Health Specialist will maintain contact with the client at least weekly to ensure that he/she is making progress toward the identified goals. During those visits, the Mental Health Specialist will document in the agency's new internal electronic record, EPIC, the specific goal discussed and the client's progress toward its achievement. The Mental Health Specialist will also document an initial general progress notes within the Pathways system.

(A.) A discharge summary will be completed fourteen days after the client's discharge from the program. The client will also be discharged from Pathways at this time. This will allow for confirmation of client's successful transition into housing and a smoother hand off to supportive housing programs.

Case Management services will take place at five community-based sites that are all easily accessible and commonly visited by the homeless: Atlanta Mission, Open Door Community, St. Luke's Episcopal Church, the Gateway 24/7 Homeless Services Center, and City of Refuge/Eden Village. Case management will expand to additional outreach service providers that are in need of engagement and resources to their homeless population.

Gaps

(A.) It has been a long concern of the state's current mental health system that has included lengthy delays in getting individuals admitted into state hospitals or other behavioral health facilities. These issues are made worse by budget cuts and increased demands. These deficiencies have an even greater impact on the homeless population because most do not have access to insurance, including Medicaid.

Access to substance abuse treatment is often a function of income, race and geography. While there are reportedly numerous substance abuse treatment programs in the metropolitan/Atlanta area, programs vary considerably regarding types of treatment modalities, availability of medical care, treatment philosophy, cost, length of stay and other variables.

Highly limited mental health and housing resources for non-legal residents of the country that have mental health and medical needs.

Resources for emergency beds (men, women, and women with children) throughout the year are vital. These beds allow time to work with a consumer while providing stability and the ability to monitor motivation and consistency.

Increased need for MARTA transportation resources.

Limited resources to create basic “Welcome Home” baskets for newly housed consumers with no income whom are pending benefits or employment.

(B.) The Mental Health Case Management program is also closely coordinated with the agency’s substance abuse services. Individuals with dual diagnosis concerns have the opportunity to be connected with Mercy Care outpatient Behavior Health and Substance Abuse groups and individual therapy. Client’s participation in dual diagnosis groups helps them to gain a better understanding of their illness and master coping strategies. Substance abuse assessments are conducted by Mercy Care clinic staff, and when appropriate, referrals are made for counseling and/or treatment. Mercy Care currently has agreements with ten local substance abuse providers to provide residential treatment services to its patients upon referral. On a case-by-case basis, Mercy Care uses available grant funding to pay for up to two months of treatment. Mercy Care Substance Abuse Specialist follows up with the referral agency on a weekly basis regarding the patient’s progress and continued compliance. Consumers are also connected to other treatment facilities where upfront funding is not required such as St. Jude’s Recovery Program.

(C.) Case Management staff are exposed to several free and paid trainings to support their multifaceted work with consumers. Some of the trainings have included Trauma Informed Care, MH & SA Services, Cultural Competence, Defining Appropriate Boundaries, specialized CMTA Case management trainings, BECK Training-Cognitive Behavior Therapy, Motivational Interviewing, VI SPDAT, and CARES (Peer Support) trainings. During each enrollment of a new consumer the system assessments of Barriers To Housing, PATH Enrollment, and VI SPDAT are completed. Case and Service notes are entered to clearly identify the PATH team servicing the consumer that users may review, thus reducing duplication of service. PATH discharge assessment of client’s placement, service connections, etc. will also be completed upon consumer transition from PATH services. In Case Managers entering the data, obtaining reporting

data will be possible. Staff attendance to HMIS meetings with PATH providers discussing updates in the system, webinar trainings, etc. have been accomplished.

Data

Mercy Care is on course with full utilization of HMIS system by each of its PATH Case Management staff. Case Management services will complete updates on Confidentiality and New User training as needed to remain compliant and up to date with procedures of the PATHWAYS system. New staff completes online training in the HMIS-PATHWAYS system and hands on support from seasoned PATHWAYS users. Review of new staff entries, clarifications of use, etc. will be performed by the Team Lead. Further trainings that are required by PATHWAYS will receive full participation by staff.

SSI/SSDI Outreach, Access, Recovery (SOAR)

New staff will be referred for SOAR training to help familiarize them with the process and benefit of the service. Number of staff trained by the end of the grant year (‘2014) was one. The remaining team members were previously trained in SOAR. Case Managers referred consumers to First Step (before the ending of its contract) and to Region 3 Medicaid Specialist for benefits assistance. Clients that were pending or in appeals (before enrollment into case management) for benefits were monitored, as they had legal representation assisting their cases.

Housing

Due to the changes that are occurring in our region as to how we identify and organize the most vulnerable in the community. Many PATH housing referrals will be based on VI SPDAT scoring and availability. Mercy Care has established Memoranda of Understanding with Quest Community Development. Transitional beds for Mercy Care male clients have been set aside in exchange for providing Case Management services specifically for referred clients. Consumers are referred to several supportive housing resources including; Caring Works, Community Friendship Incorporated, and the Georgia Housing Voucher Program. Use of fair market rate housing and senior housing (Baptist Towers, Maggie Russell, Peachstone, etc.) are also utilized for consumers that meet specified qualifications by the housing provider:

Staff Information:

Provider	# of PATH Staff	# Females	# Males	# Caucasian	# African-American	# MH Consumers
Mercy Care	5	2	3	0	5	0

Mercy Care has an over 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, Mercy Care 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.

All staff members are required to participate in an annual cultural competency training sponsored by Mercy Care. In addition, various continuing education sessions are routinely coordinated and offered by Mercy Care as well as by partners and vendors. These trainings enhance Mercy Care employees' (particularly new employees) understanding of the uniqueness of the homeless individual. Newly hired employees participate in several presentations upon their start at Mercy Care. One of those presentations focuses on client centered services which includes cultural sensitivity awareness. Staff also has access to a language line for those consumers whose primary language is not English. It is the practice of Mercy Care to reverence cultural diversity with the population we serve and of those that are providing the service.

Client Information

Projected number of clients to be Outreached: 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. Projected number adult clients to be enrolled in PATH Case Management: Contractor shall enroll at least 180 individuals who are homeless and have a mental illness in PATH-funded Case Management Services throughout the contract period.

Percentage of adult clients served with PATH funds to be "literally" homeless: SJMCS anticipates that of those served during the contract period, approximately 75% will be "literally homeless".

Consumer Involvement

Mercy Care maintains an agency-wide Client Advisory Committee (CAC) 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 Mercy Care Board meetings. In turn, the Board uses this input to improve upon and/or implement needed services. Staff also present at the CAC to share processes, feedback, and clarity regarding case management 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 Mercy Care Quality Assurance Manager, who in turn compiles the data and provides monthly performance reports to staff.

Budget Narrative

Proposed State FY 2016 Annual PATH Budget

I. Personnel Costs

Positions	Annual Salary	PATH FTE	PATH Salary
Case Management Coordinator – K. Arnold	\$65,833	0.5	\$65,833
Mental Health Specialist – R. White, Sr.	\$36,046	1.0	\$36,046
Mental Health Specialist – D. Crockett	\$39,780	1.0	\$39,780
Sr. Mental Health Specialist – A. Johnson	\$35,707	1.0	\$35,707
Mental Health Specialist- L. Hampton	\$36,810	.60	\$27,289
Sr. Mental Health Specialist – D. Al- Amin	\$33,033	1.0	\$33,330
	\$37,340	1.0	\$37,340
		Subtotal	\$275,028

II. Fringe Benefit Costs

25% includes FICA, health, dental and life insurance, pension plan, disability insurance, worker's compensation

Subtotal \$68,757

III. Transportation Costs

Parking	\$1,200
Mileage Reimbursement	\$486
Van Maintenance and Fuel	\$1,688
Subtotal	\$3,374

IV. Training Costs

Seminars	Subtotal \$1,050
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V. Housing Coordination Costs

Client Assistance	Subtotal	\$1,708
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VI. Program Supply Costs

Office Supplies		\$750
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Computer Maintenance		\$0
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Cellular Phones		\$1600
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Subtotal		\$2,350
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VII. Administrative Costs

Administrative Costs – 3% of Award	Subtotal	\$10,895
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TOTAL		\$363,162.00
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PATH Funds		\$363,162.00
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Matching Funds		\$0
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Serenity Behavioral Health Systems
3421 Mike Padgett Hwy
Augusta, GA 30906
(706) 432-7923
Intended Use Plan FY2016

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

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 region 2; 7 counties in east central Georgia: Richmond, Columbia, McDuffie, Wilkes, Lincoln, Warren and Taliaferro. We have clinics located in Augusta, Thomson and Washington. The PATH program operates out of the Augusta site. This PATH program shall receive \$143,611.28 in PATH Federal funds and \$47,870.42 in State Match funds totaling \$191,481.70 to support PATH services. A detailed program budget is attached.

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

PATH staff attends 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. At least one staff member serves on the Housing Committee.

3. Collaboration with Local Community Organizations- Community 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 for the purpose of housing or immediate shelter. We coordinate with Augusta Area Ministries Council, Antioch Ministries, First Baptist Church of Augusta, and Beulah Grove Baptist Church Community Center, Catholic Social Services, Church of the Good Shepherd and Faith Outreach Christian Center, Golden Harvest Food Bank, Goodwill Industries, GAP Ministries, Interfaith Hospitality Network for the purpose of introducing our individuals to food and furniture

banks. We coordinate with Caring Together and More, Inc. for payee services for our individuals. We also, coordinate with Serenity Behavioral Health Systems, Behavioral Health Link for mental health services. For our individuals with legal issues or concern we coordinate with Georgia Legal Services. 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 (housing and medical), Walton Community Service, Department of Family and Children Services, East Central Regional Hospital, Georgia Health Sciences Health Services, University Hospital for medical needs. We coordinate with Augusta Richmond County Government, Georgia Department of Labor for employment services.

4. Service Provision- Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients:

- 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 his/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, every Monday at the

Department of Labor from 8:30- 10:30, every Tuesday at The Salvation Army from 3:00- 5:00 and they are located at Garden City Rescue Mission every Wednesday from 3:00 - 5:00.

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.

- **Gaps that exist in the current service system:**

- a. Housing for homeless persons with sex offenses and/or felonies is very limited.
- b. Shelters for females (non-domestic violence) are limited.
- c. Shelters for families with male children over the age of twelve
- d. Employment opportunities suitable for those with disabilities and felonies still have gaps.
- e. Not having enough staff members. The homeless population seems to be growing in our area. Our current PATH team cannot always effectively serve the individuals thoroughly for being stretched between outreaching, transporting and assisting them with their goals. The duties could be shared easier with an additional member to the team.

- **Services available to for clients with Co-occurring needs:**

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. The women in our Project are referred to Hope House. In addition, the PATH program provides information to individuals about community based self-help recovery options such as Double Trouble, AA and NA.

The extent to which the staff receives periodic training on cultural competence:

Serenity Behavioral Health Systems promotes cultural diversity and offers cultural competency training to all employees including PATH staff. 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.

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.

HMIS Activities: PATH funds will be used in creative ways such as Homeless resource fairs to engage individuals through outreach to obtain and report useful information through HMIS PATHWAYS. This agency will explore flexible uses of PATH administrative funds to support HMIS activities

5. Data- PATH actively uses HMIS as the point of communication for case management, tracking services and making referrals to other community agencies and Care Logic as the EMR (Electronic Medical Records). PATH staff regularly attends employee training for the EMR (Profiler & Care Logic) and HMIS system through on and off campus training.

- The Serenity PATH team uses a separate HMIS system (Pathways) for data entry from the EMR. There are no plans to integrate the systems.
- PATH staff is required to document services and referrals for Individuals served through HMIS daily. PATH staff is allow time to attend training for HMIS through webinars
- Serenity Behavioral Health uses Care Logic regularly as the EMR to track clinical services for the individuals we serve.
- Serenity Behavioral Health Systems has completed the AIU (Adoption, implementation, or upgrade) in EHR adoption.

6. SSI/SSDI Outreach, Access, Recovery (SOAR)

- During the next available SOAR training a PATH team member will be attending.
- There were no PATH staff trained in SOAR during the grant year ending 2014 (2013-2014). During the grant year ending 2014 approximately 30 of the PATH funded consumers were assisted through SOAR. We use SOAR for disability assistance through The Salvation Army.

7. Housing:

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, which are all income based housing. We will also utilize the Georgia Housing Voucher program

if the individual meets the requirements for participation in that program.

8. Staff information:

a. Demographics of staff:

The agency employs 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	# Black African/A m.	# MH Consumers
Serenity BHS	3	2	1	2	1	1

b. Regular training is provided to the entire staff for LGBT, Cultural competency and health disparities through all staff training, webinars and off campus training.

9. Client Information: The homeless population severed by the PATH program in FY 2014 in Augusta was 56.71 % males and 43.29 % females, who are 69.95% African American, 28.17% White and 1.88% other races, with 6.57% between the ages 18-23, 18.31% between the ages of 24-30, 48.83% between the ages of 31-50, 20.19% between the ages of 51-60, 6.10% between the ages of 62 and over ;3.76% Veterans and 96.24% Non-Veteran; 49.30% were living in a short term shelter or a Safe haven, 25.35% were living in a place not meant for habitation upon first contact, 0.47% in jail,19.72% living with friends or family,0.47% rental by client and 4.69% living in hotel or motel paid for without emergency shelter voucher . The principle mental illness diagnoses were schizophrenia and Major Depressive disorders, with 60% having co-occurring substance use disorders. At least 285 adult clients are projected to be contacted, 216 to be enrolled, 95% to literally homeless and 5% to be at risk of being homeless.

10. Consumer Involvement - 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. A previous PATH recipients was recently employed with SBHS but has now ventured off to focus on their duties as President of NAMI. SBHS is very supportive of and involved with the growth the association. 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.

11. Justification for budget revision – The PATH team has three members and because of the growing homeless population in our area current PATH team cannot always effectively serve and meet the needs of the individuals thoroughly. The duties could be shared easier with an additional member to the team. We believe the team would be much more efficient with an additional member. Additional funds for training along with the new team member will allow each team member to receive required substantial training in their area of expertise(i.e. housing , peer specialist) to serve our clients effectively.

12. Revised Budget Narrative: Attached

**Proposed Annual PATH Budget
State FY 2016
Serenity Behavioral Health Systems**

1. Personnel Costs

Positions	Annual Salary	PATH FTE	PATH Salary
Program Director	\$47,000	.1	\$ 4,700
Mental Health Professional	\$36,000	1.0	\$36,000
Housing Specialist	\$25,000	1.0	\$25,000
Certified Peer Specialist	\$20,000	1.0	\$20,000
New Case Manager	\$20,000	1.0	\$20,000
		<u>4.1 FTE</u>	
			\$105,700

2. Fringe Benefit Costs @45% **\$47,565**

3. Transportation Costs

Vehicle Operation & Personal Mileage:	\$9,000	
Bus Passes:	\$600	\$9,600

4. Training Costs **\$2,500**

5. Housing Coordination Costs

Rental Assistance & Emergency Housing:	\$15,000	
Emergency Food Assistance:	\$800	
Security Deposits:	\$2,500	
Household Items:	\$1,200	\$19,500

6. Program Supply Cost

Office Supplies & Engagement tools	\$1,816.70	
		\$1,816.70

7. Administrative Costs **\$4,800**

GRAND TOTAL: \$191,481.70

- **Local Provider Description – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.**

In 1917, Atlanta Travelers Aid (dba HOPE Atlanta) 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, HOPE Atlanta has adapted its services to include not only assisting stranded travelers but also to assist those in Atlanta who experience homelessness. HOPE Atlanta 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.

HOPE Atlanta will provide PATH funded services in both DBHDD Regions 1 and 3.

In Region 1 HOPE Atlanta will receive \$211,963 to support PATH services, and \$195,658 in Region 3. A detailed budget for both Regions 1 and 3 including direct and indirect costs is included with this application

- **Collaboration with HUD Continuum of Care Program – Describe the organization's participation in the HUD Continuum of Care program and any other local planning, coordinating or assessment activities.**

HOPE Atlanta is actively involved in the Atlanta, Balance of State, Cobb, DeKalb, and Fulton Continua of Care (CoC), and receives HUD funding for supportive housing. HOPE Atlanta 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. Our PATH Team will be at the forefront of the aforementioned CoC's Centralized Intake and Assessment Systems.

- **Collaboration with Local Community Organizations – Provide a brief description of partnerships with local community organizations that provide key services (i.e., primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients and describe coordination of activities and policies with those organizations.**

The PATH 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:

Region 3 -

Hope House for substance abuse services;
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;

Region 1 -

Cobb CSB for mental health services;
Cobb Wellstar Hospital;
MUST Ministries;
and Charlie Branson, LLC for SOAR services.

- **Service Provision – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:**
 - **Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.**

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, Case Manager, and a formerly homeless Peer Counselor.

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 Case

Manager that includes housing, SSI/SSDI, employment, veteran status, substance abuse, mental health, and medical. An Individualized Service Plan (ISP) is developed in partnership with the consumer to identify goals and strategies to promote change and end homelessness. The Peer Counselor assists by helping the consumer articulate personal goals for recovery and setting objectives for achieving goals. The Peer Counselor models recovery, teaches illness self-management, and connects the consumer to self-help groups including NA, CA, and DTR.

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

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. Other gaps include a lack of long-term case management and a shortage of available assessment beds.

- **Provide a brief description of the current services available to clients who have both a serious mental illness and a 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.

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

The PATH team supports and implements the following 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 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.

- **Data – Describe the provider’s status on HMIS (Pathways) transition plan, with accompanying timeline, to collect PATH data by fiscal year 2016. If providers are fully utilizing HMIS (Pathways) for PATH services, please describe plans for continued training and how providers will support new staff.**

- **Describe if and how technology (e.g. EHR, HMIS, etc.) will be used to facilitate case management or clinical care coordination across service sectors.**

HOPE Atlanta has been using the Pathways HMIS system since its inception. Case managers fully utilize the system and touch all screens while conducting intake, assessments, and follow-up case management.

- **If clinical services are provided, please describe the provider’s status on EHR adoption.**

N/A – Clinical Services not provided.

- **If the provider use an EHR, is it certified through the Office of the National Coordinator’s EHR certification program? If not, does the provider plan to adopt or upgrade to a certified EHR?**

N/A – Not currently using an EHR.

- **Does the provider use a separate HMIS system or is the HMIS data integrated into their EHR? Does the provider have any plan to integrate HMIS with their EHR?**

N/A – Only using HMIS, not EHR.

- **SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider’s plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR during the grant year ended in 2013 (2012- 2013), the number of PATH funded consumers assisted through SOAR, and the approximate number of staff to be trained in SOAR for grant year 2014 (2014-2015).**

The agency currently has 3 staff trained in SOAR. During the current grant year we will have all PATH staff person trained on SOAR (5 staff team members including Region 1 and Region 3).

- **Access to Housing – Indicate what strategies are used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).**

HOPE Atlanta 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
- Columbia Tower Apartments
- Park Commons
- Quest 35, Inc.
- GRO Housing
- Adams House Apartments- thru Georgia Housing Voucher Program
- Rogers Transitional House in Douglasville, GA
- Caring Works Permanent Supportive Housing Program
- Atlanta PSH (HOPE Atlanta – Mercy Care)

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

- **Staff Information – Describe the demographics of staff serving the clients; how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients; and the extent to which staff receive periodic training in cultural competence and health disparities. A strategy for addressing health disparities is use of the recently revised national Culturally and Linguistically Appropriate Services (CLAS) standards: (<http://www.ThinkCulturalHealth.hhs.gov>).**

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

Provider	# PATH Staff	# Females	# Males	#Caucasian	# Black African/Am	# MH Consumers
HOPE Atlanta – Region 3	3	0	3	0	3	0
HOPE Atlanta – Region 1	3	0	3	1	2	1

- b. Staff is experienced in this field and has participated in diversity training and cultural competency 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.
- **Client Information – Describe the demographics of the client population, the projected number of adult clients to be contacted, enrolled, and the percentage of adult clients served using PATH funds to be literally homeless.**

Projected Service Expectations for SFY 2015 - 7/01/15 to 6/30/16:
Based on our FY2015 contract the program will serve:

Region 1

- 1) Contractor shall identify and have contact with at least **280** individuals who are homeless and mentally ill in PATH funded **Outreach**.
- 2) Contractor shall enroll at least **200** individuals who are homeless and mentally ill in PATH funded **Case Management**.

Region 3

- 1) Contractor shall identify and have contact with at least **195** individuals who are homeless and mentally ill in PATH funded **Outreach**.
- 2) Contractor shall enroll at least **100** individuals who are homeless and mentally ill in PATH funded **Case Management**.

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

[Appendix I – Guidelines for Consumer and Family Participation

Applicants should have experience or track record of involving mental health consumers and their family members. The applicant organization should have a documented history of positive programmatic involvement of recipients of mental health services and their family members. This involvement should be meaningful and span all aspects of the organization’s activities as described below.

- **Program Mission – An organization’s mission should reflect the value of involving consumers and family members in order to improve outcomes.**

The agency’s mission statement is, “To provide emergency services and housing assistance to individuals and families who are homeless, at risk of homelessness, or who are experiencing crisis.” Within the mission statement three goals are identified, one of which is to, “Build organizational infrastructure, financial stability, and leadership to support our operations.” An integral part of achieving that goal includes involving consumers in order to develop a more effective program and a stronger agency.

- **Program Planning – Consumers and family members are involved in substantial numbers in the conceptualization of initiatives including identifying community needs, goals and objectives, and innovative approaches. This includes participation in grant application development including budget submissions. Approaches should also incorporate peer support methods.**

HOPE Atlanta's PATH Team incorporates the services of a formerly homeless Peer Specialist and a formerly homeless Peer Counselor. Our PATH Team is always receptive and responsive to the input received from consumers and family and uses that information to improve the program.

- **Training and Staffing – The staff of the organization should have substantive training in and be familiar with consumer and family-related issues. Attention should be placed on staffing the initiative with people who are themselves consumers or family members. Such staff should be paid commensurate with their work and in parity with other staff.**

Staff is experienced in this field and has participated in diversity training and cultural competency training. We are also able to access Family Education Classes at one of our partner agencies, Community Friendship, Inc.

- **Informed Consent – Recipients of project services should be fully informed about the benefits and risks of services and make a voluntary decision, without threats or coercion, to receive or reject services at any time.**

Participation in the program is entirely voluntary. The PATH Team utilizes a Harm Reduction approach and does not try to threaten or coerce consumers at any time. A thorough intake and assessment is conducted with each participant during which they are fully informed of their rights and the potential benefits and risks of participation or non-participation in services.

- **Rights Protection – Consumers and family members must be fully informed of all of their rights including those designated by the President's Advisory Commission's Healthcare Consumer Bill of Rights and Responsibilities: information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and non-discrimination, confidentiality of healthcare information, complaints and appeals, and consumer responsibilities.**

Consumers and any available family members are informed of all of their rights including those designated by the President's Advisory Commission's Healthcare Consumer Bill of Rights and Responsibilities.

- **Program Administration, Governance, and Policy Determination – Consumers and family members should be hired in key management roles to provide project oversight and guidance. Consumers and family members should sit on all Board of Directors, Steering Committees and Advisory bodies in meaningful numbers. Such members should be fully trained and compensated for their activities.**

The agency currently employs four formerly homeless consumers, including two on the PATH Teams. A formerly homeless consumer also recently ended her two year term as Board President, and in that capacity provided oversight and guidance to all the agency's programs.

- **Program Evaluation – Consumers and family members should be integrally involved in designing and carrying out all research and program evaluation activities. This includes determining research questions, designing instruments, conducting surveys and other research methods, and analyzing data and determining conclusion. Consumers and family members should also be involved in all submission of journal articles. Evaluation and research should also include consumer satisfaction and dissatisfaction measures.**

HOPE Atlanta's PATH Program is not currently conducting any research activities.

Behavioral Health Services of South Georgia Local Provider Intended Use Plan

Local Provide Description – Behavioral Health Services of South Georgia (BHSGA) is a Community Service Board that was duly organized and recreated as a public corporation which is an instrumentality of the State of Georgia and a public agency under 37-2-6 of the Official Code of Georgia Annotated to provide disability services. These services are contracted through the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). The DBHDD Region 4 Office manages the state contracts. BHSGA is licensed by the State of Georgia and abides by all state regulations. Funding for the BHSGA is provided through Federal, State, and County funds. Income is also generated by service fees and grants. The point of contact information for BHSGA regarding any questions concerning this proposal is:

Mr. David A. Sofferin
Chief Executive Officer (CEO)
Community Service Board of South Georgia,
D/B/A Behavioral Health Services of S GA
3120 North Oak Street Extension, Suite C
Valdosta, GA 31602-1007
Phone number: (229) 671-6101
dsofferin@bhsga.com

The BHSGA organizational mission is “To lead our community in providing excellent treatment, service and education in the areas of behavioral health and developmental disabilities, fostering meaningful opportunities for mind and body wellness.” Its organizational vision is to be the leading provider of comprehensive and quality behavioral health and developmental disabilities services for all people. BHSGA provides a wide array of core and specialty services in its 10 county service area. The 10 counties served include Berrien, Ben Hill, Brooks, Cook, Echols, Irwin, Lanier, Lowndes, Tift, and Turner. BHSGA has provided services in this unique geographic area for over 30 years. It has served as a leader in the region in providing quality behavioral health services using a community based approach.

Collaboration with HUD Continuum of Care (CoC) Program - BHSGA currently operates the Shelter Plus Care Program through the Department of Community Affairs. This program has contributed to lots of local agency networking with other HUD providers and organizations that target homeless individuals and individuals with disabilities to determine their needs through outreach services, case management, and community forums.

Collaboration with Local Community Organizations - BHSGA currently works with many stakeholders in our counties and partners with two local primary care offices to provide on-site therapy services in addition to primary health care. BHSGA attends Homeless Coalition, Family Connection, Mental Health Association, and other community collaborative meetings. BHSGA has a Supported Employment (SE) program and also works closely with Vocational Rehabilitation and G&B Works who also provides SE as well. BHSGA provides Substance Abuse Intensive Outpatient services and partners with the Volunteers of America program for housing the Substance Use Disorder (SUD) population.

Service Provision – BHSGA staff will use the Behavioral Health Crisis Center (BHCC) as a prime venue to engage homeless individuals that are ready for recovery and agreeable to treatment. BHSGA staff will also attend local Homeless Coalition meetings, meet with community stakeholders, and work closely with our current HUD funded Shelter Plus Care program. Staff will also identify areas of the city/county that are known as natural shelters for homeless individuals such as under bridges, near low income areas, abandoned buildings and sites, etc.

BHSGA currently has a 10 bed, 30 day program for SUD consumers, a 2 bed, MH crisis respite apartment and approximately 100 beds in our Shelter Plus Care Program. Often all beds are filled and we have a hard time finding referral options for our consumers, especially consumers with a primary diagnosis of substance abuse. Transitional housing continues to be the largest gap in our service area. Additional identified gaps include public transportation, interim housing, and staff that will assist consumers to find permanent housing. After a consumer has been transitioned to a permanent living situation, case workers can assist to apply for benefits so

Often, our consumers acquire a job but cannot get to and from their work site. Also, if they do not receive benefits, they have no way to get to medical and mental health appointments. Case workers assist with transport as they can but cannot meet all needs. Another gap is transitional housing. However, there are many individuals who will soon receive benefits or are in line for a bed at a residential program housing voucher who struggle to find a safe place to stay in the interim. Respite apartments that are not tied to ADA criteria would be helpful to fill this gap.

As a core provider of Mental Health and Addictive Disease services, BHSGA provides a full array of both core and specialty services for the co-occurring populations. This includes: Substance Abuse Intensive Outpatient, group training, group therapy, behavioral health assessments, family therapy, individual therapy, anger management, psychosocial rehabilitation, residential supports, supported employment, case management, addictive disease support services, intensive case management, and Assertive Community Treatment.

BHSGA currently provides several evidence based practices including Motivational Interviewing, Trauma Informed Care, Dialectical Behavioral Therapy and TREM. We also employ modules and techniques from the Boston Center for Psychiatric Rehabilitation (BCPR) model. BHSGA is certainly willing to identify and facilitate other trainings that may be helpful to PATH staff.

BHSGA currently has PATH staff that already uses the HMIS system Pathways. Our current staff will be able to introduce any new staff to this system and show them how to enter new client information into the system. Our staff will be responsible to complete any data input within 3/5 days and update all information monthly to ensure that information is correct and accessible to other agencies through the use of Pathways.

Data - BHSGA currently has staff that already uses the HMIS system Pathways. Our current PATH staff will be able to introduce any new staff to this system and show them how to enter new client information into the system. Our staff will be responsible to complete any data input

within 3/5 days and update all information monthly to ensure that information is correct and accessible to other agencies through the use of Pathways.

SSI/SSDI Outreach, Access, Recovery (SOAR) – BHSGA currently has 1 PATH staff trained in SOAR. We are anticipating to train more PATH staff in the upcoming fiscal year to provide more SOAR services. 25% of our previously served PATH consumers were assisted through SOAR.

Housing - BHSGA currently provides numerous housing resources and offers a full continuum of care in our area including Shelter Plus Care, Georgia Housing Voucher, Intensive Residential, Independent Residential, Crisis Respite Residential and Substance Abuse Transitional Housing. BHSGA works closely with the local homeless shelters including New Horizons, Salvation Army and The Haven. Also, we maintain a list of local personal care homes and halfway houses for additional referrals. BHSGA has developed close working relationship with several local landlords who have a good understanding of the mental health system and the issues our consumers face. They have worked to find housing in areas of town where individuals may walk to stores and businesses. When new properties become available they contact us to inquire if the property would be appropriate for our consumers. Our partnership with these property owners will be a great resource for identifying affordable housing options.

Staff Information - See Appendix labeled “Staff Demographic Information FY 2014”

BHSGA values and respects the diversity of our communities and recognizes this diversity enriches the lives of our consumers. It is the intention of BHSGA to recognize, respect and address the needs, worth, customs, beliefs and values of all persons served and their families and to provide settings which promote comfort, trust and familiarity. BHSGA implements a Cultural Competency and Diversity Plan which addresses persons served, personnel and other stakeholders. The plan is based on the consideration of the following areas: culture, age, gender, sexual orientation, spiritual beliefs, socioeconomic status and language. This plan is reviewed annually and updated as needed. BHSGA also has a non-discriminatory policy towards all persons served, personnel and other stakeholders.

BHSGA’s Cultural Competency and Diversity Committee is made up of members from the Human Resource Committee as well as staff from across the agency. The main goal is to increase awareness of cultural competency and diversity within the agency and promote policies and practices which lead our organization in the direction of equality and accessibility. Cultural competency and diversity is critical to improving access to high quality services that is respectful of and responsive to the needs of diverse consumers.

All employees receive cultural competency and diversity training in new employee orientation and annually thereafter. Training includes review of the agency Cultural Competency and Diversity Plan, discussions regarding cultural competency and diversity as well as on-line training through the agency web based training program, Relias Learning. The Cultural Competency and Diversity Committee is currently planning a workshop on Cultural Competency and Diversity for continuing education credits for BHSGA staff.

Client Information - See Appendix labeled "Consumer Demographic Information FY 2014"

BHSGA will provide outreach services to 120 consumers per year. BHSGA will provide Case Management to approximately 60 consumers per year. We project that 60 consumers per year will be literally homeless.

Consumer Involvement - Currently, BHSGA is in the beginning stages of implementing the PATH grant. BHSGA would like to identify consumers who meet PATH criteria or who were homeless recently such as our Shelter Plus Care consumers to assist with the planning and implementation of this new program. BHSGA would form a consumer interest group to receive input and recommendations for the PATH program. Family members of consumers who meet PATH criteria would also be a great benefit to the interest group as they could provide valuable information regarding the needs these consumers. Once the program is fully operational, BHSGA would identify PATH recipients to serve as part of this group. BHSGA currently hires consumers in peer specialist roles and other areas as appropriate. We would certainly be willing to have PATH consumers work with us and volunteer within our programs.

Budget Narrative - BHSGA is planning to use the majority of the funding through the PATH grant for two employees. One will be one fulltime equivalent mental health professional with a Master's Degree in behavioral health, one fulltime equivalent Peer Specialist and one case manager. The staff's primary goal will be to effectively and efficiently reduce homelessness for individuals with mental illness and/or substance abuse problems. They will link consumers to behavioral health services, housing and other community resource needs. Staff will be based in existing BHSGA facilities with 50% of their time spent in non-traditional community settings.

The very limited public transportation in our area may also force BHSGA to utilize parts of the funding for transportation of consumers to appointments, employment activities, etc. Some consumers might need bus tickets to get to their hometown, others may not be able to be transported through the bus system and need transportation to their permanent housing by our staff. BHSGA will use leased vehicles to transport consumers, or staff may transport consumers in their personal vehicles and will be receive mileage reimbursement.

Twenty percent of the grant funding will be utilized for Housing Coordination expenses, such as temporary housing assistance for a consumer who is in a transition process to live in permanent housing. BHSGA would like to use some of the funding for emergency food assistance for any PATH consumers in the process of applying for food stamps. In addition, many consumers will come into this program with nothing but the clothes they are wearing. They will need basic household items as well as essential furniture to establish permanent housing.

BHSGA will use parts of the funding to ensure the staff is able to access PATH related information systems. This will include laptops and internet access for the staff. A minimal amount will be used to assist with office supplies, from printing, copying, phone calls, brochures, etc.

We also know that there will be tremendous needs for personal hygiene products and clothing for consumers entering the program, as well as consumers unable to receive any continuous assistance through other programs.

BHSGA will use up to 3% of the total funding for administrative related expenses, such as payroll, accounting, etc.

2016 Local Provider Intended Use Plan

Community Advanced Practice Nurses, Inc.
173 Boulevard, NE
Atlanta, GA 30312
404-658-1500

Narrative Questions:

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.

Community Advanced Practice Nurses, Inc. (CAPN) clinic is an advanced practice nurse-led, shelter-based primary and mental health care outpatient clinic based program in the heart of Atlanta in the Region 3. CAPN's model of care is integrated, holistic, trauma-informed, and patient-centered. This non-profit free clinic, now 27 years-old, provides integrated mental and physical health care, staffed by advanced practice registered nurses (APRNs). The mission of CAPN is to strengthen the lives of persons who are medically underserved and to help interrupt the cycle of poverty and homelessness for these individuals. Healthy independence is promoted through health care delivered with acceptance, compassion, and sensitivity to an individual's life circumstances. Our purpose is to: 1) Provide opportunities for people to learn healthy adaptive life skills; 2) Create a climate of supportive health care encounters; 3) Advocate for the needs and services of the target population; 4) Promote collaborative relationships with agencies serving the needs of people; 5) Foster an environment conducive to learning for health care and social service professionals.

CAPN's Physical Health Program provides free basic health care to homeless and low-income families or individuals with an emphasis on women, children and youth. Care includes: 1) complete histories and physicals, 2) immunizations, 3) well and sick care, 4) family planning services, and 5) STD screening and treatment, 6) HIV and TB screening and referral for treatment. CAPN health educators and NP staff provide education on a variety of topics including both lifestyle issues and general health concerns. This program employs preventive care practices, screenings and management of chronic diseases. With each patient encounter, CAPN providers aim to address the risk factors for specific chronic diseases and establish a care plan that is unique to each patient.

CAPN's primary mental health program, PATH, provides mental health services utilizing an integrated approach for homeless and mentally ill clients primarily located in the City of Atlanta metro area. Comprehensive mental health assessment, individual, marital,

family, and group counseling is offered with the goal of client engagement in mainstream mental health treatment and stabilization in permanent housing, primarily supportive with availability of case management services . A Board Certified and licensed advanced practice registered nurse (APRN) evaluates and treats clients for mental health and substance abuse problems. Referrals are often initiated by collaborative social service agencies in the metro Atlanta area and word of mouth amongst the homeless population.

CAPN will receive \$231,161.70 in PATH funds to support our Mental Health Program.

- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation in the HUD CoC program and any other local planning, coordinating or assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

CAPN has been an active participant in the City of Atlanta CoC since 1996. The PATH team leader regularly attends and contributes to the design team meetings for the CoC as the CoC implements the provision of coordinated assessment and intake, with the goal of securing and increasing housing availability to homeless clients. Monthly CoC meetings are also attended and CAPN is a voting member.

- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients and describe coordination of activities and policies with those organizations.

Community Advanced Practice Nurses, Inc. (CAPN) partners and collaborates with several organizations to offer opportunities for homeless women, women with children, and unattached youth in order for them to seek primary, mental health, and substance use care, education, job training, employment and permanent housing. Along with providing our clients with comprehensive physical and mental health services, we link them with other supportive services that enable them to obtain specialized health care and substance use treatment, employment and housing, thus transitioning them out of homelessness and into a life of self sufficiency. CAPN currently has a partnership with the following agencies:

Young Adult Guidance Center, Covenant House, and Stand Up for Kids are programs which cater to youth who have run away from home or are involved in the juvenile justice system. These agencies rely on the services of CAPN to meet the physical and mental health needs of their clients. Most of these youth have been exposed to some form of physical and sexual abuse. As a result, CAPN is able to provide them health assessments, counseling, and referrals to other agencies and promote their health in a safe supportive climate.

Atlanta Union Mission, Action Ministries-Atlanta, International Women's House, Women's Resource Center, Partner's Against Domestic Violence, Mary Hall Freedom House, Nicholas House, Inc. and Gilgal provide shelter to women and their children who are experiencing a wide range of issues such as substance, domestic violence, and prostitution.

We also collaborate with The Atlanta Day Shelter for Women and Children, The Atlanta Children's Shelter, Fulton County Department of Health and Wellness, Grady Healthcare, The Georgia Law Center for the Homeless, The Atlanta Center for Self Sufficiency, and Morehouse School of Medicine in order to ensure our clients get all the necessary resources to obtaining comprehensive health care and the opportunity to learn healthy life skills to secure stable employment and housing.

- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to eligible PATH clients, including:
 - Describe how the services to be provided using PATH funds will align with PATH goals to target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

The CAPN PATH team conducts outreach and case management at its primary service location in partnership with The Women's Community Kitchen sponsored by Action Ministries-Atlanta to reach individuals who are literally and chronically homeless thus coinciding with PATH goals. The PATH team also performs outreach to clients at the Atlanta Women's Day Shelter for Women and Children and Stand UP for Kids weekly. In addition our psychiatric clinical nurse specialists and psychiatric nurse practitioners provide assessment to clients served at our main location for primary care services, 173 Boulevard Ave., NE on an as needed basis. Participation in street outreach or outreach at the Atlanta Hartsfield International Airport occurs monthly. The PATH team provides a comprehensive bio-psycho-social assessment and case management to those suffering from mental health and addiction problems. In doing so, we are able to address their immediate needs and link them to mainstream mental health and substance use treatment and housing as well as other mainstream services. In addition HUD McKinney forms are completed for admission to permanent supportive housing sites.

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

There are gaps that have been identified through the PATH team collaborative via discussion at the weekly PATH collaborative meetings. Current challenges include securing adequate shelter for individuals and families, placement of single clients and

families in permanent supportive housing, and having emergency housing readily available on an ongoing basis. There is a definite lack of volume related to sheltering/emergency housing, and permanent supportive housing. Capacity needs to be greatly expanded proportional to the need identified in the metro Atlanta area. The PATH teams received emergency housing funding later this past fiscal year which has been very helpful in meeting the basic needs of our clients. Regular funding for emergency housing would greatly enhance the PATH collaborative. In terms of permanent supportive housing, case management-client ratios need to be reduced to provide satisfactory treatment for newly housed clients which will increase success in permanent housing placement.

It has been observed that wait times for initial mainstream mental health appointments average 6-8 weeks in the metro Atlanta area. Co-pays for psychotropic medication are charged to clients that have no source of income at many treatment sites and prescriptions are not filled. Low barrier access to substance use treatment has also been difficult to attain for many clients. Barriers have thus been created to successful treatment for mental health and substance use issues.

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

Outreach is done at all of our partner agency locations and admission to the PATH program is based on need for mental health services and substance use services when needed. The ability of the client to master navigation of these services and other life skills attainment is assessed as part of the need to admit to the PATH program. A comprehensive bio-psycho-social assessment is done and treatment plan is instituted. Case management is an integral part of the program, which assists clients in the procurement of mainstream mental health services and permanent housing. Our program coordinator is primarily responsible for assisting clients with permanent housing applications and is always seeking new sites to meet client housing needs. Our certified peer specialist assists with outreach and our current emergency housing program. Clients with a mental illness and substance use disorder are referred to programs targeted for co-occurring illness.

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

This agency welcomes ongoing training for our staff. Our clinicians and case management staff attend seminars, conferences and trainings to reinforce evidence-based practices, current updates on major mental health issues and illnesses, and updates on our HMIS system. Our staff is trained in usage of Pathways, the current HMIS data collection system.

- **Data** – Describe the provider’s status on HMIS transition plan, with accompanying timeline, to collect PATH data by fiscal year 2016. If providers are

fully utilizing HMIS for PATH services, please describe plans for continued training and how providers will support new staff.

CAPN uses Pathways (HMIS) on an ongoing basis for all our homeless clients living on the street or in emergency shelters. We track demographics, needs, and service referrals during each encounter with the client. CAPN participates in all trainings necessary to better track PATH data in Pathways. New staff are trained to use Pathways and are oriented and assisted in use of this HMIS system. Our program coordinator monitors data entered into Pathways to ensure data quality. Our EHR system (ATHENA) is certified through the Office of the National Coordinator's EHR certification program and also tracks client data with each encounter.

- **SSI/SSDI Outreach, Access, Recovery (SOAR)** – Describe the provider's plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR during the grant year ended in 2014 (2013- 2014), and the number of PATH funded consumers assisted through SOAR.

SOAR training for PATH staff has already been initiated for our new staff. The program coordinator attended training in January, 2015 and the certified peer specialist will attend training in September, 2015. Our 2 primary clinical nurse specialists attended training in 2009. We have had client linkage to SOAR specialists either through DBHDD site visits at our partner agency, The Atlanta Day Shelter for Women and Children or through previous referral to First Step, Inc. Approximately 45 clients have been assisted with SOAR or through private legal services. Many cases are pending or in appeal. Clients are encouraged to seek SSI benefits when chronic mental illness is impairing optimal life skills attainment.

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

Our PATH team constantly brainstorms ideas for suitable housing based on individual client need. Housing resources are explored and new housing agency partners are sought. Interagency meetings and conferences are attended to learn more about housing options and partnerships are fostered. Permanent supportive housing including shelter plus care programs and the Georgia Housing Voucher Program (GHVP) have been targeted for this vulnerable population. Use of the VI-SPDAT has been implemented to assist clients with housing procurement. Most recently we have had successful partnerships with New Horizons (Nicholas House, Inc.), Caring Works, Inc., O'Hern House (Community Friendship, Inc.), Georgia Rehabilitation Outreach, Inc., and referrals to Grady case management for referral to the GHVP.

- **Staff Information** – Describe the demographics of staff serving the clients; how staff providing services to the population of focus will be sensitive to age, gender,

disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients; and the extent to which staff receive periodic training in cultural competence and health disparities. A strategy for addressing health disparities is use of the recently revised national Culturally and Linguistically Appropriate Services (CLAS) standards: (<http://www.ThinkCulturalHealth.hhs.gov>).

Provider	# PATH Staff	# Females	# Males	# Caucasian	# Black	# MH Consumer
CAPN	6	6	0	4	2	1

We currently have 6 individuals on our mental health team. All professional staff are Board certified, licensed and have over 10 years of experience providing care to the homeless population. They are required to keep up continuing educational credits to maintain state licensure and Boards. This staff is supported by professional and lay volunteers who provide assistance to clients and staff. Our staff is sensitive to cultural differences, sexuality differences, and health disparities based on their education, professional experiences in the workplace, and personal life experiences. Competency in this area is evidenced by the high regard our staff has for the clients we serve. Ongoing continuing education in this area is encouraged and sought by our staff.

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

The majority of clients seen for outreach and enrollment are African American single adults (94%). Unattached youth (5%) aged 18-25 encompass a particularly vulnerable and unique population that is primarily seen at our outreach site, Stand Up For Kids. We have admitted a small percentage of these youth (3%) and know there are more unattached youth that need enrollment. Persistent contact with this subpopulation is ongoing. The projected number of adult clients to be contacted annually is **170 (14 per month)** and the number of clients enrolled is expected to be **156 (13 per month)**. 100% of clients are expected to be literally homeless.

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

CAPN continually seeks to involve the target population to improve the mental health services provided. Client input is obtained through the use of surveys .evaluated on a monthly basis. We probe clients on effectiveness of the services, how to improve, and what to add to existing services. Currently we have one Certified Peer Specialist employed full time and one temporary Certified Peer Specialist. Volunteers periodically

assist with programmatic support. One of our current board members is a female African American disabled formerly homeless client.

- **Budget Narrative** – Provide a budget narrative that includes the local-area provider’s use of PATH funds.

CAPN specializes in performing comprehensive bio-psycho-social assessments to assist in the procurement of supportive housing. HUD McKinney forms are completed after the evaluations if needed. Nursing assessment and case management hours have been increased to assist with requests for full mental health evaluations. The program coordinator primarily assists clients with housing procurement and associated administrative tasks for the PATH program. The CPS assists with VI-SPDAT assessments and housing procurement.

Proposed FY2016 Annual Budget

1) Personnel	Function	FTE Salary	Annualized
APRN(0.86 FTE)	Clinical assessment and Treatment	\$40/hr @ 30hr/wk	\$62,400
APRN (0.35 FTE)		\$40/hr @ 14hr/wk	\$29,120
APRN (0.25 FTE)		\$40/hr@10hr/wk	\$20,800
APRN (0.10 FTE)		\$40/hr@ 4 hr/wk	\$8,320
Program Coordinator(0.86 FTE)	Quality assurance, case management, triage	\$27/hr@ 30hr/wk	\$42,120
Certified Peer Support Specialist(0.43 FTE)	Outreach, client support	\$17.hr@18hr/wk	\$15,912
Staff Total			\$178,672

2) Fringe Benefits @25% (except part-time CPS employees)	\$23,079
3) Transportation Costs	
Cost to maintain transportation vehicle	0
Staff mileage	\$1500
4) Training Costs	

Staff Training costs (local and out of state)	\$1500
5) Client Benefit Funds	\$14,311.61
Includes Publix food cards, MARTA cards, client meds and toiletries, criminal background checks, security deposits.	
6) Supplies & Equipment	
Includes office supplies, program telecommunication, EMR	\$5164.24.
7) Administrative Costs	
Audit, Accounting, Insurance, etc.	\$6934.85
Grand Total	\$231,161.70

**New Horizons Behavioral Health
2100 Comer Avenue
Columbus, GA 31906
(706) 596-5717**

Local Provider Description – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.

New Horizons Behavioral Health is 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 in Region 6. New Horizons has a thirty year history of providing community mental health services. The array of services provided by New Horizons Behavioral Health includes: Screening, Crisis & Outreach, Outpatient, Day Treatment, Substance Abuse Intensive Outpatient, Employment, Residential, and Service Entry and Linkage Services. This PATH program is funded to serve primarily the city of Columbus located in Muscogee County.

Collaboration with HUD Continuum of Care (CoC) Program – Describe the organization's participation in the HUD CoC program and any other local planning, coordinating or assessment activities. If you are not currently working with the CoC, briefly explain the approaches to be taken by the agency to collaborate with the local CoC.

Dave Wallace, LPC, NCC, M.S. is New Horizon's Development Coordinator and serves as an active member of the local HUD Continuum of Care program. Conisha Hill (MS) is the PATH Team Lead/Program Coordinator who represents PATH in the local Homeless Coalition as well as community liaison to other area service providers. New Horizons serves as a community stakeholder in the CoC. PATH Team Lead also sits on the HUD Section 811 Planning Committee as well as the Zero in 2016 Initiative to end homelessness. PATH staff maintains relationships with local hospital staff to help coordinate follow-up services to reduce future admissions. One PATH staff is also delegated as the Housing Navigator to assist with linkage and referral for individuals who need more services and/or those with higher barriers to housing. One of the PATH team members also holds a position on the HMIS committee.

Collaboration with Local Community Organizations – Provide a brief description of partnerships and activities with local community organizations that provide key services (i.e., primary health, mental health, substance abuse, housing, employment, etc.) to PATH eligible clients and describe coordination of activities and policies with those organizations.

PATH staff works collaboratively with the local housing authority, shelter plus care 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. PATH staff also collaborate with United Way of Chattahoochee Valley for the Zero in 2016 Initiative to end

homelessness. Annually a community wide homeless resource fair called Project Homeless Connect occurs in January that New Horizons and Open Door Community House collaboratively team up to make a success. Representatives from housing, education, employment, government, food, clothing, and other services were on hand to connect homeless individuals and families with resources. PATH assists with all parts of the development of the resource fair, along with having a booth and doing outreach and working to get homeless individuals housed.

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

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

Georgia regards Outreach and Case Management as priority services and limits the use of PATH funds to these two (2) services which must be delivered in accordance to the Department’s approved service specifications. The New Horizons PATH Team implements Street and Shelter Outreach services to identify and engage literally homeless individuals and move them towards readiness to change. Outreach locations are inclusive of the Bradley Center, Health Department, Open Door Community Home Showering Program, an area not meant for habitation locally called “tent city”, under bridges, local park areas, Homeless Resource Network, etc. As the community has identified a need in South Columbus, staff has outreached behind recently closed stores and connected with services in South Columbus to ensure referral sources. PATH Team are made available to outreach on weekends and evenings as homeless resources are sought out by local churches or other community faith-based outreach services. Once enrolled in Case Management services, individuals are assisted with access to housing and linked to mainstream services and resources. ACT and Mobile Crisis Teams may call the 24 hours central line, (706) 256-3200, to make a referral to PATH or any higher level of care. PATH will utilize a “Housing First” approach as well as leverage all available resources to provide the identified consumer safe, decent, and affordable housing quickly. ACT Team members participate in an interdisciplinary meeting monthly with New Horizons staff to discuss previous and new referrals to promote continuity of care for individuals served.

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

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 staff that will go into shelters, soup kitchens and showering programs and churches on a regular weekly schedule. New Horizons has implemented a Mental Health Court program, diverting non-violent mentally ill persons from jail into treatment. Individuals referred to the Mental Health Court program, not in services and verified as homeless prior to arrest may receive PATH funded services. This will reduce recidivism by ensuring Mental Health Court participants do not immediately return to homelessness from jail. As the Columbus Housing Authority presently has a 1% vacancy rate, locating affordable housing can be very difficult for the homeless population. In 2011, it was

reported that in Columbus, GA, 486 individuals were identified as homeless. For this reason, there is constant communication and coordination with local agencies, realtors, and property managers to obtain and maintain resources.

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

PATH enrollees may participate in any program provided by New Horizons, including a psychosocial rehabilitation group/individual and substance abuse intensive outpatient program specifically designed for the dually diagnosed as well as gender-specific programming for women. Also, the Peer Drop-In program is utilized in which both homeless and New Horizons Consumers have access to co-occurring groups during the evening. The PATH Team will work closely with the local ACT and Mobile Crisis Teams to ensure continuity of care for New Horizons' eligible individuals. PATH individuals with co-occurring substance use disorders are encouraged to 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,

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

Our PATH program utilizes several different practices to maximize the effectiveness of our program in Region 6. We highly believe in a person-centered (Strengths-based) approach to outreaching, engaging and assessing individuals' needs to efficiently assist the individuals served by linking them to housing and mainstream services. In addition, we practice motivational interviewing that will provide them with the benefits of enrolling into mental health services; we actively work under a Housing-First model to assist our community of chronically homeless individuals to obtain permanent stable housing. New Horizons provides Peer Supports to develop a wellness recovery action plan (WRAP). Harm Reduction Training is attended in which staff learns best practices in interactions during outreach and case management with individuals with co-occurring disorders. PATH trainings are provided through DBHDD along with several opportunities for various Housing-First, Case management, Motivational interviewing and culturally sensitive webinars.

- **Data – Describe the provider's status on HMIS transition plan, with accompanying timeline, to collect PATH data by fiscal year 2016. If providers are fully utilizing HMIS for PATH services, please describe plans for continued training and how providers will support new staff.**

This PATH team is fully trained on HMIS and utilizes the system with ease for PATH services. 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 trainings to learn how to facilitate migration of PATH data into HMIS. This agency will explore the flexible use of PATH administrative funds to support HMIS activities.

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. 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.

- **SSI/SSDI Outreach, Access, Recovery (SOAR) – Describe the provider's plan to train PATH staff on SOAR. Indicate the number of PATH staff trained in SOAR during the grant year ended in 2014 (2013- 2014), and the number of PATH funded individuals assisted through SOAR.**

By the beginning of FY 2016, all PATH staff including Team Lead will be SOAR trained. In FY 2014, 1 PATH staff was trained in SOAR and although the referral process for serving individuals through SOAR failed, PATH staff assisted individuals by completing applications online, transporting individuals to the Social Security Office for appointments and their evaluations, and also assisting with the collection of documents required for the completion of the applications. After the individuals received their entitlement benefits letters, PATH staff put the individuals in connection with representative payee programs if they needed one, completed budgets for them and their families and continued case management as a mediator for the payee program for continued success with their new income.

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

PATH staff works collaboratively with the local housing authority, shelter plus care 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. PATH Staff 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 emergency housing while applying for permanent housing, costs associated with matching eligible homeless individuals with appropriate housing situations, and one-time rent payments to prevent eviction. PATH now works in coordination with DBHDD Region 6 to utilize the Georgia Housing voucher to link consumers with severe and persistent mental illnesses who are chronically homeless with affordable housing while linking with follow-up case management services. PATH is also able to refer eligible individuals to the Columbus Housing Authority to be placed in the community with a Section 8 Rapid Rehousing voucher. In FY 2015, PATH staff were solely able to successfully house 14 individuals with the use of the Section 8 Rapid Rehousing vouchers. PATH staff works closely with numerous local property managers and rental agencies to assist consumers in obtaining affordable housing. The PATH Team will also receive referrals from the ACT and Mobile Crisis Teams and will utilize the same strategies to end the identified individual's episode of homelessness.

- **Staff Information – Describe the demographics of staff serving the clients; how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual and transgender, racial/ethnic, and differences of clients; and the extent to which staff receive periodic training in cultural competence and health disparities. A strategy for addressing health disparities is use of the recently revised national Culturally and Linguistically Appropriate Services (CLAS) standards: (<http://www.ThinkCulturalHealth.hhs.gov>).**

Provider	Total PATH Staff	# Female	# Male	# Caucasian	# African American	# MH Consumers	Hispanic/Latino/a
New Horizons	6	5	1	1	4	1	1

All staff members receive agency based training regarding cultural sensitivity and diversity upon hire and annually thereafter. Every employee is required by this agency to attend training on consumer rights and consumer protection issues. PATH staff is required to complete annual training in both basic and advanced motivational interviewing, cultural sensitivity, and best practices when working with the homeless to incorporate these evidence-based practices into services provided.

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

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 in FY07 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.

OUTREACH SERVICES

A. Contract Performance Requirement

1. Monthly, Contractor to Outreach **29** clients.
2. Quarterly, Contractor to Outreach **87** clients, 80% Minimum Threshold of 70 clients.
3. Annually, Contractor to Outreach **350** clients.
4. Annually, Contractor to enroll **244** Outreach clients in PATH Case Management.

Contractor shall assist **40** individuals enrolled in PATH funded Case Management with the initial SSI/SSDI application process or the appeals process.

This provider projects that **60%** of the unduplicated total will report as “literally” homeless.

- **Consumer Involvement – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be involved at the organizational level in the planning, implementation, and evaluation of PATH-funded**

services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.

We currently have one PATH staff who was once PATH eligible and a previous individual served at New Horizons. This staff is a Certified Peer Specialist and also holds a BSW degree. New Horizons wholeheartedly encourages the application of individuals once served to obtain employment with New Horizons who agree to uphold the mission, vision and values of the PATH program and New Horizons Behavioral Health. There are currently 5 members on the New Horizons Board of Directors who are family members of individuals served at New Horizons. Along with the staff, the other members meet monthly and collaborate on the daily functions, services provided and development of New Horizons as a whole.

Fulton DeKalb Hospital Authority
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Atlanta, Georgia 30303
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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 \$130,800 in PATH Federal funds and \$45,761.70 in PATH State funds, totaling \$176,561.70 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 and two Mental Health Technicians (one of which is also a 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 all three PATH staff have received HMIS training through PATHWAYS.

5. Data and Provider's status on HMIS migration.

Grady Health Systems is a member of Georgia's HMIS, called PATHWAYS and an active user. This provider has participated in HMIS training and is currently entering 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 will continue to participate in HMIS webcasts and trainings in order to learn how to facilitate migration of PATH data into HMIS. 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.
- Transitional and permanent Housing: Community Friendship, Welcome House, Integrated Life, and Georgia Rehabilitation Outreach.

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 prospective 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 2016 - 7/01/15 through 6/30/16:
 - 1) Contractor shall identify and have contact with at least **168** individuals who are homeless and mentally ill in PATH funded Outreach.

- 2) Contractor shall enroll at least **120** 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. 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.

**Fulton DeKalb Hospital Authority
State Proposed FY 2015 PATH Program Budget**

1. Personnel	Annual Salary	PATH FTE	PATH Salary
1. Salary (3.0 FTE)			\$124,088.00
2. Fringe Benefit Costs (27%)			\$33,503.76
3. Transportation			\$7,600.00
-Vehicle Operation & Personal Mileage - \$4,600			
-Bus Passes - \$3,000			
4. Staff Training			\$3,000.00
5. Program Supply Costs			\$5,880.00
-Office Supplies - \$3,000			
-8 Cell Phones @ \$30/month each - \$2,880			
6. Client Engagement Tools			\$ 2,489.94
- Food/Meal Vouchers			
- Clothing (socks, coats, hats, scarfs, gloves)			
- Hygiene Kits			
GRAND TOTAL:			\$176,561.70

III. State Level Information

A. Operational Definitions

Term	Definition
Homeless Individual:	An individual who lacks fixed, regular, and adequate nighttime residence; or whose primary nighttime residence is a shelter or transitional housing designed to provide temporary living accommodations; or exiting an institution where they temporarily resided if they were in shelter or a place not meant for human habitation before entering the institution; or a place not meant for human habitation.
Imminent Risk of Becoming Homeless:	Persons who are losing their primary nighttime residence and have no resources or supports to remain in housing, or are about to be discharged from a psychiatric or substance abuse treatment facility without any resources or supports for housing.
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 a serious impairment or 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.
Co-occurring Serious Mental Illness and Substance Abuse Disorders:	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 individuals with simultaneous substance use disorder(s) and mental health disorder(s). Substance Use Disorder 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.

Footnotes:

III. State Level Information

B. Veterans

Narrative Question:

Describe how the state gives special consideration in awarding PATH funds to entities with a demonstrated effectiveness in serving veterans experiencing homelessness.

Footnotes:

III. State Level Information

B. Veterans

Describe how the state gives special consideration in awarding PATH funds to entities with a demonstrated effectiveness in serving veterans experiencing homelessness.

In FY14 GA PATH Teams served 125 known homeless veterans. All PATH providers must demonstrate work experience and background in working with veterans. Mental Health America and the Department of Veterans Affairs estimate that 25-40% of all adult males who are homeless are veterans. A 2012 Metro Atlanta Veterans Services Report that examined the quality and quantity of services available to Veterans in the Metro Atlanta area highlights the challenges faced by the state's Veterans. A total of 92 surveys (64% response rate) were completed by national and local nonprofits in a 10 county metro Atlanta area that provided services for Veterans. Approximately 82% of survey respondents working with Veterans believed that homelessness was a major problem in the veteran community. The major causes of homelessness cited by respondents included mental health disorders, substance abuse issues, and overall economic conditions (Georgia Center for Nonprofits, Metro Atlanta Veterans Services Report, 2012).

Approximately 75% of the 90 veterans surveyed in the above study reported known mental or physical health issues. About 58% had either a mental or physical disability. Approximately 32% of the disabled veteran respondents indicated they had a mental disability. Almost 29% of survey respondents had physical or mental health issues resulting from combat. Thirty-two percent of the veteran respondents who had been or were currently homeless after military service indicated that substance abuse was the cause of their homelessness, but less than 4% had sought substance abuse treatment services. (Georgia Center for Nonprofits, Metro Atlanta Veterans Services Report, 2012)

PATH Outreach Teams identify, assess, link, and support veterans who have a mental illness and are homeless. Outreach staff collaborate with case managers from the Veterans Administration to engage homeless veterans in services, including regularly scheduled combined outreach activities. During these special outreach efforts all identified Veterans who agree to accept services are placed in VA emergency shelter and assisted in accessing all VA and other benefits they are eligible for. Regional gatherings of PATH providers and VA providers have resulted in greater collaboration to serve homeless veterans. For example, the New Horizon PATH Team has an annual homeless outreach event, with several vendor booths manned by VA and other veteran-serving agencies in the Columbus area. The Serenity PATH Team in Augusta hosts a similar event. During routine PATH site visits, providers are reminded of the special consideration regarding veterans as specified in Section 522 (d) of the Public Health Service Act.

PATH Staff are well-trained in military culture, PTSD, suicide prevention, and other topics needed to work effectively with homeless veterans. In FY 2014, PATH providers had the opportunity to participate in a statewide training curriculum, in cooperation with the CABHI State Supplement grant staff, specifically designed to increase skills and knowledge in addressing the needs of Veterans and military families, with much emphasis on serving homeless

veterans with PTSD and other trauma-related illnesses. In FY15, PATH teams will have the opportunity to participate in a statewide veterans care conference.

On May 20, 2015 Atlanta's Mayor Kasim Reed announced that the City of Atlanta has made significant progress in its effort to move all homeless veterans into permanent supportive housing, putting the city on a path to meet President Obama's goal of ending veteran homelessness across the country by 2015. The City of Atlanta Continuum-of-Care will work with federal, state and regional partners, including DBHDD and its Region 3 PATH Teams on a series of short-term campaigns to house at least 75 veterans each month to reach the goal of housing all homeless veterans in the city by December 31, 2015.

III. State Level Information

C. Recovery Support

Narrative Question:

Describe how the services to be provided using PATH funds will reduce barriers to accessing effective services that sustain recovery for individuals with mental and substance use disorders who experience homelessness.

Footnotes:

III. State Level Information

C. Recovery Support

Describe how the services to be provided using PATH funds will reduce barriers to accessing effective services that sustain recovery for individuals with mental and substance use disorders who experience homelessness.

DBHDD's Office of Recovery Transformation supports efforts to create a recovery-oriented system of care that fully integrates the principles, practices, and values that allow the people we serve to live lives of recovery and independence in the community. This model signifies a shift from crisis-driven services to a prevention-focused, strength-based continuum of care that provides sustained support and is based on the strengths, the wellness, and hopes of the person in recovery.

Recovery accepts that the conditions with which a person lives, be it severe and persistent mental illness, substance use, or co-occurring disorders, are long-term situations that a person will be managing for life. The principles, practices, and values of recovery must be claimed and owned across DBHDD's service-delivery system and by community providers, including PATH Teams.

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 person-centered 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, Certified Peer Specialists (CPSs) on all 10 teams share their personal stories of recovery from homelessness, criminal justice involvement, mental illness, and substance use disorders. Homeless individuals learn from CPSs that recovery is possible and then consider change toward health and wellness for themselves. Each PATH Team includes a peer specialist. Employing a mental health consumer, especially those with lived experience of homelessness, to provide Peer Outreach has had a positive effect on the engagement process. As someone "who has been there", CPSs are better able to relate in a more experiential and relevant manner. CPSs serve as role models 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 case management process, and PATH interventions focus on the ultimate 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. 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 person-centered multi-disciplinary mental health service. Housing barriers are minimized with the use of State funded Medicaid Eligibility 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. CPSs help to guide homeless persons

experiencing mental illness through the journey from the streets to independence and recovery in the community.

III. State Level Information

D. Alignment with PATH Goals

Narrative Question:

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

Footnotes:

III. State Level Information
 D. Alignment with PATH Goals

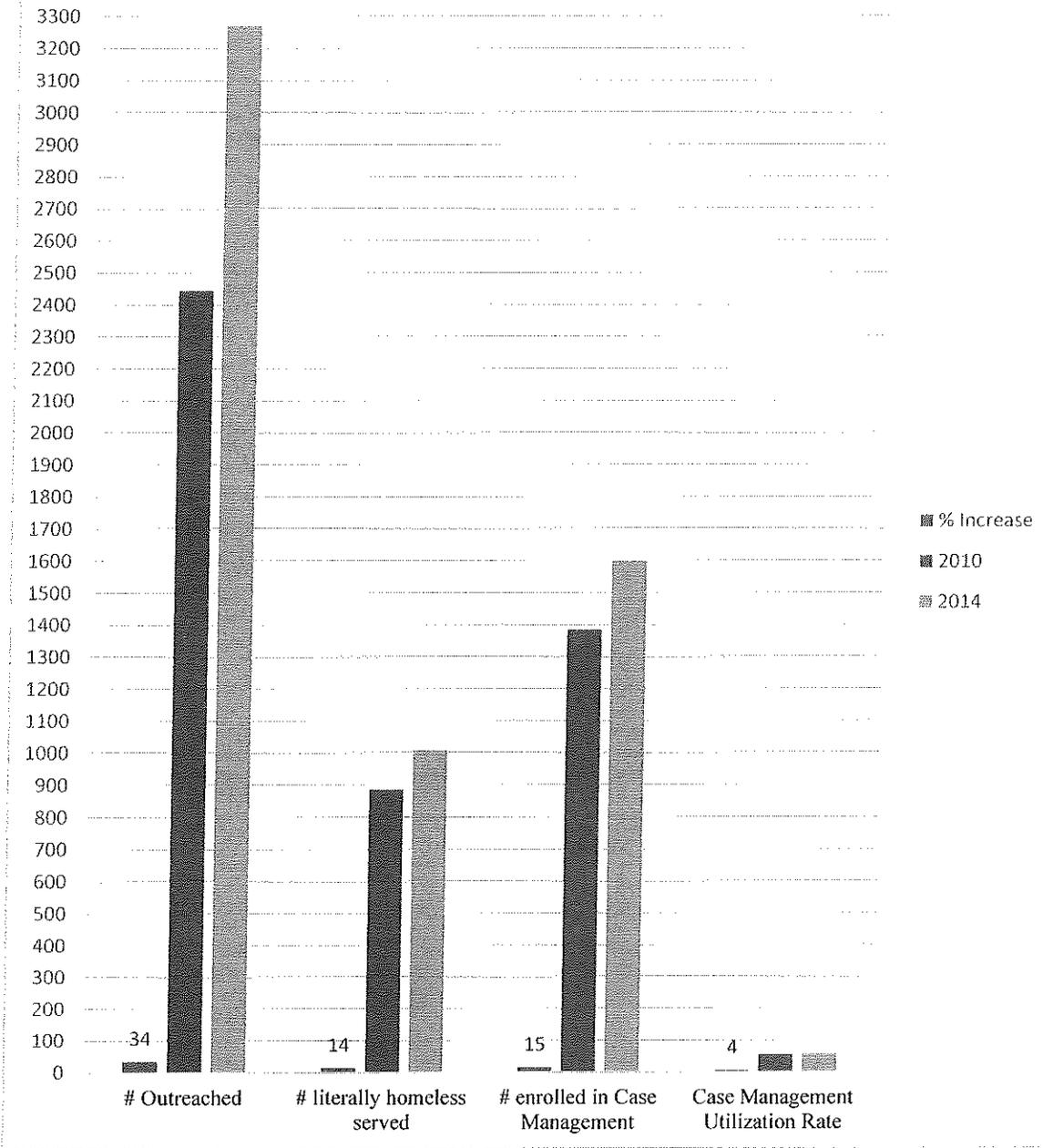
Describe how the services to be provided using PATH funds will target street outreach and case management as priority services and maximize serving the most vulnerable adults who are literally and chronically homeless.

The tables below outlines growth in statewide outreach and case management efforts of GA's PATH Teams and reach to literally homeless persons over the past five years. PATH funding has been utilized thoughtfully and efficiently each year to expand and enhance services to the target population.

Utilization Rate of PATH Funded Case Management (from PATH Annual Reports)

Year	Total # Outreach	Literally Homeless	# Receiving 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	3071		1741	1415	81%
2009	2795		1221	1163	95%
2010	2444	886 (70%)	2563	1385	54%
2011	2354	844 (69%)	2406	1272	53%
2012	4036	1722 (75%)	4053	2320	57%
2013	3748	1340 (65%)	2141	1848	86%
2014	3269	1008 (66%)	2853	1598	56%

Comparison 2010 to 2014



III. State Level Information

E. Alignment with State Comprehensive MH Services Plan

Narrative Question:

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

Footnotes:

III. State Level Information

E. Alignment with State Comprehensive MH Services Plan

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

The State Mental Health Plan incorporates PATH funded services in response to:

I. Criterion 1--Comprehensive Community-Based Mental Health Service System providing for the establishment and implementation of an organized community based system of care;

A. Non-traditional mental health services specifically designed for the homeless mentally ill, such as Intensive Case Management (ICM), Assertive Community Treatment (ACT), and Community Support Teams (CST) have been shown to be successful in engaging this group. The pillar 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 (e.g. CPS) 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.

II. Criterion 4--Targeted Services to Homeless Populations with outreach to and services for individuals who are homeless;

A. DBHDD has steadily increased 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 have not historically accessed services on their own 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, transportation hubs, and homeless gathering sites, fixed outreach to shelters, soup kitchens, and indigent health care clinics, and referral and walk-in outreach at the agency.

- III. Criterion 5--Management Systems that support training for mental health providers.
- A. Using PATH funds to provide Peer Outreach supports, the State Mental Health Plan as well as Georgia's overarching 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. Currently, all 10 PATH Programs employ Certified Peer Specialists as equal members of the PATH Team to deliver direct care.
- B. PATH Teams are provided access to ongoing state funded training, including but not limited to:
1. SOAR Training (March, September, December 2015)
 2. Mental Health First Aid (April & June 2015)
 3. Pathways Compass HMIS/HUD Standards Update (May 2015)
 4. Seeking Safety (EBP for trauma and substance abuse) (May 2015)
 5. Collaborative Documentation (May 2015)
 6. Trauma Informed Care for Homeless Veterans (May 2015; combined with CABHI State Supplement Grant staff)
 - a) Cognitive Processing Therapy (CPT)
 - b) PTSD & DSM 5
 - c) Military Culture
 - d) Impact of Stigma on Outreach and Engagement of Homeless Veterans
 7. PATH Training Summit and Combined Outreach Practicum (June 2015)
 - a) Critical Time Intervention
 - b) Housing First Philosophy
 - c) Teambuilding & Avoiding Burnout
 - d) Outreach & Engagement Techniques
 8. STAR Behavioral Health Providers Military Culture Tier 1 Training (June 2015)
 9. Annual Community Behavioral Health Symposium (August 2014; October 2015)

III. State Level Information

F. Alignment with State Plan to End Homelessness

Narrative Question:

Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning and the process of updating and testing their emergency response plans.

Footnotes:

III. State Level Information

F. Alignment with State Plan to End Homelessness

Describe how the services to be provided using PATH funds are consistent with the State Plan to End Homelessness. Describe how the PATH program supports the efforts to reduce/eliminate chronic homelessness in the state. Describe how the PATH program integrates disaster preparedness and emergency planning into their continuity of care planning and the process of updating and testing their emergency response plans.

The Georgia State PATH Contact is a member of the Interagency Council on Homelessness. Chaired by the GA Department of Community Affairs (DCA), this Council is charged with the review and implementation of Georgia's 2013 Homeless Action Plan. DBHDD's PATH Project aligns itself closely with several of the Plan's goals, for example:

Goal 1: Expand access to and use of the Federal mainstream housing and support service programs by homeless families and chronically homeless individuals. HUD-identified mainstream service programs include Medicaid, TANF, SSI, CHIP, Workforce Investment Act, Food Stamps, Adult Literacy, Vocational Rehabilitation, and Veterans Benefits. Mainstream housing programs include the affordable and supported rental and homeownership programs administered by HUD, the Georgia Department of Community Affairs (DCA), and local agencies.

- PATH teams help to decrease the average amount of time it takes homeless individuals to obtain disability benefits (SSI/SSDI), by identifying them through outreach and getting them linked quickly to DBHDD's Benefits Specialists. In addition, in 2015 Georgia's SOAR Project scheduled 3, 2-day SOAR trainings across the state.
- Georgia PATH Programs Outreached 3,269 homeless individuals and enrolled 1,598 into PATH funded Case Management. These individuals were linked to community mental health services, supportive housing, and mainstream benefits.

Goal 2: Provide supported housing for chronically homeless individuals and families that is both affordable and appropriate for the delivery of supported services. There will be an increase in supported housing units added annually with a preference for units designed to integrate primary and behavioral health care services for our most vulnerable homeless, including those who are chronically homeless.

- DBHDD works in collaboration with other ICH members and housing providers across the state to offer the GA Housing Voucher Program (GHVP). GHVP provides supportive housing to individuals with mental illness. The program focuses on chronically homeless individuals as well as those transitioning out of state institutions. In addition to rental support, voucher recipients are eligible for bridge funding which covers security deposits and moving expenses. GHVP and the bridge funding are currently administered by DBHDD. Beginning in 2015, closer collaboration DCA facilitated the transition of many GHVP recipients into the federal Housing Choice Voucher program, thereby opening up more slots in GHVP for homeless individuals with mental illness, referred by PATH Teams and other homeless service programs. GHVP and bridge funding receive state appropriations.

In total, \$2.5 million was allocated in FY12, and \$3.6 million was appropriated in FY13 with Bridge funding at \$1.5 million in FY12 and \$1.1 million in FY13. For the combined programs, \$8,975,198 was allocated for FY14, \$11,380,581 for FY15 and \$13,308,581 for FY16 (starting July 1st, 2015).

III. State Level Information

G. Process for Providing Public Notice

Narrative Question:

Describe the process for providing public notice to allow interested parties, such as family members; individuals who are PATH-eligible; and mental health, substance abuse, and housing agencies; and the general public, to review the proposed use of PATH funds (including any subsequent revisions to the application). Describe opportunities for these parties to present comments and recommendations prior to submission of the State PATH application to SAMHSA.

Footnotes:

III. State Level Information

G. 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.

III. State Level Information

H. Programmatic and Financial Oversight

Narrative Question:

Describe how the state will provide necessary programmatic and financial oversight of the PATH-supported providers, such as site visits, evaluation of performance goals, audits, etc. In cases where the state provides funds through intermediary organization (i.e., County agencies or regional behavioral health authorities), describe how these organizations conduct monitoring of the use of PATH funds.

Footnotes:

III. State Level Information

H. Programmatic and Financial Oversight

Describe how the state will provide necessary programmatic and financial oversight of the PATH-supported providers, such as site visits, evaluation of performance goals, audits, etc. In cases where the state provides funds through intermediary organization (i.e., County agencies or regional behavioral health authorities), describe how these organizations conduct monitoring of the use of PATH funds.

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 provider standards and PATH legislative guidelines. This site visit includes a interviewing the program administrator, direct care PATH funded staff, observation of the provision of PATH services, and may include a focus group with clients served. The site visit also includes a review of randomly selected PATH client records. Through the site visit and ongoing phone/video conferencing, the State PATH Contact in partnership with the six (6) DBHDD Regional Offices focuses on the following objectives:

- To provide technical assistance in reporting PATH data in the annual report;
- To monitor the performance of the agreed upon PATH funded services as stated in the IUP and Proposed Budget;
- To evaluate compliance with the agreements required under the program including the Public Health Service Act and Terms and Conditions of the Award;
- To review PATH client records;
- To ascertain strengths of the PATH program; and
- 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 by the PATH Administrative Workgroup (AWG) in 2004 is used to gather information prior to the site visit related to personnel and staff development, policies/procedures/quality assurance and improvement activities, services, fiscal management, cultural competency, consumer involvement, and service processes. Additional information is gathered during the on-site visit when meeting with the PATH Team Lead, Team Members, and the PATH Administrator.

Using the Five (5) Performance Goals for an Effective PATH Program developed by the AWG, discussions focus on:

1. Targeting services to literally homeless individuals;
2. Provision of active management and oversight;
3. Use of Quality Data and Reporting;
4. Use of Exemplary Practices; and
5. Transition to Mainstream.

A written report summarizing 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 approval of provider payment. Providers that fail to meet the PATH monthly performance expectations receive a lower adjusted payment reflecting only those PATH clients who were enrolled.

Financial oversight is accomplished through DBHDD's auditing department, which conducts on site financial audits with selected PATH providers each fiscal year. Providers are selected for audit either randomly or at the request of the State PATH Contact. All providers have a PATH-specific audit at least biennially.

III. State Level Information

I. Selection of PATH Local-Area Providers

Narrative Question:

Describe how PATH funds are allocated to areas and providers with the greatest number of individuals who experience homelessness with serious mental illnesses or co-occurring substance use disorders (i.e., through annual competitions, distribution by formula, or other means).

Footnotes:

III. State Level Information

I. Selection of PATH Local Area Providers

Describe how PATH funds are allocated to areas and providers with the greatest number of individuals who experience homelessness with serious mental illnesses or co-occurring substance use disorders (i.e., through annual competitions, distribution by formula, or other means).

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 hospital and community service management. Each of the six DBHDD regions assumes 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 guidelines, availability of funds, and may be triggered by an interested provider, the DBHDD regional office, or the State PATH Contact.

A provider may trigger this decision by requesting consideration of PATH funding based upon the submission of an Intended Use Plan (IUP) and related budget describing their proposed PATH activities. DBHDD regional office staff reviews all submitted proposals and forwards those that comply with regional planning and PATH guidelines to the State PATH Contact for further funding consideration. A Regional Office may trigger selection of a provider by contacting the State PATH Contact and requesting regional consideration for PATH funding based upon presented need. The State PATH Contact may trigger this decision by issuing a notification of funds available to the DBHDD regional offices and requesting 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. Regional staff, the Director of the Office of Adult Mental Health, and the State PATH Contact jointly participate in the selection process.

Provider 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 team, 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.

Need-based Selection & Funding

According to the 2010 US Census Bureau, Georgia has a population of 9,687,653 with a 20% population growth since 2000. The table below identifies the nine (9) counties in Georgia with the largest population, including prevalence estimates for need of mental health services. Included also are two additional PATH catchment areas (#10 & #11).

Georgia’s PATH funding allocation is based on an urban population formula, with funding priority going to those urban locations with the greatest concentration of homeless individuals (**), as well as availability of other necessary resources to accomplish housing and stability (employment, housing stock, proximity to VA Medical Center or VA Clinic, public transportation, etc.). These priority locations include Fulton (includes the City of Atlanta) 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 to identify service needs by region.

County Ranking with Prevalence Estimate for Need of Mental Health Services

#	Places	Adult Population > 18 years of age		Total Population		# Homeless Persons per 2013 PIT Count	PATH Team (s) Serving this Area
#	County	Population	MH Prev Est.	Population	MH Prev. Est.		
1	Georgia	6,997,025	377,839	8,259,667	478,850	17,000	
1	Fulton** (Atlanta)	681,161	36,783	797,936	46,125	5,959	Community Friendship; Hope Atlanta, Fulton-DeKalb Hospital Authority; Mercy Care Services; Community Advanced Practice Nurses
2	Gwinnett	571,945	30,885	691,677	40,464	1010	Note: due to lack of emergency shelter, homeless persons tend to migrate and/or are referred to housing and other available resources in Fulton County/City of Atlanta
3	DeKalb** (Atlanta)	514,698	27,794	594,103	34,146	705	Community Friendship; Hope Atlanta, Fulton-DeKalb Hospital Authority; Mercy Care Services; Community Advanced Practice Nurses
4	Cobb**	508,281	27,447	596,915	34,538	495	Hope Atlanta
5	Chatham** (Savannah)	197,926	10,688	228,360	13,123	1165	Savannah Chatham Homeless Authority
6	Clayton	182,308	9,845	219,374	12,810	253	(Hartsfield Jackson International Airport)

							Community Friendship; Hope Atlanta, Fulton- DeKalb Hospital Authority; Mercy Care Services; Community Advanced Practice Nurses
7	Richmond** (Augusta)	143,612	7,755	167,754	9,686	465	Serenity BHS
8	Muscogee** (Columbus)	131,092	7,079	155,504	9,032	294	New Horizons BHS
9	Bibb	109,654	5,921	129,292	7,492	312	
10	Berrien, Brooks, Cook, Lowndes, Tift, Turner					308	Behavioral Health Services of South Georgia
11	Douglas					186	Hope Atlanta

PATH Local Area Providers by DBHDD Region

Georgia Department of Behavioral Health & Developmental Disabilities
 Division of Mental Health
 PATH Providers



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|--|---|---|---|
| <p>1. Travelers Aid of Metro Atlanta
 75 Marietta St, Suite 400
 Atlanta, Ga. 30303
 Phone: (404) 817-7070</p> <p>2. Fulton DeKalb Hospital Authority (Grady)
 250 Auburn Avenue
 Atlanta, Ga. 30303
 Phone: (404) 616-9239</p> <p>3. Community Advanced Practice Nurses, inc.
 173 Boulevard, NE
 Atlanta, Ga. 30312
 Phone: (404) 658-1500</p> | <p>4. Community Friendship, Inc.
 85 Renaissance Pkwy, NE
 Atlanta, Ga. 30308
 Phone: (404) 875-0381</p> <p>5. St. Joseph's Mercy Care
 424 Decatur Street
 Atlanta, Ga. 30312
 Phone: (404) 880-3550</p> | <p>6. Serenity Behavioral Health Systems
 3421 Mike Padgett Hwy
 Augusta, Ga 30906
 Phone: (706) 829-4681</p> <p>7. New Horizons CSB
 2100 Corner Avenue
 Columbus, Ga 31906
 Phone: (706) 598-5717</p> | <p>8. Chatham-Savannah Authority
 for the Homeless
 2301 Bull Street
 Savannah, Ga. 31412
 Phone: (912) 780-3400</p> <p>9. Behavioral Health Services
 of South Georgia
 3120 N Oak Street Ext Suite C
 Valdosta, GA 31602
 Phone: (229) 671-8100</p> |
|--|---|---|---|

DBHDD, Office of Decision Support, 5/16/2014

III. State Level Information

J. Location of Individuals with Serious Mental Illnesses who are Experiencing Homelessness

Narrative Question:

Indicate the number of individuals with serious mental illnesses experiencing homelessness by each region or geographic area of the entire state. Indicate how the numbers were derived and where the selected providers are located on a map.

Footnotes:

III. State Level Information

J. Location of Individuals with Serious Mental Illness Who are Experiencing Homelessness

Indicate the number of individuals with serious mental illnesses experiencing homelessness by each region or geographic area of the entire state. Indicate how the numbers were derived and where the selected providers are located on a map.

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 emergency shelter, street, and institutional census counts. These efforts to estimate the number of individuals in Georgia who are homeless with a serious mental illness (SMI) have proven beneficial in the service planning and resource allocation process.

GA Department of Community Affairs' (DCA) 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 across the state. Even though Georgia conducted its first count in 2003, more consistent and reliable practices for counting sheltered and unsheltered homeless began in 2007. The 2013 Report on Homelessness published by DCA in 2014 estimated 53,553 people experienced literal homelessness in Georgia in 2013. The "1996 National Survey of Homeless Assistance Providers and Clients" indicates that 45% of homeless individuals have mental health needs. SAMHSA indicates 20 to 25% of the homeless population in the US suffers from some form of severe mental illness. Based on the 2013 Point-in-Time Homeless census count of 16,946, there is an estimated range of 3,390 to 7,600 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.

Pathways Compass Homeless Management Information System (HMIS)

DCA operates as the state housing authority and supports the Homeless Management Information System (HMIS) known as Pathways Compass. 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. All PATH providers actively participate in Pathways; entering clients into HMIS upon enrollment in PATH funded services. Recent collaboration between PATH and HMIS has resulted in greater client data integration.

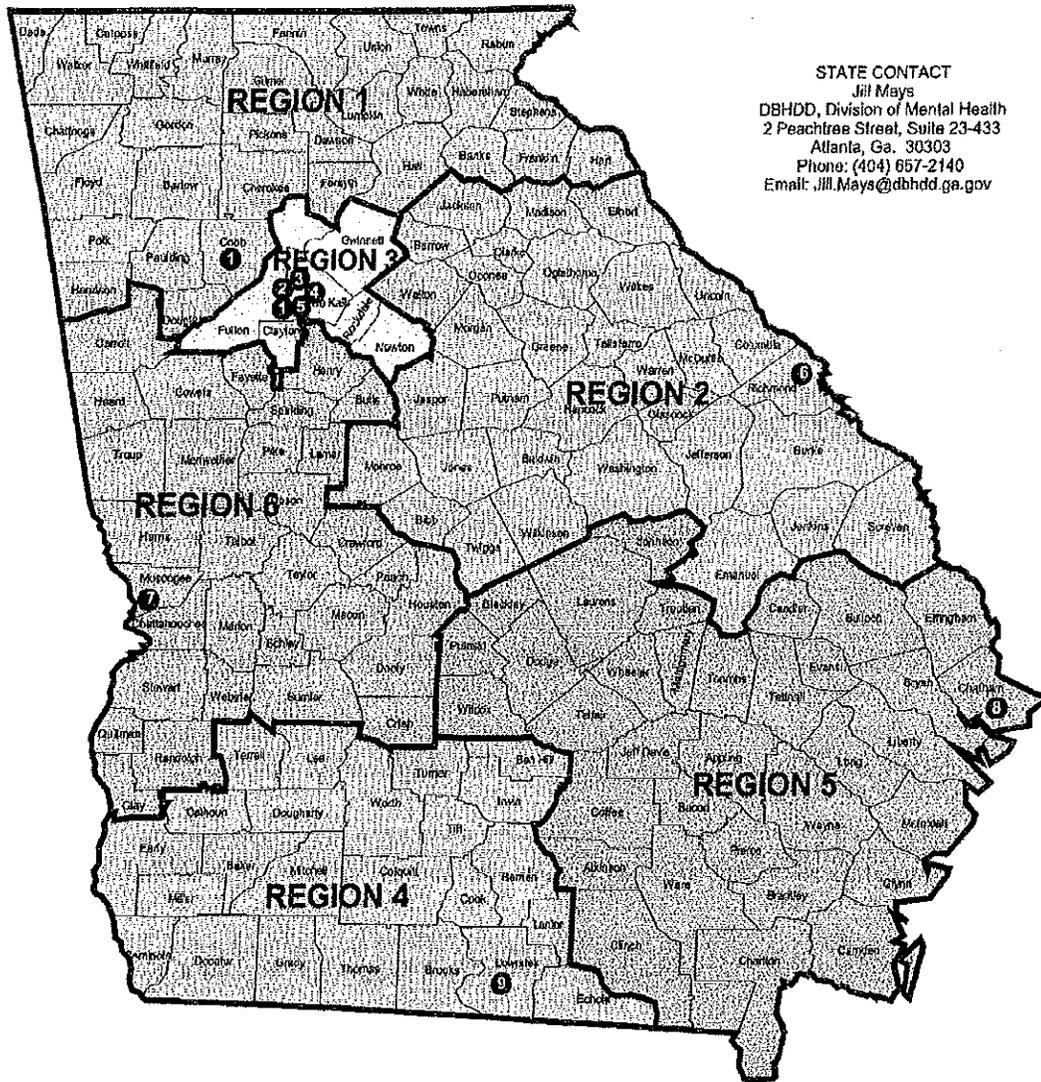
Statewide Performance Management System

DBHDD's information system tracks the number of mental health consumers who self-report as homeless when authorized for community mental health services. The Behavioral Health Planning and Advisory Council (BHPAC) tracks this data quarterly as a part of their state monitoring responsibilities. It is interesting to note that 46% of the adults reporting their living condition as homeless when authorized for mental health services are located in Region 3, which includes Atlanta/Fulton and DeKalb Counties. Therefore, Georgia dedicates nearly 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 2013 From July 1, 2012 through June 30, 2013,
Coinciding with January 2013 Point-in-Time Count*

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
Age Group														
9-17	0	0	0	0	0	0	1	0	0	1	0	0	0	0
18-20	16	20	14	18	35	40	6	5	10	10	9	9	1	1
21-30	115	128	54	102	207	298	47	51	41	45	49	57	90	102
31-40	134	132	77	141	258	407	64	56	42	43	61	70	513	681
41-50	115	189	99	213	368	663	56	65	58	85	66	118	636	849
51-60	88	121	78	149	251	571	48	52	34	52	54	95	762	1333
>60	7	14	7	21	27	81	8	6	4	10	2	14	55	146
Sub Total	475	604	329	644	1146	2060	230	235	189	246	241	363	2610	4152
FY13 Total	1079 [16%]		973 [14%]		3206 [47%]		465 [7%]		435 [6%]		604 [9%]		6,762	
FY12 Total													6,252	
FY11 Total													5,718	
FY10 Total													7,093	
FY09 Total													6,402	
FY08 Total													5,229	
FY07 Total													2,373	

**Georgia Department of Behavioral Health & Developmental Disabilities
Division of Mental Health
PATH Providers**



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Columbus, Ga 31906
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Phone: (229) 671-6100</p> |
| <p>3. Community Advanced Practice Nurses, Inc.
173 Boulevard, NE
Atlanta, Ga. 30312
Phone: (404) 658-1500</p> | | | |

DBHDD, Office of Decision Support, 5/16/2014

III. State Level Information

K. Matching Funds

Narrative Question:

Describe the sources of the required PATH match contributions and provide assurances that these contributions will be available at the beginning of the grant period.

Footnotes:

III. State Level Information

K. Matching Funds

Describe the sources of the required PATH match contributions and provide assurances that these contributions will be available at the beginning of the grant period.

Georgia remains committed to serving homeless individuals with a serious mental illness. The State PATH Contact participates in Georgia's Interagency Council on Homelessness to oversee the implementation of the State Homeless Action Plan, which includes support and advocacy for the PATH Program. 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 every \$3 of Federal PATH funds provided in the FY 2014 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.

III. State Level Information

L. Other Designated Funding

Narrative Question:

Indicate whether the mental health block grant, substance abuse block grant, or general revenue funds are designated specifically for serving people who experience homelessness and have serious mental illnesses.

Footnotes:

III. State Level Information

L. Other Designated Funding

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.

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, including PATH clients, with co-occurring disorders in acquiring skills needed to manage their illness and access community resources.

State General Revenue Funds

Any adult with a behavioral health diagnosis on Axis I or Axis II in accordance with the DSM V 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.

III. State Level Information

M. Data

Narrative Question:

Describe the state's and providers' status on HMIS transition plan, with accompanying timeline for collecting all PATH data in HMIS by FY 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new local-area providers.

Footnotes:

III. State Level Information

M. Data

Describe the state's and providers' status on HMIS transition plan, with accompanying timeline for collecting all PATH data in HMIS by FY 2016. If you are fully utilizing HMIS for PATH services, please describe plans for continued training and how you will support new local-area providers.

The Department of Community Affairs (DCA) funds Pathways Community Network to operate Georgia's Homeless Information Management Information System (HMIS) known as Pathways Compass. This single state HMIS system already collects the PATH HMIS Universal Data Elements required by FY16. More than 343 agencies are members of Pathways and enter client information to connect them to a homeless provider network. All ten (10) PATH Teams are members of Pathways, have completed user and ethics training, and actively enter client data when outreaching or enrolling a homeless individual into PATH supported services.

In collaboration with the State PATH Contact, PATHWAYS has implemented an HMIS redesign that is currently being used by all PATH providers to enter monthly PATH data into PATHWAYS to generate data needed to complete the PATH Annual Report. Training on the new system interface was completed in May 2015. One-on-one follow-up training for agencies will be provided both at the June 2015 1 ½ day PATH Training Summit and on site at individual agencies.

III. State Level Information

N. Training

Narrative Question:

Indicate how the state provides, pays for, or otherwise supports evidenced-based practices, peer support certification, and other trainings for local PATH-funded staff.

Footnotes:

III. State Level Information

N. Training

Indicate how the state provides, pays for, or otherwise supports evidenced-based practices, peer support certification, and other trainings for local PATH-funded staff.

Georgia recognizes the importance and value of training for PATH and behavioral health treatment providers across the state. Multiple approaches offering technical assistance and programmatic improvement strategies are in place through the use of PATH funds and other DBHDD training dollars. Training is made available on an agency basis through routine site visits, on a regional basis through local forums, and offered statewide via multiple formats and in varied locales to provide access to providers in all regions. More and more training opportunities are coming available through technical advancement, including webinars and videoconferencing.

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. Providers may use PATH funds to send Peer Specialists to Certification training to build a competent consumer workforce.

In Region 3, the State PATH Contact and Regional Office PATH Coordinator conduct bi-weekly Metro PATH Collaborative meetings with the five (5) PATH programs to discuss cases, share information, and organize outreach events. Training and local resource presentations are a part of the collaborative meetings.

Each year, the State PATH Contact organizes a statewide PATH training, as well as engages PATH Teams in other DBHDD-funded Training opportunities, including but not limited to:

- 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 2014, PATH Teams attended a statewide training session and follow up webinars regarding the HMIS data migration redesign implementation in addition to technical assistance.
- SOAR Training (March, September, December 2015)
- Mental Health First Aid (April & June 2015)
- Pathways Compass HMIS/HUD Standards Update (May 2015)
- Seeking Safety (EBP for trauma and substance abuse) (May 2015)
- Collaborative Documentation (May 2015)
- Trauma Informed Care for Homeless Veterans (May 2015; combined with CABHI State Supplement Grant staff)
 - Cognitive Processing Therapy (CPT)

- PTSD & DSM 5
- Military Culture
- Impact of Stigma on Outreach and Engagement of Homeless Veterans
- PATH Training Summit and Combined Outreach Practicum (June 2015)
 - Critical Time Intervention
 - Housing First Philosophy
 - Teambuilding & Avoiding Burnout
 - Outreach & Engagement Techniques
 - Accessing VA Benefits for Homeless Veterans
- STAR Behavioral Health Providers Military Culture Tier 1 Training (June 2015)
- Annual Community Behavioral Health 2-Day Symposium (August 2014; October 2015)

III. State Level Information

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

Narrative Question:

Describe how the state encourages provider staff to be trained in SOAR. Indicate the number of PATH providers who have at least one trained SOAR staff.

Footnotes:

III. State Level Information

O. SSI/SSDI Outreach, Access, Recovery (SOAR)

Describe how the state encourages provider staff to be trained in SOAR. Indicate the number of PATH providers who have at least one trained SOAR staff.

In 2009 PATH (Projects for Assistance in Transition from Homelessness) funds supported a three-year project to increase the number of successful SSI/SSDI applications for Georgians experiencing homelessness, to facilitate their recovery and enable them to become contributing members of their communities. GA's premier SOAR training initiative was among the most effective in the nation, according to an outcome report released by Policy Research Associates, Inc. For homeless individuals, the average approval rate for Supplemental Security Income/ Social Security Disability Income (SSI/SSDI) is less than 20 percent. Case managers trained by DBHDD increased the approval rate for those they assisted to 76%, more than three times the national average.

DBHDD continues to offer SOAR training three times a year for PATH and other community providers. Additionally DBHDD has hired Benefits Specialists who work directly on consumer applications within the Regional Offices. In addition to being able to refer PATH consumers to the state Benefits Specialists, all PATH teams are encouraged to have at least one SOAR trained team member of their own. DBHDD has trained over 250 agencies and over 700 individual case managers across the state.