**City of Berkeley Case Management (Shelter Plus Care)/Tenancy Sustaining Services (TSS) must be delivered with a commitment to Housing First principles of non-judgmental compassion, harm reduction and client choice – with the goal of obtaining and maintaining housing.**

**Case Manager/Tenancy Sustaining Services (TSS) activities:**

1. Assess client's strengths and need for support and services in order to obtain and maintain housing, ie assistance with Life Skills, Conflict resolution/mediation.
2. Develop an individualized plan based on the strengths and needs identified and document the provision of services and referrals for services in individual client files.
3. Provide ongoing support and coordination in the following areas (as needed):
    - Benefits Advocacy
    - Representative Payee Services
    - Health/Medical
    - Mental Health
    - Substance Use
    - Employment/education
    - Community/social building activities
    - Landlord Mediation
4. Respond to crises or emergencies as needed. Work collaboratively with other service providers as necessary.
5. Support and assist client in preparing for their annual income recertification and Housing Quality Standard unit inspection.
6. Focus efforts that result in achieving Alameda County System Performance Targets for Permanent Supportive Housing Programs. (See Attached)

**Role of Supervisor:**

1. Provide case conferences and individual clinical supervision on a regular basis, at least monthly.
2. Oversee organization and completeness of client files.
3. Coordinate trainings and ensure all staff are trained.

| **Case Management (Shelter Plus Care)/Tenancy Sustaining Services (TSS)** |
|---|
| **Frequency of Service Provision*:** |
| **<u>Existing Tenants:</u>**<br>Minimum Frequency:<br>1) Monthly in person contact with client;<br>2) Every 2 months in person meeting with client in unit; and<br>3) Every 2 months check in with landlord. |
| **<u>New Enrollments:</u>**<br>New enrollments may require higher frequency of services (at least weekly) before and after housing placement. This includes the activities below: |
| **Before housing placement:**<br>• At least weekly outreach and engagement to enroll client in Shelter Plus Care; and<br>• At least weekly contact to support finding a unit. |

**After housing placement:**

- Minimum weekly home visits for *at least* the first 90 days after the participant moves into the unit. Weekly visits should continue until the participant is stable.

***Once stabilized:***

- Monthly in person contact with client in home or office or in the community;
- Every 2 months in person meeting with client in their unit; and
- Every 2 months check in with landlord.

***All contacts and outreach efforts must be documented in client's file and HMIS.**

**Client Files must contain:**

1. Initial intake
2. Eligibility Documentation, including income verification, disability verification, and homeless verification
3. Fee schedule (if applicable)
4. Release of Information forms (as applicable)
5. Agreement to participate in services
6. Initial assessment of client status and service needs
7. Individual Service Plan (ISP) or other document that specifies client goals, steps clients will take towards those goals, and support to be provided by the case manager. The ISP should be updated periodically as the client's goals changes or are updated.
8. Case Notes which reflect the client's work towards goal in the ISP, and actions taken to resolve any concerns that arise that may jeopardize client's housing.
9. Documentation of referrals made and follow-up.
10. Exit Documentation
11. Documentation of outcomes
12. Notice of Privacy and Grievance Policies

**Training:** Agency shall provide on-the-job or external training (at least 16 hours) for each case manager. Training may include:

1. Housing First
2. Motivational Interviewing
3. Harm Reduction Strategies
4. Home Visit Safety Training
5. Housing/Income Assessment/Strategies
6. Money Management & Budgeting Assessment/Strategies
7. AOD Assessments/Recovery Model and Harm Reduction Strategies
8. Mental Health First Aid
9. Cultural Competency
10. Documentation Training
11. Goal Planning
12. Privacy and Confidentiality (including HMIS training)
13. Public Benefits/Resources
14. Psycho-social Assessments

15. Co-occurring Disorders
16. Stress Management
17. Crisis Management
18. Domestic Violence
19. Role of Case Manager, Boundaries and Limit-setting
20. Engagement Strategies, Working with Resistance
21. Understanding the legal rights and responsibilities of landlords and tenants
**22.** Entering client data and services into HMIS (if relevant)

**Screening Tools should include:**

1. Basic client data, including income, insurance/benefits, current basic needs (food, clothing, etc.)
2. Assessment of client status, including the following elements:
    - Personal History and Current Situation
    - Housing History
    - Income and benefits received or needed
    - Life skills
    - Medical information and any prescribed medications
    - AOD history and current use
    - Psychosocial functioning and mental health status
    - Relationships and social support
    - Health education including nutrition
    - Current services received by client and primary contacts
    - Legal issues
    - Parenting skills and support (if relevant)

**Client Exits:** Agencies must have a policy and procedure in place for exiting clients from the program and recording those exits in the client file and HMIS.

| Alameda County System Performance Targets | | Target |
|---|---|---|
| How Much? | Service Population: Unduplicated count of individuals served (HUD Element, APR Q5a) | Observe |
| | Service Population: Proportion of chronically homeless individuals served during (HUD Element, APR Q5a) | Observe |
| | Service Population: Unduplicated count of households served (HUD Element, Annual Performance Report/APR Q8a) | Observe |
| | Service Population: Proportion of chronically homeless households served (HUD Element, APR Q26a) | Observe |
| How Well? | Data Quality: Data entry within 3 days HUD Element, APR Q6e) | 100% |
| | Data Quality: Adult participants with income info. recorded in HUD Element at entry and annual or exit assessments (APR Q18) | 90% |
| With What Impact? | Are participants maintaining or increasing their income? (APR Q19a3) | 75% |
| | Are participants accessing mainstream benefits? (HUD Element, APR Q20b) | 78% (Inverse of the % of people with SSI at annual/assessment) |
| | Are participants enrolled in health insurance?(HUD Element, APR Q21) | 90% |
| | Are we keeping people housed for one year or longer? (APR Q22a1) | >95% |
| | Exits to Homelessness: What proportion of exits are to homeless destinations? (APR 23a&b) | <5% |