I. State Information

State Information

Plan Year

Federal Fiscal Year 2020

State Identification Numbers

DUNS Number 627383102

EIN/TIN 54-6001731

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

Agency Name Virginia Department of Behavioral Health and Developmental Services

Organizational Unit Office of Community Housing

Mailing Address 1220 Bank Street

City Richmond

Zip Code 23219

II. Authorized Representative for the PATH Grant

First Name Kristin

Last Name Yavorsky

Agency Name Virginia Department of Behavioral Health and Developmental Servi

Mailing Address P.O. Box 1797

City Richmond

Zip Code 23218-1797

Telephone (804) 225-3788

Fax

Email Address kristin.yavorsky@dbhds.virginia.gov

III. Expenditure Period

From

To

IV. Date Submitted

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

Submission Date 5/21/2020 11:47:32 AM

Revision Date 5/21/2020 11:47:42 AM

V. Contact Person Responsible for Application Submission

First Name Monica

Last Name Spradlin

Telephone (804) 655-4433

Fax

Email Address monica.spradlin@dbhds.virginia.gov

Footnotes:

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 Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C.

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

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

HHS Assurances of Compliance (HHS 690)

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

Name

Alison G. Land, FACHE

Title

Commissioner

Organization

VA DBHDS

Signature: Date:

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

I. State Information

Assurances - Non-Construction Programs

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

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

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

Name Alan G Land 5/11/2020

Title

Organization

Signature: Date:

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

I. State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

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

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR ?75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs. The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering

into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C ? 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name

Title

Organization

Signature: Date:

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

I. State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

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

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

Per 45 CFR ?75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs. The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering

into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C ? 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name: Alison D. Land

Title: Commissioner

Organization: DBHDS

Signature: Alison D Land Date: 5/11/2020

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

I. State Information

Funding Agreement

FISCAL YEAR 2020
PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH) AGREEMENT

I hereby certify that the State/Territory of Virginia 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 (including community-based veterans organizations and other community organizations) for the purpose of providing the services specified in Section 522(b) to individuals who:

- Are suffering from serious mental illness; or
- Are suffering from serious mental illness and from 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 use disorder; or
- Has a policy of excluding individuals from substance use services due to the existence or suspicion of mental illness.

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

- To support emergency shelters or construction of housing facilities;
- For inpatient psychiatric treatment costs or inpatient substance use treatment costs; or
- To make cash payments to intended recipients of mental health or substance use 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 that does the following:

- Identifies existing programs providing services and housing to eligible homeless individuals and gaps in the delivery systems of such programs;
- Includes 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;
- Describes the source of the non-Federal contributions described in Section 523;
- Contains assurances that the non-Federal contributions described in Section 523 will be available at the beginning of the grant period;
- Describes any voucher system that may be used to carry out this part; and
- Contains 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 shall:

- Identify the geographic areas within the State in which the greatest numbers of homeless individuals with a need for mental health, substance use, and housing services are located; and
- Provide 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 use, 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, 2021, prepare and submit a report providing such information as is necessary for the following:

- To secure a record and description of the purposes for which amounts received under the PATH Formula Grant Program were expended during fiscal year 2018 and of the recipients of such amounts; and
- To determine 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.

Governor/Designee Name	Alison G. Land, FACHE
Title	Commissioner
Organization	VA DBHDS

Signature: Date:

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

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Governor/Designee Name: Alison G. Land
Title: Commissioner
Organization: DBHDS

Signature: Alison G. Land Date: 5/11/2020

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

M E M O R A N D U M

To: PATH Application Review Panel

From: Monica Spradlin
Office of Community Housing
Virginia (VA) Department of Behavioral Health and Developmental Services (DBHDS)

Subject: Virginia's FFY 2020 PATH Grant Application Signature

In 2018, Governor Northam delegated signatory authority to the Secretary of Health and Human Resources for the remainder of his term in office while designating program responsibility, which includes signatory authority, to the VA DBHDS Commissioner. The delegation letter is also attached in this section of the application. Although the existing delegation letter specifies that the VA DBHDS Commissioner has been designated as having responsibility for the PATH grant, it also denoted Dr. Hughes Melton's name in the document. Sadly, Dr. Melton passed away in August 2019; however, we are moving forward towards continued progress as an agency with our new Commissioner is Alison Land, FACHE. Commissioner Land signed the funding agreement as well as other documents required for signature as, again, the delegation letter referenced the position of Commissioner as having the responsibility for the grant. However, if you determine an updated letter is warranted, please contact me at monica.spradlin@dbhds.virginia.gov and I will work to obtain a new letter. Thank you!

COMMONWEALTH of VIRGINIA

Office of the Governor

Ralph S. Northam
Governor

July 18, 2018

Wendy Pang
Substance Abuse and Mental Health Services Administration
Division of Grants Management
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Pang:

I hereby designate the responsibility for the Projects in Assistance in Transition from Homelessness (PATH) Grant, to Dr. S. Hughes Melton, Commissioner of the Virginia Department of Behavioral Health and Developmental Services, effective this date. I reserve the right to amend or withdraw this designation at any time. Questions concerning this grant should be directed to the Commissioner's office at:

Virginia Department of Behavioral Health and Developmental Services
P. O. Box 1797
Richmond, VA 23218-1797
Telephone: (804) 786-3921

I am also authorizing Dr. Daniel Carey, the Secretary of Health and Human Resources of the Commonwealth to sign the required certifications and assurances required with the submission of the annual PATH grant application for this and subsequent years of my administration.

Sincerely,

Ralph S. Northam

Patrick Henry Building • 1111 East Broad Street • Richmond, Virginia 23219
(804) 786-2211 • TTY (800) 828-1120
www.governor.virginia.gov

I. State Information

Disclosure of Lobbying Activities

Are there lobbying activities pursuant to 31 U.S.C. 1352 to be disclosed? Yes ○ No ◉

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

Standard Form LLL (click here)

Name: Alison G. Land, FACHE

Title: Commissioner

Organization: VA DBHDS

Signature: _____ Date Signed: _____

mm/dd/yyyy

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

A signed form verifyng that there are no lobbying activities has been uploaded under attachments.

I. State Information

Disclosure of Lobbying Activities

Are there lobbying activities pursuant to 31 U.S.C. 1352 to be disclosed? Yes ○ No ●

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

Standard Form LLL (click here)

Name: Alison G. Land

Title: Commissioner

Organization: DBHDS

Signature: Alison G. Land Date Signed: 5/11/2020

mm/dd/yyyy

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

I. State Information

State PATH Regions

Name	Description	Actions
Alexandria	City of Alexandria	
Arlington	Arlington County	
Blue Ridge Behavioral Health	Roanoke and Salem; Craig, Botetourt and Roanoke counties	
Fairfax	City of Fairfax, Falls Church, and Fairfax County.	
Hampton-Newport News	City of Hampton and City of Newport News.	
Loudoun County	Loudoun County and Town of Leesburg.	
Norfolk	City of Norfolk	
Portsmouth	City of Portsmouth	
Prince William	City of Manassas, Manassas Park, and Prince William County	
Rappahannock Area	City of Fredericksburg and Spotsylvania, Stafford, Caroline and King George counties	
Region Ten	City of Charlottesville and Albemarle, Green, Nelson, Fluvanna and Louisa counties	
Richmond	City of Richmond; Veterans' specific outreach is conducted in the broader Greater Richmond Continuum of Care.	
Valley	Cities of Staunton and Waynesboro; Augusta and Highland counties	
Virginia Beach	City of Virginia Beach	

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

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.

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Executive Summary

The Commonwealth of Virginia Department of Behavioral Health and Developmental Services' (DBHDS) Division of Community Behavioral Health (DCBH) has provided homeless services under Projects for Assistance in Transition from Homelessness (PATH) since 1991. In 2018, DBHDS created the Office of Community Housing (OCH) within the DCBH and PATH is now administered as a part of the OCH programming. With its allocation of $1,472,418 in Federal Fiscal Year (FFY) 2020 PATH funds, the Commonwealth will continue to provide PATH-allowable services in the communities within the state with a high prevalence of homeless persons with Serious Mental Illness (SMI) and/or co-occurring SMI and Substance Use Disorders (SMI/SUD).

Organizations to Receive Funds: In Virginia, PATH services are provided by Community Services Boards (CSBs), which serve as the single point of entry into the public behavioral health system. PATH services are available in the catchment areas of fourteen (14) CSBs with the highest rates of homelessness based on data collected in the annual Point-In-Time Count. The table on the following page provides detail on the CSB PATH programs that will operate during the 2010-2021 PATH program year.

PATH Funds Allocated to Providers: See the table below for information on each provider. PATH matching funds are provided by the individual program and include a mix of local and state general fund dollars as well as in-kind goods and services.

Service Areas: See the table below for information on the catchment area of each provider.

Services to be Supported by PATH Funds: Virginia's PATH sub-grantees will provide a range of allowable PATH services, including outreach, screening and clinical assessment, rehabilitation services, community mental health services, access to alcohol and drug treatment for persons with severe mental illness, staff training, case management, residential supportive services, and referrals for primary health care, job training, educational services, and relevant housing services. The only PATH-allowable service not offered in Virginia is Minor Housing Renovation.

Numbers of Persons to be Contacted and Enrolled: As indicated in the table below, Virginia PATH providers expect to contact an estimated 3,320 individuals and enroll 1,609 individuals during FFY 2020; approximately 88% of these individuals are anticipated to be literally homeless.

PATH Provider Organization (All CMHCs)	Service Area (City/County)	Total Federal PATH Budget	Local Match	Persons to be Contacted	Persons to be Enrolled	Percentage Literally Homeless
Alexandria CSB	Alexandria	$106,183	$37,556	100	50	70%
Arlington DBHS	Arlington County	$67,356	$40,984	610	302	98%
Blue Ridge CSB	Roanoke and Salem; Craig, Botetourt and Roanoke Counties	$75,332	$24,112	200	150	90%
Fairfax-Falls Church CSB	Fairfax and Falls Church; Fairfax County	$164,542	$163,380	240	142	99%
Hampton/Newport News CSB	Hampton and Newport News	$101,826	$50,588	200	100	80%
Loudoun County CSB	Loudoun County	$50,182	$204,884	65	40	85%
Norfolk CSB	Norfolk	$106,585	$56,073	200	100	100%
Portsmouth DBHS	Portsmouth	$53,715	$17,905	110	80	70%
Prince William Co. CSB	Manassas and Manassas Park; Prince William County.	$88,067	$39,139	150	50	97%
Rappahannock Area CSB	Fredericksburg; Spotsylvania, Stafford, Caroline and King George Counties.	$98,144	$32,715	270	130	85%
Region Ten CSB	City of Charlottesville; Albemarle, Green, Nelson, Fluvanna and Louisa Counties	$64,862	$21,620	300	130	95%
Richmond Behavioral Health Authority	Richmond (for veterans outreach, includes Henrico, Chesterfield and Hanover Counties and the City of Petersburg)	$202,710	$121,967	550	150	67%
Valley CSB	Staunton and Waynesboro; Augusta and Highland Counties	$41,147	$45,311	125	75	100%
Virginia Beach CSB	Virginia Beach	$126,949	$81,670	200	110	95%
Subtotal		**$1,347,600**	**$937,904**	**3,320**	**1,609**	**88%**
PATH and homeless service provider training and one-time PATH program support		$65,790				
DBHDS Administrative Set-Aside at 4% of total federal allocation		$58,891				
Total Virginia PATH Program Budget		**$1,472,281**	**$937,904**	**$2,410,185**		

II. Executive Summary

2. State Budget

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	37,969.00	0.00	37,969.00	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	78,750.00	28.00 %	0.28	22,050.00	0.00	22,050.00	Behavioral Health Housing Manager: Serves as State PATH Coordinator. Oversees PATH implementation, provider training and technical assistance, and grant administrations. Develops and oversees provider monitoring. Coordinates with SAMSHA and other SPCs.
Other (Describe in Comments)	53,035.00	30.00 %	0.30	15,919.00	0.00	15,919.00	Housing & Benefits Coordinator: Implements PATH provider monitoring protocols. Providers training and technical assistance to PATH providers.

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	51.22 %	$ 19,448.00	$ 0.00	$ 19,448.00	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	$ 1,474.00	$ 0.00	$ 1,474.00	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Mileage Reimbursement	$ 1,474.00	$ 0.00	$ 1,474.00	Travel for training and PATH provider monitoring visits

d. Equipment	$ 0.00	$ 0.00	$ 0.00	

No Data Available

e. Supplies	$ 0.00	$ 0.00	$ 0.00	

No Data Available

f1. Contractual (IUPs)	$ 1,347,600.00	$ 937,904.00	$ 2,285,504.00	
f2. Contractual (State)	$ 0.00	$ 0.00	$ 0.00	

No Data Available

Category	Percentage	Federal Dollars	Matched Dollars	Total Dollars	Comments

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

g1. Housing (IUPs)	3.10 %	$ 45,568.00	$ 65,084.00	$ 110,652.00	
g2. Housing (State)		$ 0.00	$ 0.00	$ 0.00	

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
h. Construction (non-allowable)				
i. Other	$ 65,790.00	$ 0.00	$ 65,790.00	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Other (Describe in Comments)	$ 65,790.00	$ 0.00	$ 65,790.00	Funding to support statewide trainings for PATH providers and to improve behavioral health system capacity to address the housing and treatment needs of the PATH population.

j. Total Direct Charges (Sum of a-i minus g1)	$ 1,472,281.00	$ 937,904.00	$ 2,410,185.00

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	$ 0.00	$ 0.00	$ 0.00	

l. Grand Total (Sum of j and k)	$ 1,472,281.00	$ 937,904.00	$ 2,410,185.00
Allocation of Federal PATH Funds	**$ 1,472,281**	**$ 490,760**	**$ 1,963,041**

Source(s) of Match Dollars for State Funds:

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

II. Executive Summary

3. Intended Use Plans

Expenditure Period Start Date: Expenditure Period End Date:

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

Primary IUP Provider	Provider Type	Geographic Service Area	Allocations	Matching Funds	Estimated # to Contact	Estimated # to Enroll	# Trained in SOAR	# Assisted through SOAR
Alexandria Department of Human and Community Services	Community mental health center	Alexandria	$106,183.00	$37,556.00	100	50	3	1
Arlington County DHS, Division of Behavioral Health Services	Community mental health center	Arlington	$67,356.00	$40,984.00	610	302	1	0
Blue Ridge Behavioral Healthcare	Community mental health center	Blue Ridge Behavioral Health	$75,332.00	$24,112.00	200	150	3	0
Fairfax-Falls Church Community Services Board	Community mental health center	Fairfax	$164,542.00	$163,380.00	240	142	3	11
Hampton-Newport News Community Services Board	Community mental health center	Hampton-Newport News	$101,826.00	$50,588.00	200	100	2	3
Loudoun Community Services Board	Community mental health center	Loudoun County	$50,182.00	$204,884.00	65	40	2	1
Norfolk Community Services Board	Community mental health center	Norfolk	$106,585.00	$56,073.00	200	100	2	29
Portsmouth Department of Behavioral Health Services	Community mental health center	Portsmouth	$53,715.00	$17,905.00	110	80	0	0
Prince William County Community Services	Community mental health center	Prince William	$88,067.00	$39,139.00	150	50	0	0
Rappahannock Area Community Services Board	Community mental health center	Rappahannock Area	$98,144.00	$32,715.00	270	130	1	31
Region Ten Community Services Board	Community mental health center	Region Ten	$64,862.00	$21,620.00	300	130	0	0
Richmond Behavioral Health Authority	Community mental health center	Richmond	$202,710.00	$121,967.00	550	150	2	15
Valley Community Services Board	Community mental health center	Valley	$41,147.00	$45,311.00	125	75	1	0
Virginia Beach Department of Human Services, Community Support Services Division	Community mental health center	Virginia Beach	$126,949.00	$81,670.00	200	110	1	5
		Grand Total	$1,347,600.00	$937,904.00	3,320	1,609	21	96

** IUP with sub-IUPs*

Footnotes:

Alexandria Department of Human and Community Services
720 N. St. Asaph Street
Alexandria, VA 22314
Contact: Krysta Pearce

Provider Type: Community mental health center
PDX ID: VA-001
State Provider ID:
Contact Phone #: (703) 746-5973

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**52,981.00**	**26,096.00**	**79,077.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	63,623.00	100.00 %	0.67	42,627.00	20,996.00	63,623.00	PATH Homeless Services Coordinator
Other (Describe in Comments)	84,437.00	15.00 %	0.10	8,486.00	4,180.00	12,666.00	Family Services Specialist Supervisor
Other (Describe in Comments)	55,756.00	5.00 %	0.03	1,868.00	920.00	2,788.00	HMIS Management Analyst II

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**28.14 %**	**$ 22,252.00**	**$ 10,960.00**	**$ 33,212.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 4,500.00**	**$ 500.00**	**$ 5,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Conference Registration Fee	$ 2,000.00	$ 0.00	$ 2,000.00	Conference registration fees
Mileage Reimbursement	$ 2,500.00	$ 0.00	$ 2,500.00	Travel to trainings
Other (Describe in Comments)	$ 0.00	$ 500.00	$ 500.00	Use of Agency Vehicle

d. Equipment	**$ 300.00**	**$ 0.00**	**$ 300.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Computer Lease/Purchase	$ 300.00	$ 0.00	$ 300.00	

e. Supplies	**$ 3,798.00**	**$ 0.00**	**$ 3,798.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 3,000.00	$ 0.00	$ 3,000.00	
Office: Supplies	$ 798.00	$ 0.00	$ 798.00	

f. Contractual	**$ 2,200.00**	**$ 0.00**	**$ 2,200.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 2,200.00	$ 0.00	$ 2,200.00	cell phone service fee

g. Housing	**$ 6,200.00**	**$ 0.00**	**$ 6,200.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 6,200.00	$ 0.00	$ 6,200.00	Client lodging

h. Construction (non-allowable)

i. Other	**$ 13,952.00**	**$ 0.00**	**$ 13,952.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 5,500.00	$ 0.00	$ 5,500.00	local travel and bus fare
Client: Other (Describe in Comments)	$ 2,500.00	$ 0.00	$ 2,500.00	Client Clothing
Client: Other (Describe in Comments)	$ 2,500.00	$ 0.00	$ 2,500.00	Client medical: co-pays, pill boxes, durable medical equipment
Client: Other (Describe in Comments)	$ 1,552.00	$ 0.00	$ 1,552.00	Client Food
Client: Other (Describe in Comments)	$ 900.00	$ 0.00	$ 900.00	Identification Purchase Costs
Staffing: Training/Education/Conference	$ 1,000.00	$ 0.00	$ 1,000.00	Non-travel staff training costs

j. Total Direct Charges (Sum of a-i)	$ 106,183.00	$ 37,556.00	$ 143,739.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments

k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 106,183.00	$ 37,556.00	$ 143,739.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted:	100	Estimated Number of Persons to be Enrolled:	50
Estimated Number of Persons to be Contacted who are Literally Homeless:	70		
Number staff trained in SOAR in grant year ending in 2019:	3	Number of PATH-funded consumers assisted through SOAR:	1

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Alexandria Department of Community and Human Services

1. Description of Provider Organization:

Name: Alexandria Department of Community and Human Services

Organization Type: Social Services and Community Behavioral Health Agency

Region Served: Alexandria City

Amount of requested PATH funds: $106,183

Contact Information: Krysta Pearce. 703-746-5973 Krysta.pearce@alexandriava.gov

Description of Providing Organization: Alexandria Department of Community and Human Services referred to as (DCHS) throughout the remainder of the application provides services to the residents of the City of Alexandria. DCHS provides services to those experiencing homelessness, mental illness, substance abuse and intellectual disabilities. In addition, DCHS assists individuals and families in accessing resources to increase overall self-sufficiency and independence. DCHS also collaborates with other community partners and supports to provide consumers with assistance in gaining shelter, permanent housing, meals, medical needs and other services as deemed appropriate.

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

- The City of Alexandria DCHS is an integral member the Continuum of Care, known locally as the Partnership to Prevent and End Homelessness. The Partnership seeks to manage the on-going community-wide planning and coordinating efforts in identifying and addressing the needs of those experiencing homelessness within The City of Alexandria. This Partnership identifies current gaps in services for PATH-eligible and homeless clients, housing needs amongst those facing homelessness and other potential resources to reduce the amount of homelessness within the city.
- The HOPC serves as a member of the Shelter Appeal Committee, Case Staffing Committee, Winter Shelter Committee, and Housing Crisis Committee. In this capacity, the HOPC provides advocacy for those with serious mental illness and co-occurring substance abuse disorders who are at risk of becoming homeless and/or those who are homeless and seeking to regain housing and/or housing resources. The HOPC coordinates with the Partnership and is the lead in the unsheltered portion of the annual HUD Point-in-Time count.
- The Partnership fully implemented the HUD Coordinated Assessment in September 2012 by creating the Homeless Services Assessment Center (centralized intake for persons seeking emergency shelter). The HOPC was the previous centralized intake worker for all single shelter intakes and is employed within the same department. This previous knowledge and collaboration allow for a smooth transition for those PATH eligible and non-eligible clients seeking out shelter services. The Homeless Services Assessment Center also has an active diversion and prevention component which seeks to divert persons from entering emergency shelter when possible.

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.

- **Shelters/ Drop in Centers:** DCHS currently collaborates with Carpenter's Shelter and Alexandria Community Shelter to provide emergency shelter for homeless individuals. These two facilities have a total of 124 emergency shelter beds, 76 of which are for single adults. The HOPC works collaboratively with the staff from both shelters, attends shelter meetings, and engages clients at both shelters to assist in connecting clients with appropriate services. Through this process the HOPC identifies any PATH-eligible clients accessing the emergency shelter system and provides necessary referral linkages. The HOPC also conducts regular outreach efforts at David's Place drop-in center which provides PATH non-PATH eligible homeless individuals with a place to shower, wash and dry laundry, and receive mail.
- **Housing:** DCHS operates a Safe Haven housing program with 12 beds. DCHS also has access to a total of 97 transitional housing bed units (35 of which are for single adults), along with 57 supervised apartment units that have been recently transitioned to a permanent supported housing model. HOPC works closely with the community mental health housing programs, Centralized Intake, Shelter Staff and Non-Profit Organizations to determine housing eligibility for PATH eligible clients. HOPC advocates for the lowest possible barriers to gaining housing for PATH eligible clients.
- **Meal Programs:** The HOPC works closely with staff at local faith-based food programs to engage individuals that are PATH-eligible. The HOPC makes frequent visits to the various food programs during meal hours and advises staff when concerns about PATH-eligible clients arise. The HOPC also provides educational support to staff in the various meal programs about the role of the HOPC and outreach and engagement efforts. In addition, the HOPC also provides community partners at the various sites with information about community services. Meal programs are currently operated by local churches, Salvation Army, Christ House, Old Presbyterian Meeting House, Downtown Baptist Church and other community volunteers and organizations.
- **Public Libraries:** The HOPC works closely with staff at local libraries to identify and engage those PATH eligible on non-eligible persons. The HOPC works directly with staff in advocating for the engagement of personal to assist clients in providing educational programs and referrals to PATH provider and other community services.
- **Emergency Assistance:** There are several organizations including Christ House, Christ Church, Old Presbyterian Meeting House, ALIVE House and other faith-based and community organizations within the City of Alexandria that assist with emergency needs such as clothing, food baskets and emergency financial assistance for both PATH-eligible and non-PATH-eligible individuals. In addition, both PATH-eligible and non-PATH-eligible are able to access various components of DCHS for emergency assistance.
- **Medical / Primary Health:** The HOPC assists PATH-eligible consumers in making the needed linkages for their service needs. PATH-eligible individuals are able to access primary medical care via Neighborhood Health, Inc. and/or the City of Alexandria Department of Public Health, and all individuals experiencing homelessness can access free medical care for minor health concerns once a week at Carpenters shelter.
- **Law Enforcement:** The HOPC collaborates with City of Alexandria Police Department and Sheriff's Department to conduct outreach efforts at local camp sites and to engage consumers in the community The HOPC also maintains relationships with local business owners within the City to address issues

related to street homeless individuals and getting them linked with appropriate services. The HOPC also partners with the City of Alexandria Police Department to facilitate a quarterly presentation on PATH and homeless services during the Crisis Intervention Team (CIT) training for police officers, sheriff deputies and other first responders. This presentation is offered to provide them with additional education on the homeless population within the City; as well as the services that PATH offers.

- **Employment Navigation:** PATH-eligible clients and non-PATH-eligible individuals are able to receive assistance with employment search, resume writing and other needed assistance to increase employability via the DCHS Work Force Development Program Employee Navigator and also via the employment specialist staff at the local community shelters. The HOPC collaborates with these programs and refers individuals as appropriate to obtain assistance from their programs.
- **Mental Health:** PATH-funded services include crisis intervention, assistance with acquiring emergency financial resources for medication and referrals for appropriate medical care. The HOPC works closely with other DCHS staff, Emergency Services, Police and other community partners to complete initial screenings for possible psychiatric hospital admissions, crisis stabilization programs, psychiatric evaluations and/or medication evaluations. These services are funded through the DCHS. Community Mental Health services are also afforded to PATH consumers who have not fully engaged in traditional mental health services. The HOPC maintains a consistent outreach effort that includes meeting consumers where they live and spending time in the community, while at the same time providing what could be traditional mental health services such as crisis intervention, mental status evaluations and counseling.
- **Substance Abuse Centers:** DCHS has a substance misuse detoxification program, a 30-day substance misuse residential program, a psychosocial rehabilitation program, as well as an array of housing programs for individuals with serious mental illness and occurring substance misuse disorders. PATH clients are a priority population for these programs.
- **Other Outreach Teams:** The HOPC works collaboratively with the Community Services Board PACT team who also provides outreach services to those with SMI but who are connected to mainstream services. This partnership allows for a broad awareness of clients who are experiencing homeless and in need shelter and or support. However, the PATH provider is the only other program that provides direct outreach to those clients who are potentially eligible for PATH.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

- The HOPC conducts regular street outreach and targeted outreach in the community in an effort to engage PATH-eligible homeless individuals. Local law enforcement and other first responders regularly contact and consult with HOPC on targeting outreach efforts. The HOPC makes regular visits to local meal sites, shelters, the drop-in center, libraries, parks, camp sites and other areas in the city in which the homeless population frequents. The HOPC uses motivational interviewing in an effort to engage and develop a rapport with PATH-eligible and other homeless individuals. The HOPC also responds to various requests by community partners and members with concerns related to homeless persons seen in the community. The HOPC provides support to the individuals encountered during outreach to educate them on available services and to build a rapport in assisting with their

needs. By engaging clients where they are at various times and locations, rapport and trust is able to grow. This relationship allows for potential opportunities to provide appropriate services and connection to mainstream services. The consistency of these services below to client; allow for those eligible to be enrolled in the PATH program to become successful long term.

- **Screening:** The HOPC completes needed screenings and gathers needed psychosocial and social history on all PATH-eligible clients. The information gathered is used to develop a service plan and identify immediate and short-term needs and goals. The HOPC uses a client centered, trauma informed and recovery-oriented approach when engaging all PATH-eligible clients.
- **Clinical Assessment:** The HOPC can complete psychosocial assessments, SMI determinations, risk assessments, VI-SPDAT, SASSI, MORS and fall risk screening. HOPC may conduct a diagnostic review with a supervisor oversight and sign off.
- **Habilitation and Rehabilitation:** Upon successful engagement the HOPC and client work together to examine available services and opportunities within the community. After identifying the client's preferences, the HOPC assists the client with linkage to the identified services. These efforts may include referrals to the West End Wellness Center (WEWC), a DCHS psychosocial rehabilitation program and or/supported employment opportunities. Referrals may also be made to the Department of Aging and Rehabilitative Services (DARS), which has staff with regularly scheduled hours at the DCHS mental health center. The concept of recovery has become an integral component of community-based services for PATH and non-PATH consumers alike. Wellness Recovery Action Plan (WRAP) has been initiated with targeted PATH consumers.
- **Case Management**: The HOPC provides all PATH consumers with case management services until each client is linked with the ongoing traditional or mainstream services. In accordance with a recovery-oriented approach, needs are identified, and goals are developed collaboratively with the client and carefully consider their needs and preferences. PATH-funded case management services include ongoing assessment of individual needs and preferences; referrals and other assistance with linking individuals to agency and community-based services; assisting in applying for SSI/SSDI, Medicaid, SNAP and other entitlements; ongoing monitoring of service provision and the efficacy of such services. Case management services are funded and provided by the DCHS through a variety of programs.

b. Any gaps that exist in the current service systems:

- Many of the barriers that providers get blocked by, are surrounded by the lack of appropriate housing needed to manage the number of clients who would highly benefit from PSH, group homes, transitional housing and or affordable housing. However, the most frequent barrier continues to be limited and/or no funds.

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

- DCHS is committed to providing comprehensive services to individuals with a co-occurring mental health and substance abuse problems. Services are integrated and follow best practice guidelines. The HOPC staff has been cross-trained and is knowledgeable on diagnoses, treatment and services in the areas of both mental illness and substance abuse. In addition, the HOPC conducts assessments for both disorders and makes the appropriate recommendations. Assessments include mental status, risk to self and others, and overall behavioral assessment based upon contact with the individual as well as any information acquired through collateral sources. The HOPC works closely with clinicians at both the Mental Health Center and Substance Abuse Services locations to provide a multi-disciplinary

team approach to address the varying needs of consumers with a mental illness and co-occurring substance abuse disorder. The City of Alexandria Detox program provides short-term detoxification and also a 30-day residential treatment program. The HOPC partners with detox staff to provide community outreach and education. In addition, substance abuse outpatient (SAOP) provides drop in groups, individual therapy and also the Matrix program.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

- HOPC determines PATH eligibility using multiple strategies including clinical records, screenings and assessments, collateral information from other providers, self-reported information and direct observation and investigation. All contacts made with client is documented in HIMS Management system.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

- PATH is currently fully operational in HMIS data reporting. The City of Alexandria Office of Community Services employs two full time HMIS Administrators who work collaboratively with HOPC. The HMIS team and HOPC coordinate monthly meetings on chronically homeless individuals, those clients in all CoC programs and PSH availability. The HMIS team also works with the HOPC monthly to provide system updates and data reports.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

- The HOPC works closely with PATH-eligible clients to assist with applying for appropriate housing options such as group homes, permanent supportive housing apartments and independent living units operated by DCHS. In addition, the HOPC works closely with staff at both shelters to make referrals to programs such as: Christ House Transitional Housing, Community Lodgings, Pathway Homes Permanent Supportive Housing, and New Hope Housing Permanent Supportive Housing. In addition, the HOPC advocates for PATH-eligible clients that may be eligible for homeless diversion and prevention resources and/or resources to assist in getting them re-housed after losing housing. The HOPC also assists consumers in making needed linkages to housing resources available through The Alexandria Redevelopment and Housing Authority (ARHA) to obtain subsidized housing. In addition, the HOPC works collaboratively with housing locator staff at both local shelters to find non-traditional housing resources from private landlords for those PATH-eligible clients with housing barriers such as: criminal background records, eviction history and/or limited funds.
- The HOPC works closely with fellow staff in the Office of Community Services and Alexandria Redevelopment Housing Authority (ARHA) to access additional resources for PATH-eligible and non-PATH-eligible homeless clients. Direct PATH funds can be provided to clients to maintain their housing long-term. HOPC may utilize PATH funds to assist a PATH eligible person with security deposits, technical or planning assistance, and one-time eviction prevention. HOPC also partners with the Office of Community Services as well as local churches and other charitable organizations who provide moving assistance and furniture, security deposits and utility assistance, diversion and prevention through TAP funding as well as eviction prevention.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

- The homeless population is very diverse throughout each of its programs. The HOPC, as a Licensed Social Worker, maintains awareness and respect to the differences in each client as staying culturally competent is key in providing those best practices to each client. Understanding and respecting those differences in clients by allowing the client to be a part of their own treatment provides for a healthy positive outcome. The City of Alexandria as well has a culturally diverse population throughout each department. The City of Alexandria is a strong advocate in providing equal and respectable services to all individuals seeking services regardless of sexual orientation, race, ethnicity, gender, age, or disability. The HOPC utilizes existing staff and community resources to accommodate the various needs of clients. Multi-lingual staff members are available for evaluation and assessment services, case management, therapy and residential services. Staff may also utilize the City of Alexandria's Language Line, a telephonic language interpretation service. Printed products are provided in multiple languages to be consistent with the population served by DCHS.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

- Every staff member and clinician at DCHS, including the HOPC is required to attend an annual training in Cultural Competence. The City of Alexandria has also launched a widespread initiative of Advancing Racial Equity.

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

- Overall Client population:
  - 337 people total "literally homeless"
  - 20 unsheltered homeless adults
- Single Adults
  - 238 of the homeless population in the City of Alexandria was male
  - 139 of the homeless population in the City of Alexandria was female
- Subpopulations (Adults Only)
  - 42 individuals were chronically homeless single adults
  - 17 individuals were veterans 2 chronic homeless
  - 46 individuals were chronic substance abusers
  - 143 individuals suffered from severe mental illness
  - 36 individuals had a physical disability
  - 32 individuals suffered from a chronic health condition
  - 10 individuals reported having a diagnosis of HIV/AIDS
- The PATH program projects contacting 100 consumers during the FY2020 and 50 enrolled- 70% of those clients enrolled will be served using PATH Funds will be literally homeless.

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

As of the year 2016, Arlington County has successfully accomplished the goal of reaching a functional zero when housing veterans with SMI. TOW/PATH continuously work in conjunction with nonprofit agencies and Veterans Affairs providers and services to continue to maintain this goal and work towards the housing of all homeless consumers in the county, most importantly the veteran population.

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

- DCHS consumers who have previously or are currently experiencing homelessness are consistently encouraged to participate at every level within the department. Family members and significant others of the consumers are also encouraged to be a part of the recovery process, which includes the opportunity to participate in department activities. Although many families are not able to provide housing to the PATH consumer, emotional support and understanding during the recovery process are equally important. The DCHS actively encourages family support trainings, supportive counseling services and groups, family education groups, therapy for individuals, couples and families, and treatment team meetings to discuss individualized treatment plans (ISPs).

Program Mission:

- The mission of The Department of Community and Human Services provides effective and essential safety net services that measurably improve or maintain the quality of life for Alexandrians. Additionally, the programs overseen by the Alexandria Community Services Board provide compassionate and effective services that support self-determination, recovery and resiliency for Alexandria residents affected by mental illness, developmental disabilities and substance abuse disorders.

Program Planning:

- The Alexandria Community Services Board which has both consumers and community members as a part of the total membership. This affords the perspective of consumers and their needs and is also inclusive of the community as services/plans are developed.

Training & Staffing:

- Former DCHS and/or PATH clients have been hired for positions in the Safe Haven program, as Peer Support Specialists and a Clinical Recovery Coach. Past and present PATH consumers also hold positions on a variety of recovery-based committees within the DCHS. In addition, DCHS offers regular training and staff development opportunities regarding recovery, client-centered services and family involvement within the treatment and service delivery process.

Informed Consent:

- DCHS provides all consumers with client rights and consumer handbook upon entry into services. The aforementioned documents explain service expectations and risks. In addition, clinicians maintain regular dialogue with consumers about their rights regarding treatment as well as their right to refuse treatment.

Rights Protection:

- DCHS provides ongoing education to consumers regarding their rights pertaining to services. In addition, the agency has a compliance officer that is also available to meet with consumers if needed concerning their rights. In addition, the addition practices HIPPA when discussing and/or exchanging any information pertaining to consumers as well as regarding documentation of clinical information.

Program Administration:

- DCHS provides opportunities within the organization for consumers and family members to serve as volunteers on the Community Service Board and other workgroups within the City of Alexandria related to services and client needs.

Program Evaluation:

- HSAC programs are evaluated based on many major components. Clients who enter the City of Alexandria's shelter system are provided with surveys to speak on their experience with the HSAC team as well as the shelter providers. The shelter providers are also provided surveys to speak on their partnerships with the HSAC team.
- Quarterly meetings are also held by the PATH provider and Finance department to review all PATH funding and ensure all monetary values are being properly allocated and utilized effectively.
- The PATH program uses data to determine the ratio between number of clients engaged vs number of clients enrolled and connected to services. In connection with the goals of the PATH Program the higher the number of enrolled clients and connection to resources the more success the higher the probability of having a successful program.
- All programs within the City that serve clients experiencing homelessness, including PATH, are further monitored monthly for client outcomes and their projects' general contribution towards preventing and ending homelessness in Alexandria. That process is managed by the Continuum of Care's (CoC) Data and Gaps & Needs Committees, who submit analysis and any corrective recommendations to the CoC Governing Board for approval each quarter. The PATH program's outcome data prompted no further review or recommended service adjustments in FY20, illustrating capacity to meet current community needs.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds. Based on historical data the following on the monetary values of each line item in FY20-FY21 budget:

- **Staffing**
  - The Homeless Outreach / PATH Coordinator is the sole provide who supports and provides resources to all PATH eligible clients. The PATH Coordinator has a salary of $61,770.28= $41,386.09 PATH and $20,384.19 match and 95% of their time is provided to support this program
  - The Family Services Specialist Supervisor provides supervision and support to the HOPC. The FSS Supervisor is an intricate part in the partnership with community partners and providing of resources to the HOPC for clients. The FSS Supervisor has a salary of $84,437.39= $8,485.95 PATH and $ 4,179.65 match and spends 5% of their time dedicated to the PATH program.
  - The HMIS Management Analyst III provides assistance to data reporting and HMIS assistance directly to the PATH provider on a monthly basis. The HMIS position $54,132.78= $1,813.45 PATH and $893.19 match is and 5% of their time is contributed to the success of the PATH Program

- **Fringe Benefits**
  - For FY 20-FY21 there is an allotted $21,620 for the PATH Provider
  - For FY 20-FY21 there is an allotted $29,533 for the FSS Supervisor
  - For FY 20-FY21 there is an allotted $18,946 for the HMIS Mgmt. Analyst II
  - Total Fringe benefits $70,119

- **Travel**

- For FY 20-FY21 travel for PATH specific trainings is allotted $1,000
- For FY 20-FY21 training conference cost is allotted $2,000 for the FY
- For FY 20-FY21 there is a $500 match that provides extra assistance in travel and training cost should extra monetary value be needed

- **Supplies**
  - For FY 20-FY21 the PATH Provider utilizes a laptop and cell phone to connect with all clients and manage secure information. The PATH Provider utilizes the HMIS Management system on the laptop provided and the cell phone is the main contact number for all clients and community partners to communicate directly with the PATH Provider while in and out of the field. The amount provided to these resources is $300. Through current contracts $1800 is supplied to contractors for the Cell Phone service fees and the wireless access card for laptop.
  - For FY 20-FY21 postage, envelopes, and any needed office supplies required for client submission of documents or resources is allotted $1,021
  - For FY 20-FY21 sleeping bags, clothing, food, hand warmers, are items that are purchased for clients' needs. There is $2,000 that is allotted for these specific items
  - For FY 20-FY21 there is $600 allotted for miscellaneous supplies that may be needed by clients, or for PATH provider in regard to supplies need for trainings, or potential resources to assist clients.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

- The City of Alexandria uses MUNIS modules that includes general ledger, purchasing, accounts payables, budgeting and human resources. The chart of accounts is a list of all of the accounts in the City of Alexandria's general ledger, and its most basic use is to aggregate information into the reports that will become the City's financial statements. Within the chart of accounts, the PATH Grant has an assigned organizational code account (OCA) for all financial transactions.
- PATH staff percentages are entered in the automated payroll system (KRONOS) according using the assigned OCA. Staff enters time bi-weekly on KRONOS for approval. Once submitted there are processes in place to ensure accuracy. The platform for approval consists of staff manager, office director, department human resources staff, and the city's human resources staff. Monthly review of payroll report ensures staff charges are appropriate.
- Client services payments are determined to be appropriate for disbursement by the program staff. Upon approval of invoices by program staff, they routed to the fiscal staff for processing. The fiscal staff ensures that expenses are consistent with the required activity and PATH eligible services. Invoices are entered in MUNIS using the appropriate OCA and cost codes. There is a three-tier approval prior to the issuance of payments.
- Monthly and quarterly reviews of the PATH Grant ensure that costs are reasonable and allowable according to cost principles description of allowable and unallowable expenses as specified in 45 CFR, Part 75, subpart F.

Arlington County DHS, Division of Behavioral Health Services
1810 N. Edison Street
Arlington, VA 22207
Contact: America Caro

Provider Type: Community mental health center
PDX ID: VA-004
State Provider ID:
Contact Phone #: 703-228-4865

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**67,356.00**	**8,376.00**	**75,732.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	75,732.00	100.00 %	0.89	67,356.00	8,376.00	75,732.00	Mental Health Worker

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0.00**	**$ 31,613.00**	**$ 31,613.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	**$ 0.00**	**$ 341.00**	**$ 341.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 0.00	$ 341.00	$ 341.00	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	**$ 0.00**	**$ 654.00**	**$ 654.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 654.00	$ 654.00	Cell Phone Service Fee

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Housing	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

h. Construction (non-allowable)				
i. Other	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 67,356.00	$ 40,984.00	$ 108,340.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 67,356.00	$ 40,984.00	$ 108,340.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 610

Estimated Number of Persons to be Enrolled: 302

Estimated Number of Persons to be Contacted who are Literally Homeless: 598

Number staff trained in SOAR in grant year ending in 2019: 1

Number of PATH-funded consumers assisted through SOAR: 0

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Arlington County Department of Human Services' Behavioral Healthcare Division

1. Description of Provider Organization:

Name:
Arlington County Department of Human Services / Behavioral Healthcare Division, Client Services Entry, Treatment on Wheels Program (TOW) / PATH

Primary Point of Contact:
America Caro, MA, LPC, EMDR-T
PATH/TOW Clinical Supervisor
(703) 228-4865
acaro@arlingtonva.us

Organization Type:
Community Mental Health Center

Region Served:
Arlington County, Virginia

Amount of federal PATH funds requested:
$67,356

Description of Services Provided:
CSB services are provided through the Department of Human Services. Services are provided to children, adolescents, and adults suffering from intellectual disabilities, substance use and mental illness. Services include assessment and evaluation, case management, therapy and counseling, residential services, employment services, day support, emergency services, psychiatric services, juvenile detention and adult jail-based services.

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

The TOW/PATH team is a team that continues to look for innovative ways in which to streamline the process for consumers to quickly access services with the County, various community partners and nonprofit organizations. The TOW/PATH team is recognized as one of the outreach programs in the county who coordinate and utilize the Centralized Access System (CAS) to facilitate client linkage to appropriate housing and services. TOW/PATH also attend several focus groups with different CoC stakeholders who meet regularly and incorporate the HMIS system to provide no wrong door for homeless individuals, and homeless families when looking to obtain assistance. The TOW/PATH program prides itself in being an active member of the Arlington Zero campaign, Bridges Out of Poverty campaign, Point in Time (PIT) data collection, Data and Evaluation Committee, 10 Year Plan to End Homelessness Services Committee, and Evaluation Governance Working Group committee amongst many other local planning committees.

The TOW/PATH team is also onsite at three local shelters in Arlington for a total of 30+ hours a week to provide services to the homeless population and also provide trainings to staff at these facilities. The team is actively connected with the Permanent Supportive Housing Program (PSH) and related housing grants. Consumers are also eligible for consideration for placement in any three of Arlington's mental health residential group homes and the Intensive Community Residential Treatment (ICRT) group home. The TOW/PATH team also sustains a referral phone line and email to better assist and facilitate with receiving referrals for homeless individuals in the community.

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 Treatment on Wheels/Projects for Assistance in the Transition from Homelessness (TOW/PATH) is a program specifically designed to meet the needs of the county's homeless SMI and those with co-occurring disorders as well as justice involved individuals; as we are part of jail diversion team for Arlington County. Services provided include street outreach, case management, linkage to psychiatric services, linkage to outpatient long term care, linkage to medication and programs which will pay for consumer's medication; linkage to medical, dental, and vision care through the agency's community partnerships, including Neighborhood Health Services Initiatives (ANHSI); and assistance in obtaining shelter placement and/or housing through the CCP, Unified Shelters (ASPAN and RPC), RPC Detox, AACH and Doorways. The TOW/PATH program also helps clients link to substance abuse treatment, including detox facilities, outpatient services and long-term rehabilitation facilities. Other services provided include linking clients to GAP insurance, Social Security Administration services, Department of Motor Vehicle services, nursing facilities; assisted living facilities and Veterans Affairs facilities and services; employment training/vocational trainings/educational services.

In a continued effort towards improving community collaborations, the PATH outreach worker has worked diligently towards improving working relationships with community partners such as Arlington Police and Metro Transit Police by incorporating a homeless co-response model. By incorporating this working model, in partnership with the police departments in our area, the PATH team has been able to help improve relationships between our homeless clients and the police while being able to provide useful resources to our community.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

The Treatment on Wheels/Projects for Assistance in the Transition from Homelessness (TOW/PATH) is a program specifically designed to meet the needs of the county's homeless, chronically homeless, and/or at risk of becoming homeless, SMI and/or co-occurring disorders, and most importantly our veterans. Services provided include daily outreach, case management, psychiatric services and medication management through psychiatric service providers; linking to medical care through the agency's partnership with the Neighborhood Health Services Initiatives, and assistance in obtaining

housing. The full time PATH worker and those that provide services under the TOW/PATH program, access housing options through the county's "Permanent Supportive Housing Program", related housing grant programs available in the community, and other housing program options available through shelters funding. As an additional support to clients who have been housed, the TOW/PATH worker will do regular home visits to help clients feel supported during their transition.
All TOW/PATH consumers are also eligible for consideration for placement in any three of Arlington's mental health residential group homes and the ICRT (Intensive Community Residential Treatment) group home. Referrals are made, when appropriate, to the Arlington Street People's Network (ASPAN), Permanent Supportive Housing program (HPRP); to the Emergency Winter Shelters, and Sullivan House (AACH) from November 1st through March 31st.
The TOW/PATH program offers open clinical/case manager open hours in varied county shelter locations and workers are on site multiple evenings per week to better facilitate the provision of mental health services and client housing needs. The two primary shelters in Arlington are: Residential Program Center (RPC) for adults, and the A-SPAN Homeless Shelter Center (HSC). There are designated TOW/PATH workers who serve as liaison to both facilities, multiple hours a week, and the TOW/PATH worker also provides multiple open group sessions on wide-ranging topics relevant to client needs. In addition to all this, the TOW/PATH program also works in partnership with Doorways for Children and Families, Doorways Safe House, B2i, and Sullivan House. A designated TOW/PATH worker will hold open hours in these locations and/or arrange for frequent visits to these locations to help support the clients served.

b. Any gaps that exist in the current service systems:

<u>Housing:</u>

There continues to be a need for larger capacity holding low barrier shelters available 12 months a year. Arlington has recently incorporated a unified shelter system which allows both shelters, RPC and HSC, to work in partnership towards improving shelter services and bed space availability. Despite the new improvements, at times, the dilemma of space availability continues to be a struggle. Arlington does also offer a program that operates 5 months a year (The Emergency Winter Shelter), which offers extra bed space during winter seasons.
In addition, all clinicians in the TOW/PATH program are participating in the 100 Homes initiative where agencies serving the homeless go out in the streets and identify Arlington's most vulnerable homeless consumers for rapid housing opportunities. Several of the TOW/PATH consumers were identified in this survey and are either now housed or very near to being housed. There continues to be a need for a personal living quarters facility in this county, where residents would sign short term leases for very small units that charge a very low rent; as well as an increase in medical respite beds for people who are homeless and are experiencing a sub-acute medical episode (post-surgery, flu, hospice care). The members of the team, of which PATH is a part, are vocal advocates for these services and serve on several committees that are continually working toward this goal.

<u>Transportation:</u>

Transportation for consumers continue to be a challenge. Public transportation has become very expensive and although most consumers are knowledgeable about and willing to use the metro system, it has become too expensive for them to pay for. Through PATH and county funds, the agency has been able to provide bus tokens, taxi vouchers, Smartrip cards and/or rides in the county vehicle, to only the most important appointments for housing, financial, medical and mental health issues. We try to provide as much assistance with transportation as possible but limited staff resources continues to make this an ongoing challenge.

Medical Attention:

We are very fortunate to have developed the partnership with ANHSI (Arlington Neighborhood Health Services Initiative) and to have an office on site at the mental health center. Many of the TOW/PATH consumers are able to take advantage of this dependable, convenient health care service on a regular basis. However, we still have too many homeless consumers who regularly show up at the emergency room for sub-acute conditions as there is nowhere else for them to go. Although some of our consumers have access to our local free medical clinic, consumers need more access to primary medical services than the clinic can offer. Whenever possible we collaborate with the hospital discharge planners and hospital ER staff to advocate for consumer care and follow-up.

Brief Counseling:

Many of those who are homeless especially those who are homeless for the first time, do not meet the criteria for serious mental or substance use disorders, yet they are under significant stress and often meet the criteria for an acute stress disorder. These issues do not rise to the level needing Emergency Services intervention. Having short term solution-focused support available benefit these individuals significantly. For this reason and need the TOW/PATH team, within the last year and a half, has developed a working partnership with peer support specialists within the agency, to help assist clients by providing additional check-ins and support. Currently the PATH clinicians and teammates provide this service while on site at various locations around the county, however, time is limited, and even brief therapy takes time. Continued team efforts are made when appropriate, to refer and connect these individuals with local agencies who offer mental health services on a sliding fee scale; but again, our consumers have limited funding and the local agencies have long waiting lists.

Psycho-Education and Medication Training:

PATH consumers would benefit from education about their disorders, the medications they are taking and strategies for managing the symptoms. Though this information is presented individually to consumers the repeated presentation in a small group setting at shelters and in drop-in centers are beneficial and a newly incorporated effort made by TOW/PATH staff. Within the past year and a half TOW/PATH has developed and put in place covering an array of topics consisting of psychoeducation on substance use, independent living skills development/sustainment, art therapy groups, and informational community resource groups. The program has had the opportunity to partner with art therapy students and recreational therapists whom have provided clients with individual and group therapy sessions on a weekly basis.

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

The Arlington County Behavioral Healthcare Division participates actively in the state-wide initiative, to adopt a “dual-diagnosis” perspective. Staff assumes that dual-diagnosis is the rule rather than the exception when assessing consumers. In addition to training all staff in the fundamentals of this perspective, one BHD out-patient team is dedicated to serving the consumers who are actively using substances and currently experiencing the symptoms of their mental illnesses. PATH consumers can be, and are, directly referred to this specific team for long term therapeutic care.

Community Mental Health Services:

In Arlington, the TOW/PATH team is a part of the Forensic Jail Diversion Team, within Client Services Entry, a Bureau within the Behavioral Healthcare Division. Our team provides the entire range of mental health and substance abuse services literally "where consumers are" rather than only at the main offices. The full range of services includes a variety of case management services and two psychiatrists has been assigned directly to the team who sees all willing consumers enrolled in the TOW/PATH program. As a subunit of BHD, we can make lateral transfers to outpatient teams when appropriate for the consumer in need of a higher level of care and long-term therapy.

Substance Use Treatment Services:

In addition to having ongoing training in substance use our TOW/PATH clinicians conduct preliminary assessments which include questions relevant to the client's mental health and substance use history. During individual sessions consumers address and explore substance use as it relates to their mental health symptoms. Staff have been trained in identifying the different levels of severity in use, abuse, and dependence. Staff are able to make referrals to substance use detox facilities and outpatient substance use programs as needed. Currently, the TOW/PATH program supervisor, possesses years of experience with substance use disorders and treatment. Her experience has allowed staff to receive a better understanding of substance use, the medical model, and the stages of change clients may find themselves in when under our program care.
As an ongoing support for clients, clinicians have developed a curriculum for ongoing open substance abuse groups, currently held in shelter locations. This group meets weekly and provides extra support to clients who may need it when managing their substance use disorder.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

The target population of the TOW/PATH program are adults 18 years of age and older, who are homeless, and/or at risk of becoming homeless in the near future, in Arlington Virginia with serious mental illness and/or co-occurring disorders. The TOW/PATH outreach worker will engage in daily outreach efforts within shelters and/or the community in an attempt to build relationships with sheltered and unsheltered clients. During the relationship building efforts the TOW/PATH worker will obtain a general sense of the clients and their needs. If the clients with whom the outreach worker has made contact with present as meeting the criteria required for TOW/PATH services, the TOW/PATH worker will offer the client TOW/PATH services and/or other resources that might be beneficial for the client. If the client decides to accept TOW/PATH services the client is then entered into HMIS/ETO and other electronic health records database, a brief TOW/PATH screening is completed with the client and linkage to all other valuable resources begin. If the client refuses to accept any type of TOW/PATH services, continued outreach efforts are made to help build rapport with the client and/or until it is determined the client may or may not benefit from TOW/PATH services. Despite the client's TOW/PATH program engagement or eligibility at the time, they are still offered community resources and information.

Outreach:

All members of the TOW/PATH team will respond to citizen concerns, police requests, other consumer reports and any other source of information about homeless people by going to the location of the report and seeking out the person described. Team members will also provide "in-reach" services at local shelters and the Clinical Coordination Unit on a daily basis. In addition, the "Path Outreach Worker" will establish weekly presence at encampments, meal distribution centers, transportation

centers, food court of local malls, day labor sites and A-SPAN (Arlington Street People's Assistance Network) Opportunity Place walk-in services for the homeless.

Screening:

All Arlington County TOW/PATH team members are Bachelors or Masters prepared Counselors and Social Workers. All have received formal training in screening and diagnosis. The team leader is licensed as a Licensed Professional Counselor (LPC) by the Commonwealth of Virginia and can verify diagnosis. A board-certified Psychiatrist is also available to provide psychiatric assessments when necessary.

Clinical Assessment:

All Arlington County TOW/PATH providers have a Bachelors and/or Masters degree. Our program currently has a bilingual outreach worker, a bilingual licensed program supervisor, and a bilingual licensed psychologist who is the overarching program manager. All TOW/PATH staff been formally trained to complete screens, clinical assessments, and program intakes. They are knowledgeable in identifying symptoms related to mental health diagnosis, and are able to provide provisional diagnosis and justifications. The team leader and clinical supervisor is a Licensed Professional Counselor (LPC) by the Commonwealth of Virginia and can validate diagnosis; and the overarching program manager is a Licensed Psychologist who is responsible for the overall programing of the TOW/PATH program and Forensics Jail Diversion team.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

The local HMIS system in Arlington is ETO and the TOW/PATH contact managing the HMIS partnership with the HMIS providers (Social Solutions) is Mr. Ahmad HajAli. Mr. HajAli has been a great contact and middleman between TOW/PATH and ETO provider. All TOW/PATH workers are currently trained to enter data into the ETO system and have been utilizing the system since June 2016. As of January 1, 2017, workers have been required to enter all clients into the ETO system, are required to complete HUD entry/exit assessments, and document in ETO all referrals made as well as services provided for each client served. The program, currently, does not have an official PATH HMIS data reporting application in the system and for this reason the HUD assessments are completed.

Some of the challenges faced with HMIS/ETO include the delay from the company Social Solutions in creating a functioning, error free, and easily accessible PATH HMIS data reporting application. The company Social Solutions agreed that a PATH HMIS data reporting application would be completed and available to our PATH program by April 4, 2017 but the application is yet to be available. This has made data collection for statistical reporting extremely difficult and tedious to collect. Another challenge has been the delay in program responsivity when entering data into HMIS/ETO. The program is slow and will often time-out the user then making logging-in multiple times a necessity. The program will often freeze and/or is delayed in responding which then causes issues for clinicians entering detailed client data and information.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

Our consumers are eligible for any and all housing opportunities available in the community without discrimination. The TOW/PATH workers make the referrals, provide transportation for consumers to view the programs or interview for admission or leasing, negotiate with landlords for leniency in terms of credit history blemishes and criminal record forgiveness. The housing programs through Arlington County and partnering agencies are listed in 4a.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

The direct service TOW/PATH team is comprised of 80% Masters prepared Social Workers or Counselors. 20% are Licensed Professional Psychologists, 20% are Licensed Professional Counselors, and 40% are currently preparing for licensure. 100% are between the ages of 30-55. 80% are female and 20% are male. 20% are African American, 60% are Latino, and 20% are Caucasian. 60% are bilingual in the English and Spanish language.

The person currently filling our designated PATH Outreach Worker position is bi-lingual, English-Spanish. All staff members receive regular training in cultural and multicultural issues, best practices when severing our LGBTQ+ community and when serving our elder/aging community. Our county is highly committed to diversity of all kinds and demonstrates and investment in staff receiving the proper training to carry out culturally competent services, regardless of job function.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Arlington County, Virginia which is located just outside of the District of Columbia, is a very diverse community and prides itself on a very inclusive and welcoming culture. This diversity is reflected in the whole of the Human Services Division, and equally in the Behavioral Healthcare Division. The agency employs individuals representing many cultures, races, ages and genders. There are also “peer specialists” amongst the staff with an initiative to hire more in the future. There are a myriad of languages spoken and information to be shared by clinicians in a variety of programs. There are regular training opportunities available on cultural issues, and the climate of the agency is such that clinicians feel free to ask cultural questions of other staff if a question arises. BHD’s board of directors is the Community Services Board (CSB) and on that board is a regular consumer representative. Hiring new staff at BHD is a panel decision and programs are encouraged to have a consumer representative on the hiring panel whenever possible. Staff meetings in the TOW/PATH program regularly includes the addressing of cultural issues and informational articles are copied and distributed. The designated PATH worker in the TOW/PATH program is certified by AHEC in “Interpreting in the Community Setting” and all clinicians in the agency are required to take “Working with an Interpreter” training. Also, all clinicians have access to the “Language Line” where interpreters of any language can be utilized. The PATH workers successfully completed a variety of courses within past year. Courses have consisted of Diversity and Inclusion, GARE Racial Equality, Motivational Interviewing, Violence Interventions, Pre-Screening for emergency crisis intervention; Adult Restoration to Competency, Risk

Assessment and Diagnosis, REACH; Trauma Informed Care (TIC), and Moral Reconation Therapy (MRT).

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

The target population of the TOW/PATH program is adults 18 years of age and older, who are homeless and/or at risk of becoming homeless in the near future, in Arlington Virginia with serious mental illness and/or co-occurring disorders. Statistical data collected from the annual 2018-2019 HMIS/ETO report concluded the following: 6% were between the ages of 18-23, 18% were between the ages of 24-30, 21% were between the ages of 31-40, 22% were between 41-50, and 24% were between 51-61, and 2% were 62 or over.
63% were male, 30% were female, and 1.2% were transgender female to male.

0% were American Indian or Alaskan Native, 2% were Asian, 58% Black or African American, 1.2% Native Hawaiian or Other Pacific Islander, and 32% were White.

Projected number of adult consumers to be contacted with PATH funds: 610
Projected number of adult consumers to be enrolled using PATH funds: 302

The percentage of adult consumers projected to be literally homeless is 98%. The TOW/PATH worker is “literally” out on the streets making contact with the priority population. This worker joins community partners to do outreach where the homeless congregate; meal stations, libraries, malls, parks etc., on a daily basis. The PATH program has now been in place for over 10 years and is well known by the homeless population in the community. We are finding that more and more of the homeless population are referred by word of mouth.

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

As of the year 2016, Arlington County has successfully accomplished the goal of reaching a functional zero when housing veterans with SMI. TOW/PATH continuously work in conjunction with nonprofit agencies and Veterans Affairs providers and services to continue to maintain this goal and work towards the housing of all homeless consumers in the county, most importantly the veteran population.

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

Arlington County Behavioral Healthcare Division subscribes to the Recovery-Oriented Approach to mental health and substance abuse service provision. This approach emphasizes client driven definitions of health and quality of life, client participation when designing their treatment program/plan, providing clients with choices when providing services, and the opportunity for the client to decide if they would like family engagement in their level of care services. The Arlington Recovery and Empowerment Center (AREC), a consumer-run drop-in center, opened in the Spring of 2009. The consumers who serve on their Board and work at AREC have been a valuable resource

around our efforts to support and encourage a recovery focused agency as well as where we need to improve.
There is also a consumer advisory committee for the Division. Currently there is not a member on this committee who is enrolled in PATH though there are people who have lived the experience of street life in their past. We conduct annual consumer satisfaction surveys. We strongly encourage our clients to allow communication between family members and TOW/PATH personnel. When such communication is authorized, we work together to establish a service plan involving the client, case manager and the family in achieving goals and objectives.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.
Amount of federal PATH funds requested: $71,563
Source and amount of minimum required 33% match fund: $35,785 The source of local match come from local county tax support.
PATH funds are used to partially fund the duties of a Mental Health Worker and the Homeless Case Management Team. Attached is a detailed budget using Excel file provided by DBHDS.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

PATH funded payroll expenses are based on accounting reports for time of the staff working 100% with PATH eligible clients. Non-personnel expenses are budgeted and require preapproval from fiscal personnel for review for grant compliance, prior to ordering. All expenses are tracked and monitored through our agency ERP system.

Blue Ridge Behavioral Healthcare
610 McDowell Avenue
Roanoke, VA 24016
Contact: Kathleen Guilliams

Provider Type: Community mental health center
PDX ID: VA-002
State Provider ID:
Contact Phone #: 540-982-6990

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**34,370.00**	**4,692.00**	**39,062.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	34,370.00	100.00 %	1.00	34,370.00	0.00	34,370.00	PATH Case Manager
Other (Describe in Comments)	51,000.00	10.00 %	0.00	0.00	4,692.00	4,692.00	PATH Manager

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**25.00 %**	**$ 9,765.00**	**$ 0.00**	**$ 9,765.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 3,290.00**	**$ 0.00**	**$ 3,290.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Conference Registration Fee	$ 250.00	$ 0.00	$ 250.00	
Mileage Reimbursement	$ 150.00	$ 0.00	$ 150.00	
Other (Describe in Comments)	$ 2,890.00	$ 0.00	$ 2,890.00	Use of Agency Vehicle

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	**$ 1,200.00**	**$ 0.00**	**$ 1,200.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Computer Lease/Purchase	$ 1,200.00	$ 0.00	$ 1,200.00	laptop

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	**$ 12,000.00**	**$ 1,350.00**	**$ 13,350.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 11,650.00	$ 1,350.00	$ 13,000.00	
Office: Supplies	$ 350.00	$ 0.00	$ 350.00	

f. Contractual	**$ 0.00**	**$ 770.00**	**$ 770.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 770.00	$ 770.00	Cell Phone Service Fee

g. Housing	**$ 11,000.00**	**$ 11,000.00**	**$ 22,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 5,000.00	$ 5,000.00	$ 10,000.00	Costs Associated with Housing PATH-enrolled Individuals
Other (Describe in Comments)	$ 3,000.00	$ 3,000.00	$ 6,000.00	Security Deposits
Other (Describe in Comments)	$ 2,000.00	$ 3,000.00	$ 5,000.00	One-Time Rental Payments
Other (Describe in Comments)	$ 1,000.00	$ 0.00	$ 1,000.00	Utility Deposits/Assistance

h. Construction (non-allowable)

i. Other	**$ 3,707.00**	**$ 6,300.00**	**$ 10,007.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Medical Contract Services	$ 100.00	$ 1,250.00	$ 1,350.00	Co-payments
Client: Transportation	$ 1,407.00	$ 1,700.00	$ 3,107.00	
Client: Other (Describe in Comments)	$ 300.00	$ 200.00	$ 500.00	Client Medication Assistance
Client: Other (Describe in Comments)	$ 150.00	$ 150.00	$ 300.00	Client Identification Purchase Costs
Staffing: Training/Education/Conference	$ 1,750.00	$ 3,000.00	$ 4,750.00	

j. Total Direct Charges (Sum of a-i)	$ 75,332.00	$ 24,112.00	$ 99,444.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 75,332.00	$ 24,112.00	$ 99,444.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 200

Estimated Number of Persons to be Enrolled: 150

Estimated Number of Persons to be Contacted who are Literally Homeless: 180

Number staff trained in SOAR in grant year ending in 2019: 3

Number of PATH-funded consumers assisted through SOAR: 0

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Blue Ridge Behavioral Healthcare

1. Description of Provider Organization:

Name: Blue Ridge Behavioral Healthcare

Organization Type: Community Mental Health Center

Region Served: Roanoke City, Roanoke County, City of Salem, Craig County, and Botetourt County

Amount of requested PATH funds: $75,332

Contact Information:

Kathleen Guilliams – PATH worker
Phone: 540-556-0795
E-mail: kguilliams@brbh.org

Brittany Huffer – PATH Manager
Phone: 540-353-2980
E-mail: bhuffer@brbh.org

Description of Providing Organization: Blue Ridge Behavioral Healthcare (BRBH) is a Community Services Board providing Mental Health, Development Disability, and Substance Use Services to adults and minors. Services include case management, crisis intervention and stabilization, psychiatric services, counseling, supportive residential services, psychosocial rehabilitation, and outpatient and inpatient substance use treatment.

Blue Ridge Behavioral Healthcare's (BRBH) mission to the community is to "provide quality community-based services that prevent and address mental health disorders, developmental disabilities and substance use disorders." BRBH provides quality services by continuously monitoring and evaluating our services to ensure their cost effectiveness and applicability to current population needs. BRBH operates multiple programs throughout the Roanoke Valley that support individuals with mental health disorders, developmental disabilities, and substance use disorders.

Our current PATH outreach worker, registered as a Qualified Mental Health Professional through the Virginia Board of Counseling, has three years of experience in the behavioral health field. Initially working with the Mental Health Case Management department with Blue Ridge Behavioral Healthcare, the PATH worker gained knowledge of mental illness and diverse populations, came in regular contact with vulnerable populations and developed skills like motivational interviewing and use of evidence based practices. The PATH worker is SOAR certified and holds the title of SOAR local lead for Roanoke and the surrounding counties.

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

The PATH manager sits on the Blue Ridge Continuum of Care Committee (COC) as well as the Blue Ridge Interagency Council on Homelessness, which is the lead entity for the COC. The PATH manager is actively involved in the activities of both committees. BRBH participates on the Blue Ridge Interagency Council on Homelessness (BRICH), which facilitates and coordinates the region's efforts to prevent, treat, and end homelessness and serves as the lead entity for the Blue Ridge CoC planning process. The BRICH includes the counties of Alleghany, Botetourt, Craig, and Roanoke; the cities of Covington, Roanoke, and Salem, and the towns of Clifton Forge and Vinton. The BRICH is composed of members from the general public, local governments, mental health programs, state and federal programs, non-profit organizations, businesses, and colleges and universities throughout the Roanoke region. A central intake (One Door single-point entry) has been implemented in an effort to assist families and individuals in obtaining and maintaining housing resources for all sub-populations.

The BRICH and CoC have implemented the Housing First model as a means to improve services and efficiency. The model states that housing should be the top priority and that individuals should not have to meet pre-conditions to qualify for housing. Since 2012, The Roanoke Valley has decreased chronic homelessness by 67% by utilizing the housing first model. One strategy introduced as part of the transformation is the use of a "by name" list, where providers collaborate to identify and triage the needs of chronically homeless individuals and families by utilizing scoring tools designed to measure vulnerability and level of service needs. Individuals with the most severe needs are prioritized.

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.

Health and Medical Services:

-Rescue Mission Health Center: provides free medical care with medication assistance. They also make referrals for specialized services.
-New Horizons Medical Center: provides medical care on a sliding fee basis to the poor and uninsured.
-Bradley Free Clinic of the Roanoke Valley: provides free medical services to the working poor, uninsured, underinsured, and individuals with Medicaid.
-Carilion Community Care Clinic: specialty referrals, follow-up care, and medications/ medications refills.
-Carilion Charity Care: provides charity care for significant medical procedures to eligible individuals.

The PATH worker makes referrals, schedules appointments, and provides bus passes for transportation. When clinically indicated, the worker accompanies clients to appointments and assists with relaying symptoms and encouraging follow through of recommendations.

Mental Health Care:

-Blue Ridge Behavioral Healthcare: provides psychiatric services, medication management services, outpatient counseling and case management services to individuals who meet the Seriously Mentally Ill criteria.
-The Rita J. Gliniecki Recovery Center: is a BRBH program that provides short-term inpatient crisis stabilization services.
-Family Services of the Roanoke Valley: provides counseling on a sliding fee scale.
-New Horizons Medical Center: provides psychiatric and counseling services on a sliding fee scale.
-Carillon Roanoke Memorial: provides short term in-patient psychiatric services.
-Lewis Gale Pavilion: provides short term in-patient psychiatric services.
-Rescue Mission of the Roanoke Valley: provides psychiatric services to homeless individuals.
-Private Mental Health Skill-Building Companies: provides one on one skills building and Psychosocial Rehabilitation services to increase independence to individuals who have Medicaid.

The PATH worker makes referrals and schedules appointments for all of these services. The worker will also cover bus fare or transport individuals to these facilities for assessment and treatment.

Substance Abuse Services:

-Blue Ridge Behavioral Healthcare: provides medically supervised detoxification from alcohol and other drugs at the Rita J. Gliniecki Recovery Center. Outpatient Counseling Services of BRBH provides day treatment and intensive outpatient services for adults with substance use disorders. This includes group therapy, which meets multiple times weekly.
-Rescue Mission of the Roanoke Valley: provides residential substance abuse treatment.
-Lewis Gale Pavilion: provides limited residential and outpatient substance abuse services.
-Veterans Administration Medical Center, Salem: provides residential and outpatient substance abuse services to area veterans.
-Bethany Hall (ARCH): provides inpatient and outpatient substance abuse treatment and case management to females focusing on females who are pregnant or have children.

The PATH worker makes and takes referrals, collaborates with providers to secure appropriate services. PATH worker will also monitor services once secured and assist with discharge.

Housing Services:

-Rescue Mission of the Roanoke Valley: provides emergency shelter to individuals and families.
-TRUST House Shelter: provides shelter to individuals and families.
-Salvation Army Turning Point: provides emergency shelter and support to women and their children who have experienced domestic violence.
-Roanoke Redevelopment and Housing Authority: provides permanent low-income housing based on income.
-Safe Homes: provides emergency shelter for domestic violence victims in Covington, VA.
-Family Promise: provides emergency shelter to families.
-Community Housing and Resource Center: provides financial assistance to those at risk of becoming homeless who have monthly income.
-Shelter Plus Care: is a funding source through the Blue Ridge Continuum of Care that provides subsidized rent for eligible individuals.
-Private Landlord Network: PATH worker has developed a small network of area property owners that are willing to rent to PATH enrolled clients.
-Subsidized Housing/Private Landlords: There are a handful of private property owners that offer housing based on income for clients that meet their eligibility criteria.

-BRBH Permanent Supportive Housing: provides ongoing financial assistance to the chronically homeless population with diagnosed with a SMI.
-Veteran Administration Permanent Supportive Housing: provides ongoing financial assistance and case management services to veterans that are chronically homeless population.
-Central Intake (COC): provides financial assistance and case management to assist in obtaining housing and retaining housing through preventative financial assistance towards past due utilities and or rent.
-Oxford House: provides safe and affordable housing with seven sites in the Roanoke area to men and women in recovery from substance use.

The PATH worker receives referrals from these providers and assesses potential clients on site. The worker follows up with eligible clients and collaborates with shelter staff. The worker makes referrals for permanent housing and assists with applications and the transition to permanent housing.

Employment Services:
-Department of Aging and Rehabilitation Services: provides assistance to eligible individuals with job training and placement.
-Goodwill Industries: provides job training and employment services
-Virginia Workforce Connection: provides education, training and employment services.
-Total Action for Progress (TAP): provides employment and case management services for ex-felons in the Re-Entry Program.

The PATH worker makes referrals, assists with application process, and transports clients for screening. Worker will also monitor services once secured and encourage continuation of services.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

The BRBH PATH worker employs intensive outreach efforts to identify individuals who are homeless and could benefit from community-based services to address a problem related to mental illness. Through the establishment of a trusting relationship, the worker attempts to encourage the individual to engage in services that will provide the treatment and support that will minimize the effects of the mental illness and increase the likelihood of successfully finding and maintaining housing. PATH worker provides “inreach” by frequenting area shelters and soup kitchens on a daily basis. The PATH worker maintains a close professional relationship with the staff of these establishments to identify referrals and collaborate on service needs. The PATH worker meets with the Roanoke City HAT team weekly to coordinate services and occasionally performs “active” outreach with the Roanoke City HAT team by seeking out homeless individuals who reside in non-traditional settings such as park benches and under bridges.

The BRBH PATH worker makes referrals to mental health services (e.g. Psychiatric services, medication management, financial assistance to obtain medications, and counseling services). The PATH worker educates the homeless client on service options and encourages engagement. The worker will facilitate an appointment being scheduled. The worker will send assessment information to the referral program to review before the scheduled appointment. The PATH worker will attend the appointment with the client if clinically indicated. The worker will follow-up with the referral program to determine outcome for services or provide any additional information. If the homeless client is opened to services, the PATH worker will continue to

provide services to the client as needed throughout the transition. The PATH worker has been working with the Engagement Specialists at BRBH to locate homeless individuals who are discharged from area hospitals and do not show up for their follow-up appointment.

The BRBH PATH worker assesses the need for substance use treatment and will make referrals to BRBH programs and community treatment programs. The worker will provide monthly bus passes to individuals so that they can attend treatment programs. The worker will maintain contact with the referral program to ensure client participation and will also maintain contact with the client while receiving services.

b. Any gaps that exist in the current service systems:

The Roanoke area currently has a shortage in services for the youth homeless population. The youth population has a difficult time accessing shelters for the general population, and at this time there are no shelters geared toward this specific population. Until recently there was a day shelter for the youth population being operated by the Salvation Army. Unfortunately, due to funding limitations this shelter has been closed indefinitely.

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

BRBH routinely offers integrated care to those consumers with co-occurring disorders. Homeless clients with co-occurring disorders can be assessed for appropriate level and intensity of treatment at the Access Center. If appropriate, they are offered crisis stabilization and medically supervised detoxification services, followed by Intensive Outpatient Group Therapy and individual counseling. The Veteran's Administration Medical Center also offers detoxification services. A large shelter in the Roanoke area, the Rescue Mission, offers a faith-based residential treatment program. This is made available to individuals who can abide by the rules and regulations of the program. In addition, individuals not requiring inpatient care are offered MICA groups available in conjunction with day treatment or intensive outpatient, case management and psychiatric services through the Department of Adult and Family Services BRBH. The PATH worker assesses the needs of the homeless individual and will make referrals to any of the above listed programs.
.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

The PATH worker meets with individuals during street outreach, referrals or scheduled appointments and completes a Blue Ridge Continuum of Care Client Intake Form. This form assists with determining housing status such as homelessness or at risk of homelessness. The form also documents whether there is a history of substance use. The PATH worker utilizes evidence-based practices by using motivational interviewing techniques to gather relevant information from the individual concerning past SMI diagnoses, family history, and observing behavioral actions. The individual signs a Blue Ridge Homeless Management Information System Client Consent For Data Collection Release Form if the individual agrees to engage in PATH services. The PATH worker then investigates the individual's housing status by visiting them where they stay on the streets, in the shelter, or requesting a copy of the eviction letter from their current residence. Then the PATH worker will request medical and psychiatric records to determine past SMI diagnoses, or assist the individual with getting established with BRBH and a Primary Care Physician to get a SMI and/or Substance Abuse diagnoses. The PATH worker enrolls the individual in PATH services and documents the case management services in HMIS.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

Blue Ridge Behavioral Healthcare has participated in HMIS (Blue Ridge Community Assistance Network-BRCAN) since its implementation in 2006. The current provider is Service Point. The PATH worker and manager are trained and fully utilizing HMIS for PATH data entry. In addition to HMIS, PATH worker enters data into Cerner, BRBH's electronic medical record to show registration of services. Ongoing training and support is offered through the Blue Ridge Community Assistance Network of existing and new staff.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

The PATH Worker meets with individuals and assesses housing needs and ability to secure and pay for housing. If the individual is without shelter the worker will encourage the individual to enter a shelter or provide funding for emergency housing. If the individual is residing in a shelter, the worker will meet with the individual and relay temporary and permanent housing options to them. The worker will assist the individual in applying for and securing the most appropriate housing. The worker can utilize PATH funding for one time rental assistance and security deposits.

The PATH worker also attends the Community Wide Case Conferencing for the Chronically Homeless. This is a bi-weekly meeting to review high scoring VI-SPDAT cases in attempt to collaborate and secure housing for individuals based on highest need. This meeting is a derivative of the Veteran's Initiative, which has been very successful in our area.

PATH worker collaborates with the BRBH Permanent Supportive Housing Program to determine eligibility in the program and assistance with gathering additional information, if needed.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

The PATH worker consults with supporting agencies such as Refugee and Immigration Services and the Hispanic Consortium to seek assistance when the situation requires a change in approach or a change in provider. PATH manager attended this year's Roanoke Language Access Conference focusing on Building Bridges Across Cultures.

BRBH strives for all staff to be able to effectively communicate in a respectful manner that is easily understood by diverse populations. BRBH is sensitive to this and several staff have been certified as Qualified Bilingual Staff. The agency is mandated to provide language access services. The AT&T Language Line is available for staff to use for interpretation services. The agency also utilizes Commonwealth Catholic Charities Interpreter Services, and has a contract with a certified interpreter for the deaf.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities. Cultural Competence training is part of New Employee Orientation for all new employees of BRBH. The PATH worker participates in online trainings offered through the company's e-learning system, mandated at least annually.

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

a. The demographics of the target population.
American Indian or Alaska Native: 4 %
Asian: 0 %
Black or African American: 23 %
Native Hawaiian or Other Pacific Islander: 0 %
White: 73 %
Other: 0 %

*Based on the most recent demographics of enrolled PATH clients

b. Projected number of adult consumers to be contacted with PATH funds: 200
c. Projected number of adult consumers to be enrolled using PATH funds: 150
d. Percentage of adult consumers projected to be "Literally Homeless: 90% PATH consumers are projected to be literally homeless.

The Outreach Worker visits shelters, residential facilities, hospitals, local jails, parks, abandoned buildings (i.e. housing, warehouses), known "hotspots" within the surrounding wooded areas and greenways, and other areas frequented by homeless individuals. She also receives referrals from all public or private facilities along with the local Homeless Assistance Team (HAT) and Roanoke City Police Department. The worker assists individuals in the search for permanent or transitional housing. PATH funds are used to pay for security deposits, rent or emergency housing. This is instrumental in getting individuals stabilized and working toward more permanent housing, utilizing the Housing First Model and referring them to supports in the community.

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

The PATH worker visits area overnight shelters, day shelters and the HAT team office on a regular basis. When a homeless veteran is identified, the PATH worker educates them on all resources including those specific to veterans such as the VA medical center and Trust House. The PATH worker makes referrals to the VA homeless outreach worker. The homeless Veteran decides where to receive their services. Representatives from the VA Medical Center participate in the Blue Ridge Continuum of Care and the Blue Ridge Interagency Council on Homelessness and service collaboration occurs at these meetings. The Blue Ridge Continuum of Care actively participated in the Veteran's Initiative and was successful in bringing veterans' homelessness to a functional zero.

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

Blue Ridge Behavioral Healthcare actively seeks input from family and clients. Currently BRBH has 8 Peer Recovery Specialist positions, 1 Parent Peer Support Partner, and 1 Youth Support Partner employed across various programs throughout the agency. Informed consent is assured through agency policy and procedures. BRBH adheres to the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded, or Operated by the Department of Behavioral Health and Developmental Services* and reports all concerns to the Office of Human Rights.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

Personnel Costs – BRBH PATH employs an Outreach Worker (1.0 FTE). Supervision of the outreach worker and the PATH funds is provided by the Director of Mental Health Skill-building Services (0.10 FTE). Fringe benefit costs are calculated at 25% of salaries.

Vehicle Operating Costs, Personal Mileage – This is for maintenance costs for the vehicle available for PATH outreach activities, and for personal mileage reimbursements incurred when the agency vehicle is not available.

Training Travel- Travel related costs for attending workshops and trainings.

Conference travel- Travel related costs for attending state and national conferences.

Supplies- Represents the costs of office supplies, and outreach supplies such as backpacks, blankets, raingear, clothing, and personal hygiene items made available to clients.

Contractual Costs: Represents the cost of service fees for the PATH Worker's cell phone.

Co-payments for Primary Health Care: A small fund is available to pay applicable co-payments for needed medical care for PATH eligible clients.

Medication Purchase Assistance – These funds cover financial assistance with the cost of medications for medical and psychiatric conditions when personal and public resources are not available.

Identification related purchase costs – A small fund is available to assist clients with the costs of securing acceptable identification, and will include assistance with the costs of securing birth certificates.

Security Deposits – This category is for PATH-enrolled individuals who are in the process of acquiring rental housing but who do not have the assets to pay the first and last month's rent or other security deposits required to move in.

One-time Rental Payments: These funds are for individuals who cannot afford to make payments themselves and are at risk of eviction without assistance.

Costs Associated with Housing: This is expenditures made on behalf of PATH enrolled individuals who are establishing a household. This may include items such as rental application fees, furniture and furnishings, and

moving expenses. This may also include paying for credit checks and outstanding debts that otherwise would keep them from successfully securing available housing.

Bus Passes – Funds are available for the purchase of bus passes to provide client access to medical appointments, assessments and treatment programs.

Staff Training – Non-travel related costs of registration and participation in training activities.

Office Rent – Occupancy costs associated with the office space available for the PATH worker.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The PATH manager approves all requests for PATH funding. To access PATH funding a PATH request must be completed documenting the nature of the request and items documenting eligibility. PATH funds are prioritized by funding availability and client need. The PATH manager utilizes the following guidelines for requests for PATH funding:

a. Guidelines for PATH requests
    1. Housing supplies $500 max
        - Mattress/bed purchase (Mattress Warehouse provides a discount) – request a check from Accounts Payable using requisition form
        - Furniture/housing needs (linens, kitchen supplies, cleaning, etc.) – purchase a Walmart or Visa gift card – use agency credit card
    2. One-time rental assistance to avoid eviction
        - PATH and non-PATH requests (no limit, but generally we strive to avoid paying more than 2 months – can be adjusted based on funding)
        - Must have a copy of the eviction and amount
            - Must have a sustainability plan
            - Can only be used once a fiscal year
    3. Security deposit/First month rent (no limit on amount; single BR or efficiencies, can be a boarding house)
        - PATH – can pay both at once if needed
        - Non-PATH – security or 1st mon – <u>not both</u>
        - Request check from Accounts Payable using requisition form
        - Must have copy of lease agreement
    4. Hotel stays to avoid being on street
        - No more than 5 days in fiscal year
        - Typically use the Days Inn or Ramada Inn
        - Use agency credit card
    5. Valley Metro
        - Check cut 3x a year ($500 at a time) – request from Accounts Payable (AP)
        - Put funds on BRBH PATH account set up.
        - Pick up designated amount of tickets (monthly, daily, and single ride)
    6. Utility Assistance (no limit – be cautious based on budget – I usually negotiate splitting between client/PSH and PATH)
        - Do not use online or telephone portal (there is a fee).

- Request check from AP using requisition form
- Include account number and payment mailing address on requisition
- Obtain copy of bill, deposit letter, or shut off notice
- Must have sustainable payment plan if avoiding shut off
- If a shut off notice – call utility company to pledge funds with tax ID

The PATH Outreach Worker and PATH Manager utilize an excel spreadsheet to track all expenses. PATH manager meets with the PATH Outreach worker for regular supervision in which the PATH budget is reviewed. The BRBH PATH program has created great relationships with area vendors and because of this we are confident in the pricing and quality of the services and products we receive.

The PATH manager also works closely with the agency finance team on budget creation, budget adherence, and any purchase of goods or services that fall outside the realm of normal expenses. The finance team utilizes a separate accounting software (SAGE Intacct) where PATH revenues and expenses can be reconciled against the records the program keeps on its Excel tracking sheet.

Fairfax-Falls Church Community Services Board
12011 Government Center Parkway, Suite 836
Fairfax, VA 22035
Contact: Neva Ortuno

Provider Type: Community mental health center
PDX ID: VA-006
State Provider ID:
Contact Phone #: 703-533-5763

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**109,614.00**	**108,739.00**	**218,353.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	87,137.00	100.00 %	0.50	43,743.00	43,394.00	87,137.00	Behavioral Specialist II
Other (Describe in Comments)	70,940.00	100.00 %	0.50	35,612.00	35,328.00	70,940.00	Behavioral Specialist II
Other (Describe in Comments)	60,276.00	100.00 %	0.50	30,259.00	30,017.00	60,276.00	Behavioral Specialist II

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**25.16 %**	**$ 54,928.00**	**$ 54,641.00**	**$ 109,569.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 0.00**	**$ 0.00**	
No Data Available				
d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	
No Data Available				
e. Supplies	**$ 0.00**	**$ 0.00**	**$ 0.00**	
No Data Available				
f. Contractual	**$ 0.00**	**$ 0.00**	**$ 0.00**	
No Data Available				
g. Housing	**$ 0.00**	**$ 0.00**	**$ 0.00**	
No Data Available				

h. Construction (non-allowable)				
i. Other	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

j. Total Direct Charges (Sum of a-i)	$ 164,542.00	$ 163,380.00	$ 327,922.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 164,542.00	$ 163,380.00	$ 327,922.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted:	240	Estimated Number of Persons to be Enrolled:	142
Estimated Number of Persons to be Contacted who are Literally Homeless:	238		
Number staff trained in SOAR in grant year ending in 2019:	3	Number of PATH-funded consumers assisted through SOAR:	11

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Fairfax-Falls Church Community Services Board

1. Description of Provider Organization:

Name: Fairfax-Falls Church Community Services Board (CSB)

Organization Type: Community Mental Health Center

Region Served: Services are provided to citizens of Fairfax County and the Cities of Falls Church, Fairfax and Herndon.

Amount of received PATH funds: $164,542

Contact Information: Carlos Estrada, (703) 799-2842, carlos.estrada@fairfaxcounty.gov

Description of Providing Organization: The Fairfax-Falls Church CSB offers a wide range of services, including outreach, outpatient, case management and residential services. All the services emphasize evidence-based practices that incorporate consumer recovery involvement in the process. The Fairfax-Falls Church CSB provides assessment, referral, crisis intervention, case management, counseling, emergency services, hospital discharging, youth services, intensive case management, residential treatment, day treatment, detoxification, jail diversion, assertive community treatment, peer support, vocational and medication/psychiatric services to those needing Mental Health, Substance Abuse and Intellectual Disability services. From the beginning of the establishment of the CSB, services were provided to the homeless population. The CSB started providing outreach services in the late 1970's in collaboration with the community faith-based and non-profit organizations. Shortly afterwards shelters were constructed which included on site services from the CSB. When the McKinney-Vento Homeless Act was approved, title VI provided funds specifically for PATH outreach workers along with shelter plus care, single room occupancy program, emergency and transitional shelter program, and the housing demonstration program. We participated in the collaboration with other programs using these funds for housing for SMI and clients with a co-occurring disorder. In addition to PATH workers the CSB provides additional outreach services through intensive case management and assertive community treatment teams. PATH participates in the Continuum of Care and provide ongoing collaboration and consultation with other community providers to help meet the housing needs of the SMI and co-occurring homeless individuals. In FY 1999, the State of Virginia nominated the Fairfax County PATH team as recipients of the Exemplary Program Initiative Award stating that "this program has consistently displayed excellence in both program design and the delivery of PATH and other related services". The PATH team was notified on April 6, 2020 of their selection to receive a CSB Spirit of Excellence Honors Award this Fall in the area of Customer Service for their exemplary performance.

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

PATH workers actively partner with the Fairfax County CoC in several important ways. Every year PATH staff plan, train, and participate in the Point in Time count in Fairfax County. PATH was also involved with the CoC by working together on the 100,000 Homes initiative and is currently participating in the Built For Zero initiative to attempt to end chronic homelessness in Fairfax County. PATH workers were on the Registry Week planning committee for the 100,000 Homes initiative and helped identify places to administer vulnerability indexes, as well as help administer them. PATH staff have had the opportunity to travel to

different areas of the country to attend Built For Zero learning sessions using funds provided by Fairfax County's Office to Prevent and End Homelessness. This is an ongoing initiative for OPEH and the CoC over the next few years. PATH workers also meet frequently with the regional CoC groups that problem solve ways to help connect the unsheltered people to housing. PATH workers attend different meetings with the CoC including outreach meetings, homeless veterans meeting, hypothermia coverage meetings, and coordinated housing referral pool meetings. The PATH team will follow the workflow created and use all necessary forms that are required by the CoC in order to continue to support individuals in need of housing and be able to place housing referrals in the HMIS. Finally, PATH workers are a significant part of the yearly hypothermia prevention program in Fairfax County through planning, providing on site assistance at the shelters and providing training to volunteers that help in the program.

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.

Fairfax County's goal is that every person who is homeless or at risk of being homeless is able to access and maintain appropriate affordable housing and services. Coordinating this effort for the County is the Office to Prevent and End Homelessness (OPEH). We provide services to PATH clients in partnership with OPEH and other county agencies including the Department of Housing and Community Development, the Department of Family Services, the Department of Systems Management for Human Services, the Public Health Department, Public Schools, Police Department, and the Office of Emergency Management. In addition, we work with numerous faith-based and non-profit organizations to serve the needs of PATH clients. These agencies include Christian Relief Services, NA/AA, Northern Virginia Family Services, Lutheran Social Services, OAR, New Hope Housing, Cornerstones, United Community Ministries, the Lamb Center, FISH, Western Fairfax Christian Ministries, ACCA, SOME, FACETS, Rising Hope, Catholic Charities, ECCO, Multi-Cultural Clinical Center, NAMI, Good Shepherd Housing, and Shelter House. PATH outreach workers are actively involved in the county's Homeless Healthcare Program which provides primary care Nurse Practitioners and a CSB Psychiatric Nurse Practitioner. PATH community outreach workers routinely focus on linking clients to affordable mainstream medical and dental services. In coordination with the Public Health Department, and two emergency shelters (Embry Rucker and Bailey's Homeless Shelters) and the Department of Family Services, there are ten medical respite beds dedicated to homeless individuals with acute medical conditions. The CSB has partnered with Neighborhood Health, a community health care network in efforts to integrate medical and behavioral health at all CSB sites. Neighborhood Health provides primary health services for low income, uninsured, residents at three locations in the county. The CSB's collaborative efforts with Pathways Homes Inc., Gateway Homes, New Hope Housing, FACETS, and Reston Interfaith helps ensure that clients served by PATH have safe, affordable, and supportive housing. PATH often partners with PRS, Inc., a local non-profit that operates two Recovery Academies in Fairfax County, to help clients gain skills and insight needed for their recovery. PATH also partners with the CSB's Vocational Services, Department of Rehabilitative Services, Laurie Mitchell Employment Center, and Service Source to help clients secure employment. PATH links clients to several Peer-Run Recovery Centers that offer drop-in services such as peer support, meals, psychoeducational and recreational programming, and service referrals (i.e.: vocational supports). Other drop-in sites for PATH clients include the Lamb Center, First Christian Church, Bailey's Shelter, Cornerstones Shelter and Rising Hope Mission Church. In the winter, many PATH clients who live outside go to hypothermia shelters which are run by non-profit organizations under contract with Fairfax County's Office to Prevent and End Homelessness. PATH staff schedule dates and times on a weekly basis with the different non-profit organizations as well as the health department to do outreach in the community. PATH staff serve 4 different regions in Fairfax County. Each region is served by a specific PATH staff who will coordinate outreach with the different non-profits and the Fairfax County Health

Department of its respective region. The FCHD psychiatric nurse assigned to each region is an integral part of these coordinated outreach efforts. On several occasions, the PATH team has coordinated and participated in joint outreach efforts with Fairfax Detox staff as well.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

Outreach:
PATH workers outreach individuals "where they are" in the community for assessment and engagement, taking resources, such as sleeping bags, food and bus tokens to the client. Daily, PATH workers visit camps, streets, emergency shelters, hypothermia shelters, peer support drop in centers and non-profit homeless drop in centers. Engagement and linking to mainstream services is the primary focus of these interactions. PATH workers facilitate/coordinate drop-in groups (in-reach) throughout the County. In the north county area, this occurs twice a week at the Cornerstones Shelter. In the south county area, it occurs twice weekly at the Gartlan Community Mental Health Center. In central county, PATH supported drop-ins are available twice a week at the Lamb Center. During these groups, clients have access to showers, washers and dryers, meals, and other needed items, such as underwear, coats in winter, etc. There are also onsite services at the drop-ins including: a medical nurse practitioner from the Public Health Department, a CSB psychiatric nurse practitioner, CSB psychiatrist, and a non-profit outreach worker with our homeless healthcare program. Additionally, PATH workers receive referrals from individuals and outside agencies.

Screening:
An initial eligibility screening occurs with all identified potential clients and a more comprehensive assessment is completed when individuals are willing to engage in mental health or co-occurring treatment services. PATH workers refer to psychiatric emergency services, detoxification services, or emergency medical care when needed. On-going assessments occur throughout the engagement process to determine appropriate case management needs. Psychiatric screenings are done by the Psychiatrist and Psychiatric Nurse Practitioner. An emphasis is placed on engagement into mainstream services, collaborative case management, and linking the individual with affordable housing resources.

Clinical Assessment:
PATH workers are trained mental health therapists who can provide clinical assessments without being intrusive. PATH workers rely on clinical observation, motivational interviewing, building rapport, stages of change, engagement level, and past clinical history to complete clinical assessments.

Community Mental Health Services:
The PATH workers provide referrals and linkage to CSB mainstream services such Behavioral Health Outpatient Services, Jail Diversion, PACT, Intensive Case Management teams, Adult Partial Hospitalization, Co-Occurring Residential Treatment Programs, as well as the CSB's Crisis Stabilization Unit and Emergency Services. PATH participates in outreach and crisis intervention with our mobile crisis and detox diversion units. PATH clients have access to our low-cost medications through our Genoa pharmacy, patient assistance programs, and medication samples. We also provide CSB subsidized psychiatric medication as needed.

Substance Use Treatment Services:

PATH workers use motivational interviewing, harm reduction, and trauma informed techniques to provide supportive counseling and engagement for individuals with co-occurring disorders. PATH provides referrals to individuals whom only present with a substance abuse disorder to Detox, medication assisted treatment, outpatient services, SOME, and residential substance abuse treatment programs.

Training of Community Provider Staff on PATH and its Consumers:
The Fairfax Falls Church CSB has a strong commitment to providing evidence based/best practices training to all staff. Trainings have included and continue to include: Trauma sensitive services, DBT, working with homeless veterans, motivational interviewing, suicide assessment/prevention training, ethics in behavioral health, MANDT, CPR, First Aid, OSHA, Blood borne Pathogens, Human Rights, and the REVIVE training. Additionally, we have participated in webinars on SAMHSA, PATH, SOAR and National Healthcare for the Homeless websites. PATH staff provides training to other CSB, County and non-profit staff about working with mentally ill homeless clients. The County offers additional onsite training and e-learning courses on a variety of subjects for professional development. The CSB offers REVIVE training to the different non-profit organizations and to consumers.

Residential Supportive Services:
PATH provides support during client transition periods from the streets to shelters and other supportive housing. We continue to follow clients through the transition period as they begin to make the adjustment from homelessness. On-going collaboration occurs with the new service provider to plan and coordinate the transition at the client's pace.

SSI/SSDI Outreach, Access, and Recovery (SOAR):
Currently the PATH team/Fairfax has 3 full time PATH workers trained at doing SOAR applications. Two PATH staff are considered SOAR leaders and provide support to Fairfax county. The State Coordinator will be working with the CoC to expand SOAR in our region and PATH will play an integral part in that expansion. It is the goal of the PATH team/Fairfax to train more PATH staff in the future.

b. Any gaps that exist in the current service systems:

Currently, PATH is working well within the CSB's and CoC's service systems. PATH functions well as a "front door" to services within the CSB service system, allowing staff to directly open new cases and link them with mainstream services within the CSB. PATH also partners closely with services and resources available through agencies that are part of the CoC in Fairfax County.

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

Our co-occurring continuum of services provides Evidence Based Practices such as Motivational Interviewing, Harm Reduction, and the Principles of Recovery and Housing First. The full range of CSB co-occurring services is available to all clients at various stages of recovery. These services include emergency services/mobile crisis units, crisis stabilization programs, detox, outpatient medication assisted treatment, intensive outpatient program, residential treatment programs, vocational/day support, partial hospitalization programs, peer-run recovery programs, outpatient services, and intensive case management services through Jail Diversion, PACT and ICM programs. Specific residential treatment programs that focus on co-occurring treatment are New Horizons and Cornerstones. These co-occurring programs offer apartment living aftercare beds to help integrate clients back into the community.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

PATH workers engage homeless individuals at bus stops, streets, woods, etc. PATH workers will also respond to community calls and police calls regarding the whereabouts of homeless individuals.
PATH staff will meet clients in the community, will use motivational interviewing to engage clients. PATH staff will use clinical techniques to assess for SMI and/or co-occurring disorders. If individual is homeless and has an SMI or a co-occurring disorder, PATH staff will begin the engagement process. If individual does not meet PATH criteria, then PATH staff will refer individual to appropriate services and resources to meet their needs. Once individual is willing to accept PATH services and meets PATH criteria: homelessness/at risk, SMI, and/or co-occurring disorder, individual will be enrolled in the PATH Program.
Documenting individual's participation in the program takes place in the Electronic Health Record (Credible and HMIS).

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

The CSB PATH team and IT department have integrated the elements required for reporting into the existing HMIS medical record. The IT department has met with HMIS administrators and collaborated around technical assistance issues. Currently, the Fairfax PATH team is in compliance with the HMIS system. Fairfax PATH has worked closely with the CoC to resolve issues regarding HMIS data. PATH workers participate in the coordinated housing referral through the HMIS system and attend periodic HMIS trainings.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

We work closely with the Office to Prevent and End Homelessness and all the homeless services with whom they contract to deliver services to the homeless population, including housing placement. The Fairfax County CoC has a strong focus on homeless prevention, housing, and rapid re-housing, with housing locators throughout the community. The CSB provides a range of transitional housing programs such as apartment programs and some extension aftercare beds. Additionally, the CSB has several permanent supportive housing units funded by DBHDS which are used to house many of those served by PATH. A strong collaborative effort exists between Pathway Homes, New Hope Housing, Christian Relief Services, FACETS, PRS, Brain Injury Services, The Brain Foundation, Good Shepard Housing, Shelter House, Cornerstones and the CSB to provide permanent supportive housing for homeless individuals in Fairfax County, including those served by PATH.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

Diversity is an on-going priority and focus of the CSB with a special committee that coordinates with State in providing training and consultation to staff in cultural competence. Because the County is one of the most diverse in the U.S., PATH workers are very experienced in working with individuals from different cultures, religions, ages and sexual preferences. The CSB has a multicultural, multi-linguistic team with therapists and psychiatrist who support the PATH staff in providing off site assistance to clients of all cultures. In additions

to having a number of bi-lingual staff, the CSB contracts with on call translator services which are available in person and over the phone. Human Rights and other CSB forms have been translated into multiple languages. We also work with different non-profit and faith-based organizations to link clients to legal, immigration, social support and community resources that are culture specific. We participate in a regional consortium providing mental health and co-occurring deaf services to individuals. PATH staffs are well versed in the use of a TTY system.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

There are monthly multi-cultural trainings offered on a variety of topics. Other trainings offered include Language and Cultural Competence, Sexual Harassment and a County wide Diversity Conference.

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

a. Projected number of adult consumers to be contacted with PATH funds: 240
b. Projected number of adult consumers to be enrolled using PATH funds: 142
c. Percentage of adult consumers projected to be "Literally Homeless": 99

The Fairfax county consists of a diverse population with different races, language, cultural, and socio-economic backgrounds. The PATH staff is able to outreach these different populations. The PATH program has staff fluent in Spanish and Japanese. The county also provides a translation phone line the PATH can utilize.

The demographics of the target population from FY 19 year-end report data:
Black or African American: 60
Asian: 1
Hispanic or Latino: 10
Caucasian: 72
Native American: 1
Data not collected: 1
Client doesn't know: 1

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

As part of our routine outreach, PATH staff engages homeless veterans. PATH staff will work closely with the Veterans affairs outreach workers with the focus of assisting homeless veterans to access needed services. PATH staff also participate in meetings with the COC and the Veterans Affairs liaison dedicated solely to assist homeless veterans in accessing housing and services.

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

The CSB has a very active Office of Consumer and Family Affairs and the director works with the executive staff at the CSB to assist families and consumers with advocacy, training, giving feedback and influencing

policy. The CSB mission states that it "*partners with individuals, families, and the community to empower and support"* clients. Transformation work also continues in the form of the CSB Recovery Initiative. Homeless consumers, advocates and staff are an integral part of the work to improve the CSB service system. Peer Support employees, including some that were formally homeless, are an important part of our service delivery system. In addition to individual support to clients they provide ongoing WRAP groups throughout the county. Volunteers who were former PATH clients are a part of all PATH homeless drop-ins and outreach efforts. Many formerly homeless clients serve on the board of the consumer run drop-ins. PATH staff refer to and support these drop-ins through outreach activities. PATH workers inform and take clients to meetings for county budget and housing issues to encourage client participation in the process. Active and former clients sit on our Consumer Advisory Board which reports to CSB executive staff and participates in planning, developing and prioritizing services. The CSB assists in funding the consumer run drop-ins and in providing scholarships to attend training opportunities throughout the state. PATH clients who live outside in tents and in the shelters have attended and enjoyed some of these trainings. The CSB has a dedicated Human Rights and Consumer Advocacy staff member to assist consumers their rights regarding treatment as well as their right to refuse treatment.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

PATH funds and CSB matching funds are primarily used to cover part of the personnel expenses to operate the program. Homeless non-profit services and PATH staff routinely partner health department nurse practitioners to conduct coordinated street outreach to homeless individuals. PATH works in conjunction with non-profits during hypothermia season as well to identify and deliver services to individuals who meet PATH criteria. PATH staff are able to smoothly and effectively collaborate with non-profit housing programs, PSH programs coordinated by the CSB, emergency shelters, homeless drop-in centers, and the office to end and prevent homelessness to refer and transition homeless individuals into shelter/housing. The CSB continues to exceed the required funding match to provide much needed outreach, engagement, and case management services to homeless and at-risk population.

The funds provided by DBHDS are matched by 49.8% by the CSB to cover the salary and fringe benefits for 3 of the program's full time outreach staff. The CSB's match of 49.8% exceeds the 33% minimum requirement for matching State funds. All other expenses listed in the budget document submitted with this application are covered by the Fairfax Falls Church Community Services Board (i.e.: laptops, cell phones, vehicles, office supplies, outreach supplies, staff training, tokens, etc.). Additionally, the CSB covers all expenses (salary/fringe benefits, equipment, training, etc.) for the remainder of the staff assigned to the PATH team, which include one full time outreach worker, one full time supervisor, four part time outreach workers, one part time peer support specialist, and psychiatric prescriber coverage by two psychiatric nurse practitioners and one psychiatrist.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The program has direct program operations oversight by the assigned PATH supervisor and manager. The program's financial oversight is done by the Intensive Community Treatment service director and the CSB's finance department.

Hampton-Newport News Community Services Board
2712 Washington Ave
Newport News, VA 23607
Contact: Dee Schwartz

Provider Type: Community mental health center
PDX ID: VA-007
State Provider ID:
Contact Phone #: 757-245-0217

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**50,748.00**	**24,996.00**	**75,744.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Outreach worker	39,818.00	100.00 %	0.67	26,678.00	13,140.00	39,818.00	
Outreach worker	22,212.00	100.00 %	0.67	14,882.00	7,330.00	22,212.00	Outreach assistant
PATH Administrator	55,820.00	10.00 %	0.07	3,853.00	1,898.00	5,751.00	
Other (Describe in Comments)	106,780.00	5.00 %	0.03	3,683.00	1,815.00	5,498.00	Adult Clinical Director
Other (Describe in Comments)	47,860.00	5.00 %	0.03	1,652.00	813.00	2,465.00	Resource Development Specialist

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**26.13 %**	**$ 19,792.00**	**$ 9,748.00**	**$ 29,540.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 3,169.00**	**$ 1,561.00**	**$ 4,730.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Mileage Reimbursement	$ 154.00	$ 76.00	$ 230.00	mileage related to training
Other (Describe in Comments)	$ 2,010.00	$ 990.00	$ 3,000.00	Use of agency vehicles
Other (Describe in Comments)	$ 1,005.00	$ 495.00	$ 1,500.00	Training Conference Costs

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	**$ 2,680.00**	**$ 1,353.00**	**$ 4,033.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 2,010.00	$ 1,023.00	$ 3,033.00	

Office: Supplies	$ 670.00	$ 330.00	$ 1,000.00	

f. Contractual	**$ 1,937.00**	**$ 954.00**	**$ 2,891.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 972.00	$ 479.00	$ 1,451.00	security contract
Other (Describe in Comments)	$ 965.00	$ 475.00	$ 1,440.00	cell phone contract

g. Housing	**$ 5,407.00**	**$ 3,093.00**	**$ 8,500.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 3,732.00	$ 2,268.00	$ 6,000.00	client: items to move into housing
Other (Describe in Comments)	$ 1,675.00	$ 825.00	$ 2,500.00	Rental Assistance

h. Construction (non-allowable)				

i. Other	**$ 18,093.00**	**$ 8,883.00**	**$ 26,976.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 1,675.00	$ 825.00	$ 2,500.00	bus tokens
Client: Other (Describe in Comments)	$ 670.00	$ 430.00	$ 1,100.00	medication assistance
Office: Other (Describe in Comments)	$ 15,413.00	$ 7,463.00	$ 22,876.00	Utilities, office space, janitorial, insurance
Staffing: Training/Education/Conference	$ 335.00	$ 165.00	$ 500.00	

j. Total Direct Charges (Sum of a-i)	$ 101,826.00	$ 50,588.00	$ 152,414.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 101,826.00	$ 50,588.00	$ 152,414.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 200

Estimated Number of Persons to be Enrolled: 100

Estimated Number of Persons to be Contacted who are Literally Homeless: 160

Number staff trained in SOAR in grant year ending in 2019: 2

Number of PATH-funded consumers assisted through SOAR: 3

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Hampton-Newport News Community Services Board

1. Description of Provider Organization:

A. **Name:** Hampton-Newport News Community Services Board

B. **Type of Organization:** Community Mental Health Center

C. **Description:** HNNCSB has been providing services to the target population since 1971 - over 47 years - and for 25 years through the PATH program. It was one of only 18 ACCESS Demonstration Project sites in the nation from 1994-1999. Since 1997, HNNCSB has developed and managed an extensive array of homeless services and housing programs – from outreach, SOAR, emergency housing, permanent supported housing programs, and integrated housing options. As evidenced by the many positive outcomes, such as the high percentage of placement of PATH clients in permanent housing, staff and agency administration consistently demonstrate the high degree of expertise, knowledge, and leadership in addressing the needs of the target population and the resources available to serve them throughout the region

D. **Region Served:** The Cities of Hampton and Newport News, Virginia, with some programs available throughout the region – HPR-V.

E. **Amount of PATH Funds:** The HNNCSB is requesting $101,826 in PATH funding with a match of $49,634 which is above the match requirement. The total budget for this project is $151,460 for fiscal year 2020.

F. **Primary Contact:** A Dee Schwartz AliceS@hnncsb.org 757-240-5288

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

HNNCSB staff has been indisputably active and a leader in the regional CoC – to include being a founding member since its beginning in 1996. HNNCSB has approximately 8-10 staff members who actively and regularly participate in the Greater Virginia Peninsula Homelessness Consortium, which is the local CoC for this region. PATH staff members attend all general meetings and trainings. The Homeless Services Supervisor participates in the membership meetings, Program Monitoring Committee, SOAR committee, and Services Coordination And Assessment Network (SCAAN), which is the coordinated intake system currently in place. As a SCAAN member, she interacts with other local organizations to engage those persons identified as needing PATH services. Through SCAAN she utilizes different streams of funding and resources that benefit PATH clients. Another member of the team attends HMIS meetings which ensure HMIS compliance and data quality. The HNNCSB Resource Development Specialist attends all membership meetings, Program Monitoring, and HMIS committees. The PATH team provides engagement services for all organizations in the CoC. The HNNCSB Director of Property and Resource Development is one of the founding members of the Peninsula CoC and participates on the Mayors and Chairs Commission on Homelessness and contributes to the Homelessness sections of the HUD Annual Action Plan for the City of Hampton and the City of Newport News as well as providing input into the Consolidated Plans for both cities.

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.

Following assessments by the PATH staff all clients receive referrals and linkages to appropriate medical, dental, health, employment, vocational services and other appropriate housing providers, including the Free Clinics, local health departments, Health Care for the Homeless, the Veterans Administration, and South Eastern Virginia Health Systems (SEVHS - formerly Peninsula Institute for Community Health). SEVHS now has a primary care clinic at the HNNCSB services campus and the HNNCSB has added an on-site pharmacy to assist consumers fill medications prescriptions. Job training and education referrals include VEC, local education programs, and GED/literacy classes. Housing referrals include the Hampton Redevelopment and Housing Authority, Newport News Redevelopment and Housing Authority, local disability housing providers, HUD-funded low-income housing providers, HNNCSB permanent supported housing and other CoC permanent housing providers, Prevention/Rapid Rehousing funded housing, Assisted Living Facilities, Elderly and Disabled Housing providers, Veterans Administration Housing, Domestic Violence Housing and private market housing.

PATH eligible clients are provided services through linkages offered by the PATH staff. Temporary housing services are provided by the HNNCSB, Peninsula Rescue Mission, Transitions Family Violence Services, Menchville House, Veterans Homeless Housing programs, and other partners in the community. These year-round shelters provide referrals to the PATH staff if the need is recognized. They encourage on-site outreach efforts made by the PATH outreach staff.

Newport News LINK and Hampton HELP both coordinate winter shelters that target the non-sheltered homeless – PORT and A Night's Welcome. They operate approximately 22 weeks from late October through early April. PATH staff is assigned to both winter shelters and make multiple weekly visits. A Homeless Outreach Specialist was added to the homeless services staff and provides intensive outreach to the city of Newport News. The Homeless Outreach Specialist makes referrals to PATH when appropriate. PATH clients are provided showers, food, and clothes washing opportunities at Clean Comfort operated by the Hampton Roads Community Action Program. This is a key outreach site for PATH staff.

Healthcare for the Homeless provides primary health care to PATH clients. Services include medication assistance, transportation to appointments, and linkages to additional health services on an as-needed basis. Healthcare is also provided to PATH clients through the two local Health Departments. Referrals are made to PATH from Healthcare for the Homeless. Outreach efforts are conducted at the clinic sites. Dental services are provided through the local Health Departments, SEVHS dental clinic and the HELP dental clinic. SEVHS offers full dental care on a sliding scale with a small one time registration fee. As mentioned earlier, SEVHS now has a primary care clinic at the HNNCSB services campus and the HNNCSB has also added an on-site pharmacy to assist consumers fill their medications prescription.

HNNCSB PATH staff have a satellite office at the newly opened Newport News Homeless Day Services Center. This allows staff to better coordinate with other local agencies who are providing services for homeless individuals. It also allows for homeless individuals to access a variety of services and agencies in one location. HNNCSB was a large part in the planning and opening of the day center and continues to be an active community partner.

Coordination with other outreach teams is done on many levels but most of the coordination occurs after the client is identified. The PATH team works with the VA outreach and homeless services to ensure the

veterans are properly engaged and receive needed services and participates in VA Stand-Downs for veterans who are homeless. HNNCSB PATH team notifies and plans with the Norfolk PATH Team when clients go to the year-around shelter located in that city. PATH staff work with the CoC Regional Housing Focused Case Managers and Outreach worker to identify eligible clients in the local continuum.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

The PATH team focuses on street outreach - visiting campsites, abandoned buildings, and other places not meant for human habitation on a regular basis. They take food, cooking supplies, clothes, and other useful household/personal care items. They engage people slowly and earn their trust so that they will be more willing to connect to services. “In-reach” is provided every Wednesday at the HNNCSB for walk-in appointments. “In-reach” clients have been referred by other community agencies or by word of mouth from the homeless population. PATH staff regularly have hours at the Newport News Homeless Day Service Center where the homeless can go for meals, showers, laundry, food, and services. The new Day Service Center has become well-known to the homeless population and a regular on-site presence by PATH allows for regular and consistent contact with many PATH-eligible individuals.

PATH staff receive referrals from the Regional Housing Crisis Hotline. Staff also encourage all PATH clients to call and register with the hotline if they have not done so already.

Once the client is enrolled in the PATH program, staff provides community based case management services to begin mainstream benefits applications and treatment. The amount of case management received by the client is dependent upon what the client desires and consents to.

The PATH staff utilizes the VI-SPDAT as an assessment tool. This is used in conjunction with clients being presented at the CoC SCAAN bi-weekly meetings. This tool is used to help SCAAN committee members and PATH staff prioritize the most vulnerable individuals when providing housing services.

b. Any gaps that exist in the current service systems:

We believe that current gaps in service system exist in housing for Non-chronic homeless individuals with behavioral health issues, housing for PATH-eligible individual who have spouses/ partners, and individuals with Substance Use Disorder only. Another gap in service is the ability to find adequate housing for individuals who are on sex offender registry.

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

HNNCSB offers PATH clients a myriad of services on-site that are accessed by the PATH Outreach Specialist at the HNNCSB’s Homeless Services offices and throughout the two cities served. These services

include: emergency services, regional crisis stabilization unit, case management, PACT, outpatient mental health services, medication services, intensive day services, access to in-patient treatment and discharge planning, services for pregnant women with substance abuse histories and women with children with substance abuse disorders, extensive substance abuse services: ARTS, MATS, day treatment, residential treatment services, opioid replacement clinics, SA case management, and clinical staff which includes a psychiatrist specializing in providing services to, and coordinating services for, clients with co-occurring mental illnesses and substance abuse disorders.

HNNCSB has staff available to PATH clients to assist with preparation of applications for Social Security, Social Services, Medicaid, and other mainstream benefits and to assist in the appeals process if clients are denied benefits. PATH staff was trained in SOAR in 2005 and uses SOAR to assist clients with expediting SSI and SSDI applications. With the recent Medicaid expansion PATH clients have had increased access to mental health and medical services and assistance with prescriptions.

Most services provided by the HNNCSB are available to those with co-occurring disorders. The HNNCSB added a Substance Abuse Case Management Team and a SA staff psychiatrist in 2001.The employees in these services have considerable experience working with people with co-occurring disorders. HNNCSB also operates a licensed Opioid Replacement Clinic.

HNNCSB has psychiatrists on staff that provide outpatient services to individuals with substance abuse as their primary diagnosis as well as co-occurring mental health diagnoses. HNNCSB offers AA and NA meetings and hosts the local SAARA and NAMI chapters, who recognize and support those with co-occurring disorders. HNNCSB operates a substance abuse clinic called Partners in Recovery, which serves those with dual diagnoses. Detox services can be accessed with an out-of-catchment referral to Virginia Beach and medical detox is available at the local psychiatric and medical hospitals. The HNNCSB also provides onsite peer support for dually diagnosed individuals.

The HNNCSB operates a crisis stabilization unit in Hampton. Norfolk also has developed a crisis stabilization unit with a dual-diagnosis tract. These services are available to all PATH clients with co-occurring disorders.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

The PATH worker meets with individuals during street outreach, referrals or scheduled appointments and completes a Blue Ridge Continuum of Care Client Intake Form. This form assists with determining housing status such as homelessness or at risk of homelessness. The form also documents whether there is a history of substance use. The PATH worker utilizes evidence-based practices by using motivational interviewing techniques to gather relevant information from the individual concerning past SMI diagnoses, family history, and observing behavioral actions. The individual signs a Blue Ridge Homeless Management Information System Client Consent For Data Collection Release Form if the individual agrees to engage in PATH services. The PATH worke Chronic homelessness and current homelessness are verified through third party verifications. HMIS records by other providers assist in documentation of homelessness – particularly around dates of shelter stays. Also the client is asked to write their own history of homelessness as a timeline for the past four years. Often letters of support from probation and parole, social services agencies and other community resources will assist in the verification of homelessness.

SMI verification is a multi-pronged effort. PATH staff, with their extensive education, training and experience make diagnostic impressions through outreach efforts. Potential PATH enrollees are presented to the Homeless Services Supervisor, who is a MSW with over 20 years' experience and an Emergency Services

pre-screener. EHR records are reviewed to determine if an individual has received appropriate diagnostic assessments in the past. If sufficient documentation exists to verify SMI, the person is enrolled. However, if sufficient documentation does not exist, the individual may be enrolled, however, staff work to get the individual appointments to facilitate mental health assessments by a qualified licensed professional. PATH staff also make referrals to LMHP's for a detailed MSE. Once SMI verification has been obtained by a LMHP, the information is included in the EHR and the PATH documents updated to include these verifications.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

PATH staff has been entering data into HMIS for many years. The local Continuum of Care (GVPHC) has an HMIS sub-committee. PATH staff responsible for data input in HMIS attend this committee for updates, trainings and data changes. New staff is trained as needed. Current challenges include changes in staff with both PATH and the Planning Council – the HMIS Administrator - and having everybody up to date on trainings. This has improved and will continue to improve. All PATH data is recorded in HMIS upon a client entering the program. Updates to this information is entered into the system as the client reports and at the time of the client's annual assessment. The Resource Development Specialist is our agency HMIS administrator and runs monthly HMIS APRs for data quality checks to help identify and correct any errors found in our information or data system. Since this was implemented, our data quality has increased immensely and data input timeliness has improved as well. The office of Property and Resource Development at our agency has a data entry clerk to help oversee all databases we utilize. This individual is highly knowledgeable in HMIS and has helped to pinpoint challenges our staff is having with our data entry and assists us in correcting those issues in a timely manner.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

Over many years, the HNNCSB has expanded the development of a variety of housing options to meet the expressed housing needs of consumers. HNNCSB connects consumers with safe, decent and affordable housing provided by a landlord with an understanding of their needs and willingness to work with residents to eliminate housing barriers, avoid evictions or unstable housing conditions, and to increase access to the amount of affordable housing available to the PATH consumers.

HNNCSB has also developed an extensive array of housing options available for the PATH clients, including: Emergency Housing, HUD and DBHDS funded permanent supportive housing, HNNCSB Mental Health Residential Supervised housing, HNNCSB owned and/or operated apartment complexes with rent subsidies and homelessness as a tenant preference.

HNNCSB's emergency housing program offers shelter, food, and services to individuals with mental illnesses and substance abuse disorders who were inappropriate for other shelter programs or who had exhausted other program time requirements. This program provides 8-beds, 4 beds for women and 4 beds for men.

HNNCSB developed a Shelter Plus Care permanent housing program in partnership with the Newport News Redevelopment and Housing Authority. This program provides permanent supported housing to homeless, seriously mentally ill clients (and co-occurring disorders) through a grant provided by HUD's Continuum of Care Supportive Housing Program. Nine two bedroom units and three one bedroom units are located at two properties operated by Hampton-Newport News Community Services Board.

HNNCSB operates another HUD Supportive Housing grant called Safe Harbors. This program operates in leased units in the city of Hampton and Newport News, and provides housing and service-engagement strategies for PATH clients. HNNCSB consolidated the Safe Harbor program with their Onward PSH program in 2019 and now has 39 beds available.

The PATH staff is the main referral source for participants for both HUD programs and continues to provide case management services until the individuals indicate a readiness for mainstream mental health services.

In partnership with DBHDS, the HNNCSB was awarded a Road2Home permanent supported housing grant for chronically homeless individuals with serious mental illnesses, who also may have co-occurring substance abuse. PATH staff work closely with the Road2Home team to provide appropriate referrals when necessary.

The Hampton-Newport News Community Services Board has additional apartment complexes that it owns and operates: Dresden Apartments and Bay Port Apartments. Housing and property management are separate from clinical services and service connections are not a requirement for remaining in the housing. Services such as mental health case management and PACT are provided to residents in their units as needed and enrolled. Bay Port has 16 one-bedroom units and Dresden has 32 on-bedroom units. PATH clients are eligible to apply for these permanent housing programs and there is a homeless preference. Referrals to property management can be generated by the PATH staff. PATH funds assist PATH clients accessing housing options, if necessary. The HNNCSB manages a 48 unit apartment complex for the disabled and/or elderly. The homeless population receives a priority at this complex.

HNNCSB owned and operated housing incorporates Evidence Based Practices including: housing first, low to no barrier housing, consumer choice, leases in the name of the individual, housing that is not tied to service requirements or program rules, housing and lease focused property management supports, and extensive support with reasonable accommodation requests.

The PATH Outreach Specialist is well trained in assisting PATH clients in the application of both public and private market housing by helping to obtain needed documentation and identification for the application and assisting with denials and turn-downs by advocating on behalf of PATH clients and filing appeals. The PATH staff advocates for the mentally ill homeless population with different housing providers. The PATH staff also links to additional supportive services to help reduce the risk of the client not maintain their housing.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

The HNNCSB has created a Peer Recovery Services program that works with all HNNCSB programs, including PATH, to assist with meeting the diverse needs of people served. Wellness Recovery and Action Plan workshops and classes are presented with special groups for women, younger adults, and children. Peer Recovery Services hold trainings for the HNNCSB to assist all staff gaining increased knowledge and skills working with the diversity of the clients served.

To increase racial/ethnic competence, the Hampton Newport News Community Services Board requires staff training to address the issues of diversity. It is an annual mandatory training for all employees in addition to Human Rights and Confidentiality Training. A broad range of community resources aids the PATH case manager and outreach assistant with linkages to services that address the areas of race, religion and culture. The PATH staff has the knowledge and experience of supervisors and other staff as an available resource for consultation if needed.

As part of regular HNNCSB program evaluations, PATH clients are asked to complete Consumers Satisfaction Surveys. The PATH Supervisor ensures that these surveys are distributed, collected, the results analyzed, and suggestions incorporated into the program.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

To increase cultural competence, the Hampton Newport News Community Services Board offers staff training to address the issues of diversity. It is mandatory for all employees to attend Cultural Diversity Training annually in addition to Human Rights and Confidentiality Training and Person Centered training. A broad range of community resources aids the PATH case manager and outreach assistant with linkages to services that address the areas of race, religion and culture. The PATH staff has the knowledge and experience of supervisors and other staff as an available resource for consultation if needed. The Resource Development Specialist is an active member of the agency Cultural Competency Committee.

The HNNCSB during annual training provides and utilizes a wide variety of materials. The staff also utilizes materials when engaging the population that are gender, age, and culturally appropriate. For example, the HNNCSB provides clients rights in several different languages and for those with limited literacy a picture version is available as well as a verbal review via staff member.

Staff members working with PATH attend annual Fair Housing and Virginia Landlord Tenant Act workshops to keep current on issues that continue to impact PATH consumers due to race, culture, disability, ethnicity, etc. PATH staff and Supervisor attend the annual national Health Care for the Homeless Conference where additional training is obtained including cultural competency information.

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

A. The demographics of the catchment area population are:
   - American Indian or Alaska Native NN 0.5% Hampton 0.4%
   - Asian NN 3% Hampton 2.2%
   - Black or African American NN 40.6% Hampton 49.6%
   - Hispanic or Latino NN 4.2% Hampton 4.5%
   - Native Hawaiian or Other Pacific Islander: NN 0.2% Hampton 0.1%
   - White NN 51.1% Hampton 42.7%
   - Other NN 0.4% Hampton 0.5%

B. The projected number of adult clients to be contacted: 200
C. The projected number of adults to be enrolled: 100
D. The percentage of adult clients to be served using PATH funds who are literally homeless: 80% those contacted and all of the ones enrolled using PATH funds will be “Literally Homeless”.

HNNCSB PATH Outreach activities are almost exclusively targeted to identify and contact those who are “literally homeless”. It is extremely rare to have regular contact through PATH with individuals who are not “literally homeless”. For those individuals, appropriate referrals and linkages are made to the most suitable community resources

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

The HNNCSB PATH team interfaces and treats homeless veterans with SMI the same as all other PATH clients. Many area veterans are already connected to services, since the large VA hospital is located in Hampton, so they are often ineligible for PATH services. The HNNCSB PATH team still assists them with resource identification, location, and linkages. For those who are eligible, the team works to connect them to required and requested services including but not limited to the VA, Wounded Warrior, HNNCSB, and other community programs. The HNNCSB staff works extensively with the veteran service continuum in the area through the Continuum of Care, the regional VA, and the local Military Affairs Committee. The HNNCSB worked successfully with the CoC and VA on Ending Veteran Homelessness Campaign as the Peninsula was one of the 5 Virginia teams that ended functional veteran's homelessness, allowing Virginia to claim the first state to have achieved that title. The resource development specialist attended and participated in the planning process and the Director of Property and Resource Development was on the state leadership team. During the 100 day challenge, the region housed 136 homeless veterans, some of them located and referred to housing by the PATH team. The HNNCSB PATH team and homeless services department continues its effort to outreach and identify homeless veterans with SMI, several of whom were referred to and accepted into the Road2Home housing program operated by HNNCSB.

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

A. Program Mission-

HHNCSB mission is to provide a comprehensive continuum of services and supports promoting prevention, recovery, and self-determination for people affected by mental illness, substance use, and intellectual and developmental disabilities and advancing the well-being of the communities we serve.

HNNCSB believes strongly in the policy of including homeless and formerly homeless persons in the operations and policy development of our services, to the extent that their opinions affect decisions at all levels of the organization.

B. Program Planning –

PATH clients, living in HNNCSB Emergency Housing, are responsible for the daily operation of the shelter. These homeless individuals plan the shopping, cooking, and menu planning. They determine chore lists and community living rules with PATH staff helping to ensure that the rules are followed. House meetings are held to allow residents to work out conflicts and handle interpersonal issues; staff is available to mediate the proceedings.

C. Training and Staffing –

All staff at the HNNCSB receive extensive training each year on a number of various issues, including consumer's rights and family issues. The HNNCSB believes that all employees are valuable assets, but especially those that have utilized the services and have lived experiences. Therefore has a growing number of Peer Support Specialists that are active or past consumers, including a number who were PATH-eligible. They bring their lived experience to improve all services, language, attitudes, and communications with the people we serve. Homeless and formerly homeless consumers are also included in CIT training offered to first

responders through the HNNCSB. They provide a critical point of view and learning opportunity to these training courses.

D. Informed Consent –

At intake consumers are fully informed about the services that are offered at the HNNCSB and those services are provided on a voluntary basis without threats or coercion, and the consumer may receive or reject services at any time.

E. Rights Protection –

At intake consumers and family members are informed verbally and in writing of their rights concerning services, information disclosure, treatment options, their right to choose the most appropriate services in their opinion, confidentiality policies and contact names, addresses and phone numbers for complaints, appeals, and consumer advocates.

F. Program Administration, Governance, and Policy Determination –

The HNNCSB has a Consumer and Family Member Advisory Council that works to provide guidance and oversight to the organization. Consumers and/or family members sit on various projects and companies associated with the HNNCSB. In the last year, 7 members of the CFMAC were formerly homeless.

A formerly homeless individual heads up the Peer Recovery Services Program at the HNNCSB. Peer Specialists are currently working at the Crisis Stabilization Unit, PACT, Psychosocial Rehab, Residential Services, and Housing Programs, such as KEYS and Road2Home.

G. Program Evaluation –

As part of regular HNNCSB program evaluations, PATH clients are given Consumer Satisfaction Surveys. The PATH Supervisor ensures that these surveys are distributed, collected, the results analyzed, and suggestions incorporated into the program. A Peer Specialist works on the Quality Management Team.

Two formerly PATH clients have been members of the Local Human Rights Commission. Consumers and/or family members currently sit on the HNNCSB Board of Directors. Six formerly homeless individuals sit on the HNNCSB Consumer and Family Advocacy Council and has been active participants in communicating the needs of homeless individuals with regard to program development. Homeless and formerly homeless individuals and PATH clients participate in community meetings addressing operational and policy issues. The meetings are chaired by consumers, including one formerly homeless chairperson. The HNNCSB has hired several formerly homeless individuals through consumer-hire positions or regular staff positions. In this capacity, these program support staff provides valuable information with regard to the development, management, operations, supervision

11. **Budget Narrative:** Provide a budget narrative that includes your local plan for the use of PATH funds.

The HNNCSB is requesting $101,826 in PATH funding with a match of $49,634 which is above the match requirement. The total budget for this project is $151,460 for fiscal year 2020.

Position	Salary	Effort	Responsibilities
Path Outreach Specialist	$39,818	100%	Provides Outreach, responds to referrals, makes assessments, offers linkages to appropriate services,

			and participates in Continuum of Care, Clinical intakes, reporting and documentation.
Path Outreach Assistant	$22,212	100%	Assists with Emergency Housing operations and responsibilities, assists clients with appointments, assists with housing and benefits appointments, provides supportive counseling, and assists with reporting and documentation.
Supervisor, Homeless Services	$5,750	10%	Directly oversees program and supervises outreach specialist and assistant. Presents individuals at SCAAN.
Director, Adult Clinical Services	$5,499	5%	Supervises Homeless Services Supervisor. Assures budget and grant requirements are met.
Resource Development Specialist	$2,465	5%	Manages grant reporting requirements and HMIS system.

Fringe Benefits:
Fringe benefits are calculated at approximately 39% for full time employees. Benefits includes payroll taxes, health insurance, disability and life insurance, contribution to the Virginia Retirement System, and worker's compensation insurance.

Travel:
Use of the agency vehicle: Costs are being determined by historical usage costs over the last few years. PATH staff use agency vehicles when conducting outreach efforts and to transport clients when necessary. $3,000 for the year.
Training Travel: 400 miles of travel for training at the current IRS rate of 57.5 cents per mile.
Training Conference Costs: Funds are being requested for staff to attend conferences including but not limited to DBDHS sponsored trainings and the Governor's Housing Conference. $1,500 for the year

Equipment:
No equipment costs are being requested.

Supplies:
Office supplies: Supplies for the PATH office and the satellite office at the Newport News Day Center. Office supplies are needed for general operation of the project. Initial outreach done on the street utilizes paper copies of releases and assessment tools. $1,000 for the year
Outreach supplies: Bottled water, socks, food, and other items for the clients - total $3,033 for the year.

Contractual:
Cell phone service: Cell phones for that PATH Outreach Specialist and Assistant. Cost is based on historical usage. $1,440 for the year
Security: Security for the PATH facility (9am to 4pm) 1 day a week totals $1,451 a year.

Other:
Medical Assistance: $1,100 to purchase client prescriptions and over-the-counter medications that they cannot afford.
Rental Assistance: $2,500 to pay for one time rental assistance, security deposits, and other related expenses.
Bus tokens: $2,500 for the year. With the opening of the Newport News Day Center clients are utilizing the bus system at an increased rate to get to the day center. Bus tokens allow clients to travel to and from the day center and to the PATH main office.

Non travel staff training: $500 per year to cover the cost of training that does not require any travel.
Client Support: $6,000 for household items and related expenses to assist moving people into housing or work. Funds will also be used to help clients obtain identification required documents.
Rental of office space, insurance, and janitorial services for the PATH offices is $22,876 for the year. This is based on historical figures.

Match: Match is calculated at 33% of each expense. Our total match of $49,634 exceeds the required amount of match.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The Resource Development Specialist, Director of Adult Clinical Services and the Homeless Services Supervisor work closely together to assure that all programmatic and financial requirements are being met. All requisitions require a minimum of two signatures before being submitted to financial services. Financial services also has a system for checking expenses that involve a minimum of two individuals.

The Resource Development Specialist runs reports in HMIS on a monthly basis to assure data quality and accuracy. She works with PATH staff to correct any data entry issues and reports data to the local Continuum of Care on a monthly basis.

Loudoun Community Services Board
906 Trailview Blvd SE
Leesburg, VA 20175
Contact: Shannon Sink

Provider Type: Community mental health center
PDX ID: VA-018
State Provider ID:
Contact Phone #:

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**42,082.00**	**133,465.00**	**175,547.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	92,980.00	100.00 %	0.45	42,082.00	50,898.00	92,980.00	PATH Clinician
Other (Describe in Comments)	82,567.00	100.00 %	0.00	0.00	82,567.00	82,567.00	PATH Clinician

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0.00**	**$ 70,219.00**	**$ 70,219.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
e. Supplies	**$ 7,000.00**	**$ 0.00**	**$ 7,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 7,000.00	$ 0.00	$ 7,000.00	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
f. Contractual	**$ 0.00**	**$ 1,200.00**	**$ 1,200.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 1,200.00	$ 1,200.00	Cell Phone and Internet Service Fees

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
g. Housing	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

h. Construction (non-allowable)				
i. Other	**$ 1,100.00**	**$ 0.00**	**$ 1,100.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Staffing: Training/Education/Conference	$ 1,100.00	$ 0.00	$ 1,100.00	

j. Total Direct Charges (Sum of a-i)	$ 50,182.00	$ 204,884.00	$ 255,066.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 50,182.00	$ 204,884.00	$ 255,066.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted:	65	Estimated Number of Persons to be Enrolled:	40
Estimated Number of Persons to be Contacted who are Literally Homeless:	55		
Number staff trained in SOAR in grant year ending in 2019:	2	Number of PATH-funded consumers assisted through SOAR:	1

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Loudoun County Department of Mental Health, Substance Abuse and Developmental Services

1. Description of Provider Organization:

The Department of Mental Health, Substance Abuse and Developmental Services (MHSADS) provides services to individuals in the Loudoun community with mental health, substance use or developmental/intellectual disabilities. MHSADS offers assessment, referral and resource information, mental health and substance use treatment, case management, crisis intervention and stabilization, psychiatric services, DD waiver eligibility screening, discharge planning, employment and day support, in-home support, residential services, intensive community treatment, PATH and prevention and intervention programs.

PATH funds requested: $50,182

Point of contact: Loudoun County PATH Program Manager: Shannon.Sink@loudoun.gov, 703.737.8526

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

The Loudoun County Continuum of Care (CoC) meets regularly to discuss issues concerning those experiencing homelessness among the various non-profit, faith based, government, and private groups advocating for the needs of Loudoun citizens who are experiencing homelessness. The CoC serves to network and provide consolidated support for housing related initiatives within Loudoun County. The CoC Coordinator is a positon within the Department of Family Services (DFS). The CoC worked closely with DFS to create a new Information & Referral (I & R) program. The I & R program is one front door for individuals experiencing homelessness or at imminent risk. Individuals contact I & R and are screened. I & R answers the Coordinated Entry Intake Line for Loudoun County so they can access quick information for permanent supportive housing, access to emergency funds, rapid re-housing, emergency shelter, cold weather shelter and drop-in center services. PATH works closely with the I & R team within Loudoun and provided training to I & R program staff during this fiscal year.

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.

PATH has unique and valuable partnerships with some of the following organizations. The Loudoun Free Clinic provides free healthcare services to the uninsured and indigent while support is offered to apply for Medicaid. HealthWorks (FQHC) provides primary care to those with insurance. PATH provides continuity of care with both of these organizations. PATH has long standing relationships with the Leesburg Police Department and the Loudoun County Sheriff's Office. Both refer directly to PATH and accompany when needed to outreach to potentially dangerous individuals (CIT officers). The Good Shepard Alliance, Volunteers of America, Mobile Hope and the Loudoun Abused Women's Shelter are some of the non-profit providers that PATH coordinates with on a regular basis. Volunteers of America provides PATH with access to their shelter and drop in centers to conduct outreach on a weekly basis. The Loudoun Friends of Mental

Health is non-profit provider that contributes only to those supported within MHSADS. PATH also collaborates with Crossroads United Methodist Church, Loudoun Cares, Loudoun Hunger Relief, St. James Episcopal Church, Catholic Charities and LINC food pantry. PATH works closely with the MHSADS Intensive Community Treatment Team (ICT) in order to provide outreach services within Loudoun County to engage individuals. PATH collaborates with the Loudoun County Department of Library Services and provides outreach to two libraries each week. The Loudoun County Department of DFS I & R program joins PATH to conduct outreach at one library each week. The I & R team joined PATH when conducting outreach to the Dulles International Airport during this fiscal year.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

The PATH team marshals resources and leverages relationships to provide outreach, case management and assistance to adults with serious mental illness (or co-occurring) who are experiencing homelessness or who are at risk of experiencing homelessness. The PATH team determines the immediate needs and works to build rapport in order to facilitate access to necessary support (MHSADS Same-Day Access for on-going healthcare, ICT for on-going wrap-around healthcare, physical healthcare, veteran services via local Loudoun or the VA and DFS I & R for housing support). When individuals obtain long-term housing PATH works closely with other providers to avert another episode of experiencing homelessness. PATH is one of the only agencies providing street outreach services to adults experiencing homelessness in Loudoun County. PATH creates outreach packets as tools that could include disposable cell phones, backpacks, water, juice boxes, granola bars, bug spray, cotton under garments, socks, sun screen, flashlights, winter gear, canned goods, wipes, tissue and trash bags. PATH will outreach to targeted "hot spots" like Starbucks, public libraries, bus stops, tent encampments, the wooded areas (W O &D, and neighborhood trails), the airport and locations identified by I & R, local law enforcement agencies and citizen reports.

b. Any gaps that exist in the current service systems:

Loudoun County does not have a substance use rehabilitation or detoxification units/services and as a result individuals need to access these services outside of the jurisdiction. Some individuals are unwilling to leave the area for said support. Affordable housing is a major gap in Loudoun. The Loudoun Permanent Supportive Housing Program had only 2 openings in the last fiscal year. The Housing Choice Voucher program waiting list has not been open in years (waiting to wait). The Affordable Dwelling Unit (ADU) has barriers such as a small number of units, a need for good credit and some with a criminal record are excluded. The public transportation system is limited (hours, weekends, routes and holidays) for those attempting to maintain employment. The Loudoun County Homeless Services Center (emergency shelter, cold weather shelter and drop-in center) will not allow entry to individuals on the sex offender registry.

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

PATH engages the individual and assesses mental status and the effects of substance use. The contact can determine if the individual is a danger to self or others. This contact may lead to coordination with the Emergency Services (ES) staff and/or law enforcement if there is a safety risk. Individual's actively using and/or experiencing withdrawal may be referred to MHSADS Same-Day Access to determine if they are appropriate candidates for County funded detoxification programs and/or residential treatment.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

If an individual states that they are experiencing homelessness or are at risk of experiencing homelessness then the individual is believed to be in that predicament (self-report) and referral sources are also believed. PATH will engage individuals in PATH services by providing PATH Outreach services until they are able to engage and verify SMI status. PATH will open individuals to PATH Enrolled services when a SMI diagnosis is verified. If an individual has been provided healthcare services for SMI in their past then the matter of diagnosis is simple as PATH will use previous documentation by the licensed professional. If an individual has not received PATH services previously and has not been previously provided healthcare for SMI (documented by licensed professional) then PATH will provide Outreach Services and try to connect to mainstream healthcare for SMI and will have the licensed professional provide a documented diagnosis (thus knowing if there is SMI). If an individual is unwilling or unable to partake in traditional healthcare for SMI then PATH will refer to the Loudoun County Intensive Community Treatment team and a licensed professional will attempt to engage the individual, assess and provide the SMI diagnosis. Individuals will not be receiving PATH Enrolled Services until a SMI diagnosis has been determined by a LMHP. Documentation is done in Service Point, PDX, OAT and Anasazi (electronic health record).

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

PATH is completely integrated into the utilization of HMIS data reporting. PATH staff documents each service delivery into HMIS per contact. PATH attends the training webinars from the Substance Abuse and Mental Health Services Administration's Homeless and Housing Resource Network to keep up with current thinking in terms of HMIS. Any new staff will undergo PATH new employee orientation and shadow current PATH staff for on the job training for HMIS responsibilities.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

PATH supports individuals with obtaining available housing. PATH provides case management supports with locating rental properties, application completion, application fees, negotiating landlord agreements, Housing Choice Voucher applications, and obtaining credit reports and criminal background checks. PATH works with the Loudoun County Department of Family Services (DFS), Continuum of Care Lead Agency, by connecting individuals to the Coordinated Entry Intake line for Rapid-Rehousing funds and prevention programs. PATH completes the assessment tool VI-SPDAT and submits to the CoC to support individuals in applying for permanent supportive housing placement.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

PATH is sensitive to the needs of those supported based upon the professional experience of the staff (over 50 years of combined experience). Varied trainings encourage professionalism and increase competencies to work with all demographics. MHSADS provides Concepts of Person-Centered Practices and Principles of Recovery to all staff. Moving Toward Self-Direction and Self-Determination Through Person-Centered Care is another training offered. PATH has weekly team meetings and regular individual supervision. PATH

relies on trainings and education to offer inclusive care planning to those supported. MHSADS offers ethical trainings on relevant topics, i.e., the ethics of clinical confidentiality in complex settings as well as gender ethics and the ethics of person-centered compliance.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

MHSADS offers cultural diversity training through our Human Resources Department. PATH is required to complete an annual training called Target Solutions, which addresses issues concerning workplace diversity. Staff attended training on health disparities for individuals with SMI. MHSADS has printed literature and forms both in English and Spanish, while providing access to the language line when individuals are trying to access mental health services. A non-English speaking individual or family contacting the Department for services requiring telephone interpretation will be routed to a translation service. Individuals who are seen face to face and require interpretation will be connected to a translator for interpretation services. Written translation services may also be accessed via vendors contracted by the Department. The departmental electronic health care record also requires that we collect demographic information on those we support.

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

a. # to be contacted: 65
b. # to be enrolled: 40
c. % of those literally experiencing homelessness: 85%
d. Demographics:
   American Indian or Alaska Native: 2.5%
   Asian: 2.5%
   Black or African American: 20%
   Hispanic: 10%
   Native Hawaiian or Other Pacific Islander: 0%
   White: 65%
   Other: 0%

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

PATH staff screen every individual for possible veteran status. If the veteran does not have possession of a DD214 then they receive assistance in getting this vital document. Depending on the needs and desires of the person, referrals are made to the VA Medical Center (WVA) and Friendship Place (DC). PATH has established good rapport with the VA Medical Center. Volunteers of America, Chesapeake operates a Supportive Services for Veteran Families Program and applicable individuals are referred to that program. Loudoun County has a Virginia Department of Veteran's Services, the Loudoun Benefits Office in Ashburn as well as the Department of Veteran's Affairs Vet Center in Leesburg. PATH has established working relationships with both of these organizations and has successfully referred applicable individuals. PATH staff collaborate with the DFS Veterans Services Coordinator. The Coordinator provides individualized support to resource veterans to their specific needs.

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

A former PATH individual requested to have an impact on Loudoun County in terms of resources allocated to help those currently experiencing homelessness. PATH staff facilitated the process for the individual to be included in the CoC membership. PATH staff asked other current and former PATH individuals if they desired to participate in the CoC and all others have declined thus far. PATH staff will continue to attempt to be a bridge for PATH individuals so that their voice may be heard as well. Most of the PATH individuals supported lack the support system of family. Less than 10% have family involvement. A considerable percentage of those supported will not consent to PATH staff having contact with family/support systems. Another barrier to family involvement is that recently most supported in PATH tend to be transient. Loudoun County has a contracted Peer Support Specialist and PATH individuals have regular, weekly access to peer support. All current and some former PATH individuals are invited to gather for psychosocial activities to connect and celebrate milestones (housing, employment, sobriety, etc.) on a weekly basis. PATH staff invite former PATH individuals to share their journey of recovery. The Peer co-leads a substance use group for current and former PATH individuals. The experience of those who were previously supported in PATH is a valuable recovery tool to share with others currently experiencing homelessness. The Peer Support Specialist joins PATH staff during weekly outreach at the library. It is a great resource to have the Peer provide outreach as well as mentor individuals on how to gain recovery capital.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

The budget includes 2.0 FTE that provide PATH outreach, advocacy and case management. The PATH Clinician positions devote 100% of their time to providing PATH services.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The PATH program has a bi-weekly team meeting. This is a robust discussion of meeting the needs of those supported, maintaining compliance with governing bodies and updates on leveraging relationships with others, in the marketplace, for the benefit of those supported by PATH. PATH staff are provided regularly scheduled individual supervision and consults, at a moment's notice, with the Program Manager. The PATH team regularly reviews the roster. PATH ensures that individuals being supported are getting their needs met, care conceptualizations (recovery trajectories and planning) are done and troubleshooting on how to best connect to mainstream services. The Program Manager projects the amount of needed emergency funds per fiscal year. The Program Manager works with the MHSADS Finance Branch staff to closely oversee that PATH Federal funds administered by DBHDS (and match) support PATH individuals. All credit card authorization forms indicate the PATH Program as the funding source for PATH program purchases. Additional money may be requested of the Department and if local funding is available then it is approved.

Norfolk Community Services Board
225 W Olney Rd
Norfolk, VA 23510
Contact: Megan Honan

Provider Type: Community mental health center
PDX ID: VA-008
State Provider ID:
Contact Phone #: 757-823-1686

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**76,755.00**	**26,215.00**	**102,970.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	61,352.00	100.00 %	0.68	41,621.00	20,958.00	62,579.00	
Case Manager	38,823.00	100.00 %	0.90	35,134.00	5,257.00	40,391.00	

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**28.48 %**	**$ 29,321.00**	**$ 17,158.00**	**$ 46,479.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 6,700.00**	**$ 6,700.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 5,200.00	$ 5,200.00	Use of Agency Vehicle
Other (Describe in Comments)	$ 0.00	$ 300.00	$ 300.00	Training Travel mileage
Other (Describe in Comments)	$ 0.00	$ 1,200.00	$ 1,200.00	Training Conference Costs

d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

e. Supplies	**$ 0.00**	**$ 1,000.00**	**$ 1,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 0.00	$ 1,000.00	$ 1,000.00	

f. Contractual	**$ 509.00**	**$ 1,200.00**	**$ 1,709.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 509.00	$ 0.00	$ 509.00	HMIS license
Other (Describe in Comments)	$ 0.00	$ 1,200.00	$ 1,200.00	Cell Phone Service Fee

g. Housing	**$ 0.00**	**$ 2,000.00**	**$ 2,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 2,000.00	$ 2,000.00	Rental Assistance

h. Construction (non-allowable)				
i. Other	**$ 0.00**	**$ 1,800.00**	**$ 1,800.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 0.00	$ 1,300.00	$ 1,300.00	bus tokens
Client: Other (Describe in Comments)	$ 0.00	$ 500.00	$ 500.00	Identification Purchase

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
j. Total Direct Charges (Sum of a-i)	$ 106,585.00	$ 56,073.00	$ 162,658.00	
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 106,585.00	$ 56,073.00	$ 162,658.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 200

Estimated Number of Persons to be Enrolled: 100

Estimated Number of Persons to be Contacted who are Literally Homeless: 160

Number staff trained in SOAR in grant year ending in 2019: 2

Number of PATH-funded consumers assisted through SOAR: 29

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Norfolk Community Services Board

1. Description of Provider Organization:

Name: Norfolk Community Services Board

Organization Type: Community Mental Health Center

Amount of federal PATH funds requested: $106,585

Region Served: The City of Norfolk

Primary Point of Contact: Meghan Honan, Meghan.Honan@norfolk.gov, (757) 274-9377

Description of Services Provided: The Norfolk Community Services Board (NCSB) is a department of the City of Norfolk and provides community based public mental health, intellectual disabilities, and substance abuse disorders services as well as supportive housing to the residents of the City of Norfolk. NCSB has over 47 years of experience planning, establishing, evaluating, maintaining, providing, and promoting the development of an effective and efficient system of Mental Health, Intellectual Disabilities, Substance Use Disorders, Prevention, and Rehabilitation services for the citizens of Norfolk. The NCSB provides a continuum of services including Housing and Homeless services, Infant Development, Children's services, Prevention Services, Emergency Services (which is a twenty-four hour mobile crisis unit), Crisis Stabilization (which is a community based short-term crisis unit), Intake and Outpatient Counseling, Integrated Care Clinic, Opiate replacement, Case Management, Mental Health Supportive Services, Program of Assertive Community Treatment, Treatment Courts, and Crisis Intervention Team (CIT) Assessment Center. NCSB works collaboratively to ensure effective community partnerships within the City of Norfolk and with regional partners to ensure that persons who are vulnerable have access to an integrated system of services.

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

In 2011, Norfolk Continuum of Care (CoC) merged with the jurisdictions of Western Tidewater and Chesapeake to form the Southeastern Virginia Homeless Coalition. The Housing and Homeless Services Leadership attends monthly CoC meetings where work is done to preserve critical resources, identify gaps in the service system, promote effective coordination of homeless services, and ensure that standards of care are met.

The CoC works collaboratively with the Southeastern Virginia Homeless Coalition to coordinate a continuum of care for homeless individuals. PATH staff attends the Southeastern Virginia Homeless Coalition monthly meetings and partners with other homeless service providers, many of whom are also CoC members. PATH supervisor or designee also participates in the HMIS committee meetings.

PATH and Homeless Initiatives (HI) staff also provide support one night a week at NEST during the season (Norfolk's winter shelter). This has allowed a more collaborative effort to engage hard to reach individuals. PATH and HI have been successful with this engagement by also providing support to the NEST volunteer staff. Housing and Homeless Services provides data entry into HMIS for all NEST participants. PATH provides weekly outreach at community meals in order to connect with residents undergoing housing crisis. Norfolk CSB is open Friday mornings as "walk in days" where any person experiencing homelessness can come in and see a PATH worker for assistance.
The CoC has adopted HUD's coordinated assessment process. Singles Service Coordination Committee (SSCC). This committee is attended by key partners to include: NCSB Housing and Homeless services, NCSB mental health case management program, LGBT life Center, VA medical center, Commonwealth Catholic Charities, STOP organization, Salvation Army, Union Mission, The Planning Council, Virginia Veteran and Family Support, and Virginia Supportive Housing. Utilizing the VI SPDAT 2.0 (vulnerability index) as an assessment tool this year assists the continuum with identifying and placing the most at risk of our homeless population. Housing and Homeless Services leadership staff chair this meeting bi-monthly to present cases and take referrals. All PATH staff are in attendance.

PATH staff also works collaboratively within the NCSB Housing and Homeless department to identify local needs and coordinate outreach efforts with key community partners. In addition, PATH serves as team leads in the Point-in-Time Count and Project Homeless Connect.

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.

In addition to CoC collaborations, PATH collaborates with many local organizations; including but not limited to:

Norfolk Community Services Board – PATH staff effectively partners with staff from various internal programs to link homeless consumers to needed services. In July 2019, Norfolk's Office to End Homelessness was dissipated, and staff were placed under the NCSB umbrella as Homeless Initiatives. With this change, two outreach positions were added to the CSB's Housing and Homeless Services. Now PATH/Homeless Initiatives work side by side in the community. This change has been amazing for the team itself and has really increased the capacity to serve those who are experiencing homelessness that do not meet the criteria for PATH. This has also allowed H&H services to run Project Homeless Connect for the first time in February 2020. Other internal departments PATH works directly with are: Intake, State Funded Permanent Supportive Housing, Flexible Employment Supports Team (FEST), I-Care (psychiatric and primary care services), Mental Health Case Management, Outpatient Counseling, Substance Abuse Services, Emergency Services, and Crisis Stabilization. PATH staff collaborates with program staff and follows the consumer through the process to ensure access to service is successful.

Hampton Roads Community Health Center (HRCHC) – HRCHC is the local FQHC and Health Care for the Homeless (HCH) Program. Primary care and prevention are the focus of this medical team. PATH staff stays current regarding their eligibility/service policies and links homeless consumers who are uninsured and in need of medical care. NCSB has added staff at two of the Norfolk HRCHC locations to provide service integration. In addition to the three community clinics available to PATH

consumers, HRCHC has added a fourth clinic at one of the NCSB facilities, increasing access to integrated care for PATH consumers. All the HRCHC sites are HCH-available locations.

Bon Secours Care-A-Van: A mobile medical unit that travels throughout the Hampton Roads area providing health care to adults and children who are uninsured. All services are free. The Care-A-Van provides general medical care, routine evaluation and treatment of common acute illnesses. PATH staff stay informed of the van location/schedule and provides referrals to homeless persons who need affordable medical care.

Union Mission Shelter and Day Center– Provides emergency shelter, transitional housing, meals, clothing, shower, laundry facilities, and an outreach office. Path staff work closely with Union Mission to facilitate prompt interventions when needed. In addition, PATH staff provides training to shelter staff regarding PATH services and resources for homeless individuals.

The Salvation Army – Provides emergency shelter and transitional housing as well as assisting individuals with day services including clothing vouchers, lockers, laundry services, voicemail and telephone services. Salvation Army and PATH staff work closely together to facilitate prompt interventions when needed. In addition, PATH staff provides training to their staff regarding PATH services and resources for homeless individuals. This collaboration promotes flexibility with the resources offered to PATH consumers, e.g. after hours' support is provided to PATH consumers.

The Norfolk Emergency Shelter Team (NEST) -- Provides meals and shelter to homeless adults during the winter months. NEST is a coalition of churches that provides overnight shelter on a rotating basis. Transportation to the shelter is provided every evening during the winter months of November – April. PATH staff are present at each church site weekly to provide support and to conduct assessments. They also hand out resources available within the community.

St. Columba Day Center – Provides transitional housing for single adults, rental and utility assistance, food pantry, clothing closet, etc. St. Columba also has a prescription drug program that provides prescription medication assistance to individuals who are homeless in the city of Norfolk. PATH staff have a working relationship with the manager and staff that includes open communication which helps to facilitate prompt services for PATH consumers.

Ghent Area Ministries -- A faith-based outreach ministry dedicated to assisting those in need in the Norfolk community through financial assistance, resources, and services. Those with financial difficulties receive help with rent, utilities, prescriptions, food, local transportation, and obtaining state IDs. Additionally, clients receive assistance through The Coat Closet and the Food Pantry. PATH staff collaborates with the director who has their mobile numbers to request prompt outreach/intervention and, in turn, Ghent Area Ministry staff are flexible in aiding PATH consumers, e.g. they are willing to provide services for homeless clients who do not have ID's, etc.

Virginia Supportive Housing: Non-profit organization that provides various services to improve individual's economic self-sufficiency and housing stability while promoting mental health and substance abuse recovery. PATH staff work closely with all local Virginia Supportive Housing staff, providing support, linkage to services, and advocacy as needed.

SSA: PATH staff members are SOAR trained and local SSA representatives participated in the training. PATH staff has a local contact that helps to resolve problems related to benefit acquisition, improve communication and ensure that the application process goes smoothly.

Housing Authority: Norfolk Redevelopment and Housing Authority provides a continuum of housing options to households of all incomes seeking affordable housing. PATH workers assist consumers with applying for placement on housing waitlist and navigating the application process.

Norfolk DSS/DHS: HART Team (homeless outreach and services team), food stamps, Medicaid, SSA application assistance and adult services. PATH staff coordinates with HART team and may refer/share clients. NCSB has a partnership with DSS that includes DSS eligibility workers being co-located in NCSB service centers. PATH staff members have excellent working relationships with local eligibility workers which facilitates walk-in appointments and prompt activation of benefits.

Faith Community: Numerous sites provide soup kitchen, pantry and clothing services, and occasional emergency shelter. PATH workers utilize contact information at local churches to facilitate referrals to these services and respond to calls with concerns about homeless consumers. This relationship allows for some services to be provided to PATH consumers after hours.

Salvation Army ARC Program – Provides substance abuse residential treatment. The PATH case manager knows the manager and can facilitate a smooth transition from shelters to the residential program when appropriate. The ARC program is open to PATH referrals due to the involvement and responsiveness of PATH staff.

Veterans Administration: The Veterans Administration provides services to homeless Vets through community outreach, medical services and housing options using Veterans Affairs Supportive Housing (VASH). PATH staff collaborate with the veterans' administration outreach team in a coordinated effort to ensure Veterans are linked to appropriate services.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

The Norfolk PATH team has utilized targeted street outreach as the primary method of engagement since the beginning of the program. The PATH workers spend a significant part of outreach time identifying and engaging persons on the streets, in woods or camps, and other areas where homeless persons are found. This ensures that the most vulnerable or least likely to be served are reached by our staff. For those not willing to immediately engage, the PATH workers have the flexibility to continue trying, be creative, and provide safety education while working to develop a professional relationship with the individual. It is our goal that no person experiencing mental illness and homelessness in Norfolk goes without having an outreach attempt made to engage them in services.
The Norfolk PATH team has a strong history of partnership to maximize community impact of the program. Norfolk PATH program also has been a key partner for providing outreach and follow-up for Project Homeless Connect and the Annual Point in Time Count. Emergency Services Preadmission

Screening program is under the Clinical Acute Division and this program works closely with the PATH workers as well. The crisis counselors are extremely mobile and conduct most of their crisis evaluations in settings such as client homes, on the street, or in local emergency rooms. Individuals identified as homeless and in need of services are referred to those services as well as our PATH team for follow up and further outreach as needed. These individuals can also be referred to our 24 hour crisis stabilization program. The Crisis Intervention Team (CIT) continues to enhance opportunities for effective outreach interventions.

The NCSB has also partnered or developed relationships with local medical clinics to address medical and psychiatric needs. These relationships include but are not limited to the Sentara Norfolk General Hospital, Park Place Medical Center, Bon Secours Medical Van, and the Lions Club Eye Vision and Hearing Program, and the Park Place Dental Clinic.

Outreach in locations where persons who are homeless gather is critical to success of the program. PATH has established partnerships to provide direct support at the Salvation Army Shelter and Day Center and Union Mission Shelter and Day Center as well as direct outreach to Norfolk public libraries and Norfolk Department of Parks and Recreation.

Norfolk PATH is a part of the Vulnerable Adult Services Team (VAST) which meets monthly. During this meeting PATH staff meet with Norfolk City Codes Department, Norfolk Police and Fire Department, Adult Protective Services, and Emergency Services to discuss concerns regarding the most vulnerable residents of Norfolk. PATH staff provides outreach to locations identified at this meeting as well as on an ongoing basis that are identified by Norfolk City Codes Department and the Norfolk Police Department.

The PATH program can target their time and resources to ensure that they not only provide outreach and engagement, but have the time and focus to provide case management services to coordinate care, maintain connections, and ease the person into the next phase of services without a gap in service delivery.

PATH consumers are connected to multiple housing options that come available through the CSB Housing and Homeless department as well as through other community partners. These housing options include:

Shelter Plus Care: This is a HUD Homeless Program that provides vouchers for housing with support services for persons experiencing homelessness and have disabling conditions. PATH has the ability to make targeted referrals to this program operated by Norfolk CSB.

Regional Efficiency Supportive Housing "SRO" program (Gosnold, Cloverleaf, South Bay, Heron's Landing and Crescent Square): These buildings have identified units for persons experiencing homelessness from Norfolk. The PATH program helps to facilitate referrals and assists persons in accessing this housing resource operated by Virginia Supportive Housing.

Homeless Initiatives Tenant Based Rental Assistance Program: This program assists persons experiencing homelessness with rental subsidies while PATH connects them to stabilization services and case management services so they may become self-sufficient through increased income and/or more permanent subsidy.

Road2Home Permanent Supportive Housing: - provides vouchers and Housing Stabilization support to single adults experiencing homelessness and disabling behavioral health disorders. This also includes veterans.

Keys: assist individuals who have been recently discharged from state psychiatric hospitals and who can live independently with housing placement and support services.

Housing First "My Own Place": This is a program launched by Norfolk CSB in partnership with the Office to End Homelessness in 2008 and is operated by the partner non-profit, Virginia Supportive Housing. Although the program is open to persons of all disabilities that meet Chronic Homeless criteria, the Norfolk PATH program is considered a primary referral source and a partner in outreach and engagement for this program.

NCSB continues to work with the City of Norfolk and Norfolk Redevelopment and Housing Authority (NRHA) to identify new opportunities to increase housing opportunities for PATH-eligible consumers. A partnership agreement was finalized by the Southeastern Homeless Coalition in early 2017, where NRHA agreed to give 20% of the housing choice and public housing turnover units to the homeless population. This “move on” program targets those that are graduating from another housing program that no longer require the support services portion, but still need the subsidy. This creates a flow that allows us to graduate participants that have done well and creates an opening for our most vulnerable individuals.

As part of PATH case management, PATH program recipients are connected to public benefits such as SNAP and Medicaid. Path Staff are SSI/SSDI Outreach, Access, and Recovery (SOAR) Certified specialists and can assist program in applying for this benefit.

PATH consumers engaged in PATH case management, are referred to a plethora of services that Norfolk CSB and the outside community has to offer to include, but are not limited to:
> Obtaining documents including state identification, social security card, and birth certificates
> Primary and Mental Health Care
> Mental Health Support Services — Provides training in activities of daily living which assists consumers with securing and stabilizing housing in the community.
> Crisis Stabilization — Provides acute crisis services for those at risk of hospitalization or homelessness.
> Emergency Services — Provides crisis response in the community 24 hours a day, 7 days a week, 365 days of the year.
> Mental Health Case Management — Provides case management services that include referrals to community resources and coordination of care.
> Outpatient Substance Use treatment, including intensive outpatient treatment, opioid treatment, substance use disorder case management and peer support.
> Employment services including FEST and DARS referrals

All the above services assist consumers with obtaining and maintaining long term housing. PATH staff meet consumers where they are at and provide referrals based on consumers individual needs.

b. Any gaps that exist in the current service systems:
<u>Shelter Availability</u>
Individuals with substance abuse problems face multiple barriers to accessing housing while suffering from addiction, as most shelters require sobriety to access their service. Lack of shelters for those actively working on their recovery provides a significant gap in services as they are “screened out” of most housing options. This also can be a barrier for persons who are actively symptomatic from

psychiatric conditions. Finally, safe shelter for youth and persons in the LGBT community is a gap in the system.

Lack of Substance Abuse Services

Currently, the City of Norfolk has no local detox center, little outpatient detoxification services other than Opioid Treatment, and very limited residential substance use treatment facilities. Most individuals seeking detoxification services have to wait for an available bed through a neighboring city and it is extremely difficult to access the 28-day residential treatment programs many of which are out of state and require a stable housing plan at entry. Many of the programs that are available are abstinence-based or "cold turkey" programs and they have not been very effective for the homeless population.

The provision of care for the Indigent is fragmented as many of the uninsured use hospital emergency rooms after delaying treatment for routine illnesses or chronic diseases. The fragmentation of care has contributed to capacity constraints in local hospitals. There are increasing numbers of illness acuity in both inpatient and outpatient settings and increases in hospital service use. Services are available through community health centers and free clinics but many indigent individuals with go without care. Medicaid Expansion has helped in this area tremendously, but this issue remains.

Other gaps include: Adequate numbers of affordable permanent housing options for single adults, low-barrier housing, partial hospitalization (day) services, employment training, affordable health care and dental care, prescription assistance, homeless prevention and respite care for medically fragile homeless persons.

In an attempt to diminish the gaps in service, the outreach worker will assess the needs and level of care for clients to include case management and outpatient services. They will be screened initially to assess whether or not their immediate needs can be met by enrolling in any of the existing programs offered by the Norfolk Community Service Board. If the participant doesn't meet the criteria of any of the existing programs, the consumer will be assessed and guided to the appropriate community resource. PATH staff participates in the Southeastern Virginia Homeless Coalition and affiliated committees which allows them to learn about new resources and partner with other homeless providers to assist consumers with closing the gaps.

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

Integrated Services: We have internal integrated care services that is available for consumers. Crisis Stabilization is able to integrate MH and SA services. A recent increase in outpatient groups have expanded services available for substance abuse recovery with co-occurring mental illness.
Primary Health: Resources include Hampton Roads Community Health Clinics, Sentara Ambulatory Care Center, Bon Secours Care-A-Van, and EVMS Hopes Clinic and Hampton Roads Community Health Center (HRCHC). These clinics work with PATH on a referral basis. Hampton Roads Community Health Centers are the local HCH provider sites and PATH also assists in providing homeless certifications so their clients can access services under that grant.

Mental Health: There are numerous mental health providers in the community for persons with insurance, however, NCSB is the only mental health provider for persons who have no ability to pay. These services include but are not limited to psychiatry, outpatient counseling, and case management. PATH consumers who have insurance are assisted with accessing services at their provider of choice, including the local psychosocial programs.

Substance Abuse: Norfolk has a strong network of 12 step recovery programs and several faith based programs to assist in recovery. Also, the Salvation Army ARC and Pathway programs are located in Virginia Beach and serve Norfolk citizens. Otherwise, Norfolk CSB is the only substance abuse provider for persons who are indigent and Norfolk is one of only 3 public Opioid Clinics in Hampton Roads.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

During the outreach and engagement process individuals are evaluated as information becomes available. PATH workers are skilled in identifying mental health and substance abuse issues as well as using motivational interviewing to explore other needs such as medical issues. Norfolk PATH uses a needs assessment where information on needs and resources can be documented as information is collected. Once a person is enrolled, the worker ensure that the information to screen for needs and the PATH presumptive mental health eligibility is documented. For those not eligible, they are then referred to Homeless Initiatives for ongoing outreach and assistance.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

PATH staff began entering data into HMIS on April 1, 2016. We continue to be challenged with the amount of time it takes to enter data into HMIS as well as our electronic health record. As a CoC, we have requested additional online HMIS trainings as new data elements are added. PATH staff also sit on HMIS committee and participate in quarterly meetings. New PATH staff are also trained in HMIS by our CoC lead agency, The Planning Council. Additional trainings can be requested by Housing and Homeless Services as needed.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

The NCSB collaborates with the CoC and Norfolk Homeless Consortium to network with other providers of homeless services and stay abreast of housing options. PATH staff members have established working relationships with housing providers which assists them with being able to link their consumers to suitable housing. Some of those housing options are listed below:

Union Mission: Provides emergency shelter, transitional housing, and permanent SRO type housing.

Salvation Army: Provides emergency shelter and a recent expansion to limited longer term shelter.

St. Columba Center: Provides transitional housing.

For Kids: Provides family emergency shelter, transitional housing, and permanent supportive housing.

YWCA: Provides emergency shelter and transitional housing.

NEST: Provides emergency shelter during winter months.

Virginia Supportive Housing (SRO): Gosnold Apartments, Cloverleaf Apartments, South Bay, Herons Landing, Crescent Square, Church Street Station. Apartments offer affordable, safe housing for single adult, chronically homeless and disabled individuals.

Virginia Supportive Housing (Housing First): Provides permanent supportive housing to Chronically Homeless individuals through a scattered site model.

NCSB Shelter Plus Care: Provides scattered site permanent supportive housing to homeless individuals with disabilities, including those with mental health and substance abuse disorders.

Norfolk Road2Home Permanent Supportive Housing funds-funded through DBHDS PATH clients that are also Road2Home eligible can also be considered for a housing voucher with ongoing Road2Home staff support

Homeless Initiatives Tenant Based Rental Assistance Program: This program assists persons experiencing homelessness with rental subsidies while PATH connects them to stabilization services and case management services so they may become self-sufficient through increased income and/or more permanent subsidy.

Keys: assist individuals who have been recently discharged from state psychiatric hospitals and who can live independently with housing placement and support services

NRHA/ROI: Units for rent to CSB consumers at entry and can be retained after graduating from CSB services. These units are specified for those experiencing homelessness or exiting state operated mental health facilities. One of these buildings has a transitional unit that can be used for up to 29 days for any PATH eligible consumer.

NRHA/SVHC: "Move on" program. A partnership between Southeastern Homeless Coalition and NRHA where NRHA agreed to give 20% of the housing choice and public housing turnover units to the homeless population. This "move on" program targets those that are graduating from another housing program that no longer require the support services portion, but still need the subsidy. This creates a flow that allows us to graduate participants that have done well and creates an opening for our most vulnerable individuals.

In addition, the NCSB works with NRHA, local boarding homes and landlords to locate safe, affordable housing resources.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

Click here to enter text.Norfolk Community Services Board provides Cultural Diversity training and testing to new employees and requires annual training updates in order to ensure cultural competency among staff. This training is designed to educate staff regarding the need to be cognizant of how cultural differences can impact services and the ability to effectively engage consumers; staff members are taught about the importance of providing services in a manner that is sensitive to the unique needs of diverse clients, including differences in age, gender and ethnicity. The PATH program also has access to intake counselors who are bilingual and referral capacity to the LGBT Center for persons of that community in need of a more targeted intervention or safe resources.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

Norfolk Community Services Board provides Cultural Diversity training and testing to new employees and requires annual training updates in order to ensure cultural competency among staff. This training is in addition to the organizational value and active recruitment of a culturally diverse workforce that is representative of our consumer base. Focus areas of training in cultural competence encompasses an understanding of different communication needs and styles of client population, culturally competent oral communication, culturally competent written and oral communication, communication with community, and intra-organizational communication.

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

Looking at the PATH data from 7/1/2018 to 7/1/2019, the PATH demographics were as follows:

PATH street outreach-175 persons outreached, 89 were enrolled. 113 of these were men, 59 women. 115 of these outreached were black/African American, 48 were white, 1 was Asian, 2 were American Indian/Alaska Native, 1 was Native Hawaiian, 6 were of multiple races, 2 refused to answer. 168 of these outreached reported being non-Hispanic/Latino, 7 reported being Hispanic/Latino
PATH services-213 outreached, 48 enrolled. 139 of these were men, 70 were women, 2 identified as trans female, 1 as gender non-conforming, 1 data not collected. 127 of these outreached were black/African American, 71 were white, 3 Asian, 5 American Indian or Alaska Native, 6 multiple races, 1 date not collected. 201 of these outreached were non-Hispanic/non-Latino, 11 Hispanic/Latino, 1 data not collected.
For this upcoming grant year, PATH staff will outreach roughly 300 persons, enrolling around 125 of them. The current COVID-19 pandemic may affect the numbers outreached for FY 19 and FY 20. The percentage of adults being served by PATH funds that are literally homeless is 100%. Due to the high rate of homeless individuals in our community, PATH staff are only working with those that meet the literal homelessness definition.

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

PATH staff works in collaboration with the Virginia Veteran and Family Support as well as the VA outreach workers. Once a homeless veteran is identified by PATH the linkage is immediately made for VA services. If the client is not eligible for VA services, then PATH continues to assess the individual for PATH eligibility. If the individual is not PATH eligible then linkage to other outreach services happens. The Housing and Homelessness team also sits on a veteran's update committee through the CoC to case plan for each veteran in the community experiencing homelessness.

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

The NCSB employ consumers and we are working on increasing employment opportunities for individuals with serious mental illnesses and substance use disorders. In addition, the NCSB Board of Directors consists of volunteers from the City of Norfolk to include consumers and the families of consumers.

Consumers are active participants in their treatment; they provide informed consent and actively participate in their plan of care. Consumers are fully informed of their rights at the initiation of services and annually thereafter. Consumers also participate in surveys to determine what things help or hinder their progress.

The Consumer Advisory Committee has been disbanded, consumer sessions and townhalls on certain projects and activities can be scheduled with the NCSB Consumer Members of the Regional Consumer Advisory Council.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

a) Staffing:

1. Position-Case Manager III-lead PATH outreach worker. Conducts street outreach to homeless individuals in the city of Norfolk. Attempts to develop relationships with persons experiencing homelessness. Completes a face-to-face assessment to determine functional limitations, eligibility for service, progress, and need areas. Face-to-face contact occurs through street contact, site visits, and office visits, or in another community settings. This position also sits on a multitude of committees within the community that address homelessness. Coordination of services, linkage to services and supports, advocating for the consumer needs, and empowerment are just some of the duties that go along with this position. Case Manager II- Conducts street outreach to homeless individuals in the city of Norfolk. Attempts to develop relationships with persons experiencing homelessness. Completes a face-to-face assessment to determine functional limitations, eligibility for service, progress, and need areas. Face-to-face contact occurs through street contact, site visits, and office visits, or in another community setting.
2. Salary/rate-The estimated salary for this position ranges from $35,000-$45,000. The staff member that is in the current PATH CM III position has been an employee for over 25 years, so her current salary is over $63,000/year. The $41,621 of this salary is charged to the grant, while the remaining is used for local cash match. The second position's salary is over $40,000/year, $35,134 of that is charged to the grant, the remaining is used for local cash match.
3. Percent of time-Both PATH staff spend 100% if their time on PATH duties.

b) Fringe Benefits: Both PATH staff have a portion of their fringe benefits charged to the grant in the amount of $29,321. The remaining portion of the benefits are used for local cash match.

c) Travel: All travel for PATH staff is considered in-kind match and is not charged to the grant.

d) Supplies: All supplies used by PATH staff are considered in-kind match and are not charged to the grant.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

PATH program staff are supervised by the Programs Manager with Housing and Homeless Services. Programs Manager conducts chart audits of all PATH cases to ensure proper clinical diagnoses are in the file. Documentation of homelessness is gathered prior to the enrollment into the program and placed in the client's paper file. Programs Manager also runs monthly data reports out of HMIS to review data quality of all PATH entries. Outcomes reporting is also completed monthly out of the NCSB's electronic health record, where linkage to mental health treatment and housing is tracked and reported on. Programs Manager approves all expenses paid out of the PATH grant to ensure compliance to the grant requirements. Norfolk CSB's financial department provides oversight to all expenses as well and requires a multi-layer approval process for all payment vouchers that are paid out.

Portsmouth Department of Behavioral Health Services
505 Washington Street, Suite 200
Portsmouth, VA 23704
Contact: Dwight Williams

Provider Type: Community mental health center
PDX ID: VA-011
State Provider ID:
Contact Phone #: (757) 393-8618

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**40,000.00**	**0.00**	**40,000.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	40,000.00	100.00 %	1.00	40,000.00	0.00	40,000.00	

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**26.00 %**	**$ 10,400.00**	**$ 0.00**	**$ 10,400.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 1,000.00**	**$ 1,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 1,000.00	$ 1,000.00	Use of Agency Vehicle

d. Equipment	**$ 2,000.00**	**$ 0.00**	**$ 2,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Computer Lease/Purchase	$ 2,000.00	$ 0.00	$ 2,000.00	

e. Supplies	**$ 0.00**	**$ 4,405.00**	**$ 4,405.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 0.00	$ 4,405.00	$ 4,405.00	

f. Contractual	**$ 1,315.00**	**$ 500.00**	**$ 1,815.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments

Other (Describe in Comments)	$ 1,315.00	$ 0.00	$ 1,315.00	HMIS License Fee
Other (Describe in Comments)	$ 0.00	$ 500.00	$ 500.00	Cell Phone Service Fee

g. Housing	**$ 0.00**	**$ 5,000.00**	**$ 5,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 5,000.00	$ 5,000.00	Rental Assistance

h. Construction (non-allowable)

i. Other	**$ 0.00**	**$ 2,000.00**	**$ 2,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 0.00	$ 1,000.00	$ 1,000.00	
Client: Other (Describe in Comments)	$ 0.00	$ 1,000.00	$ 1,000.00	Identification Purchase

j. Total Direct Charges (Sum of a-i)	$ 53,715.00	$ 12,905.00	$ 66,620.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 5,000.00**	**$ 5,000.00**	
l. Grand Total (Sum of j and k)	$ 53,715.00	$ 17,905.00	$ 71,620.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 110

Estimated Number of Persons to be Enrolled: 80

Estimated Number of Persons to be Contacted who are Literally Homeless: 77

Number staff trained in SOAR in grant year ending in 2019: 0

Number of PATH-funded consumers assisted through SOAR: 0

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Portsmouth Department of Behavioral Healthcare Services

1. Description of Provider Organization:

A. **Name:** Portsmouth Department of Behavioral Healthcare Services

B. **Type of Organization:** Mental Health, Substance Use Disorder, Intellectual Disability/Developmental Disability Community Service Board

C. **Description:** Portsmouth Department of Behavioral Healthcare Services (PDBHS) provides mental health, intellectual disability, substance use and co-occurring disorder services to the citizens of the City of Portsmouth. Services provided are: 24 hour/7 days a week for emergency services/crisis services, outpatient treatment for mental health and substance use disorders, case management services for MH/SA and ID/DD, restoration services, crisis stabilization, supportive and residential services, jail diversion, co-occurring, Methadone, SA prevention, psycho-social rehabilitation day support, ID/DD Day support, HIV/AIDS education/outreach and testing, homeless outreach and permanent supportive housing services. For the past 32 years the Portsmouth Department of Behavioral Healthcare Services has provided services to the homeless mentally ill population beginning in 1987 when funding was provided by the Stuart B. McKinney Act. Over a period of time a fairly comprehensive program has emerged using a combination of PATH funds for case management services, state and local funds for temporary housing, medical care, food/water, and federal funding for permanent housing and in-kind services for day support, out-patient and crisis intervention services. The Portsmouth Department of Behavioral Healthcare Services has provided mental health services for approximately 37 years and over the past 13 years has adopted best practices for serving co-occurring populations.

D. **Region Served:** The City of Portsmouth

E. **Amount of PATH Funds:** $53,715

F. **Primary Contacts:** Dwight Williams, dwight.williams@portsmouthva.gov, (757) 393-8618 Ext 8042

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

PDBHS works closely with Portsmouth's CoC. CoC meetings are attended on a regular basis and have been for many years. The Program Administrator for the PATH program is the current secretary for the PHAC (Portsmouth Homeless Action Committee) of which all CoC members are required to hold membership in. The Program Administrator has also had an active role in developing and implementing the coordinated entry and coordinated assessment which is now in use by the Portsmouth CoC. The Portsmouth CoC has had in place committees for coordinated entry that periodically review outcomes and make changes as needed to ensure efficient and seamless entry into housing.

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.

DBHS has given their support to the faith-based organization CCIA. Portsmouth DBHS works closely with Oasis Social Ministry and the PATH Case Manager assists with linking the homeless person for food, clothing and hygiene needs. The PATH case manager provides onsite time at Oasis Social Ministry and consumers are also referred to Portsmouth DBHS and PATH by that agency. The PATH case manager is an identified partner with Portsmouth Volunteers for the Homeless (PVH). The PATH case manager has been involved with the Portsmouth Police Department (PPD) for training CIT officers and works with the PPD's Homeless Outreach Team (HOT). The PATH case manager works closely with PDBHS mental health and substance use services to get PATH consumers assessed as soon as possible for eligibility and enrollment into behavioral healthcare services to address: mental health outpatient counseling needs, substance abuse counseling needs and referrals to detox/substance abuse residential treatment, psychiatric physician service needs, social integration needs and referrals to skill building programs to improve independent living and psychosocial functioning. The PATH case manager refers clients to the Maryview Foundation, Portsmouth Public Health Department, and Hampton Roads Community Health Center to address medical needs and receive primary medical care. Portsmouth DBHS adopts a model of treatment that addresses behavioral healthcare needs and medical needs simultaneously. The PATH case manager works with Portsmouth Department of Social Services to obtain community supportive services and benefits such as SNAP and Medicaid entitlements. The PATH case manager coordinates with other outreach teams through the Portsmouth Community Assessment Network meetings which are held twice each month. All case managers and outreach workers of the Portsmouth CoC agencies are expected to attend this meeting. Participation includes a collection of HUD and ESG-funded housing and service providers that meet around a By-Name List and case conferencing to identify those with high vulnerability, particularly recidivism.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

PATH funds pay for 1 full time case manager. This PATH case manager has set days and times at Oasis Outreach Ministries, Portsmouth Public Library, and Third Avenue Baptist Church. The PATH case manager will carry back packs with bottled water, HBA articles, food/snacks, and small articles of clothing, i.e. socks, underwear, hand sanitizer and facial masks while under the COVID-19 pandemic in order to facilitate communication with the homeless population. The PATH case manager is aware of gathering points of homeless individuals throughout the city of Portsmouth and will make stops in these locations. At this time the PATH case manager is the only dedicated outreach case manager in Portsmouth. As such other agencies provide information when they are approached by or notice a PATH eligible individual.

PDBHS does support evidence-based practices. The PATH case manager has attended trainings in Fair Housing Practices. The PATH case manager completed the state mandated 11 Case Manager Competency Modules thru the Virginia Commonwealth Education Center. In the future the PATH case manager will attend informational trainings geared toward increasing knowledge on identification and treatment of individuals with mental illness and/or co-occurring issues such as: Person Centered Planning, Motivational

Interviewing, Trauma and Resiliency, and Substance Use Disorders. PDBHS currently holds 4 licenses for Portsmouth's HMIS system. The PATH case manager has received training in the system from the CoC's HMIS coordinator to become more proficient with using this system. PDBHS's PATH case manager has been entering data into the HMIS system for the last year. The PATH case manager will also begin documenting PATH services and outreach into Portsmouth DBHS electronic health record, Credible.

PDBHS has a jail diversion program in place that works in conjunction with the Mental Health Docket at Portsmouth's courts as well as the Portsmouth Community Criminal Justice Board. In addition to that program PDBHS is part of a new grant in the Hampton Roads Regional Jail (HRRJ) specifically working with mentally ill inmates and assisting in facilitating successful release including housing issues. The PATH case manager will be working with the case managers in the HRRJ program to address housing barriers upon discharge. The members of PHAC that offer permanent supportive housing embrace Housing First principles which include accepting chronically homeless in spite of criminal background. PATH has established a collaboration with Hope House Foundation in Portsmouth. This is a faith based housing program for mentally ill and will take homeless with criminal backgrounds depending on the charges. PDBHS has a representative from Department of Aging and Rehabilitation Services (DARS) on site weekly who will accept referrals from PATH for individuals seeking job opportunities.

The PATH case manager is going to work on holding a job fair specifically with employers who are interested and willing to hire those who are homeless, have criminal backgrounds, mental health issues, etc. The PATH case manager will coordinate with DARS, the Virginia Employment Commission (VEC) and Eggleston Services.

The PATH program has established relationships with the Hampton Roads Community Health Clinic and the Maryview Foundation to facilitate referrals between these agencies. This helps link the PATH consumers to needed medical care.

The current PATH case manager continues to work on becoming SOAR certified. The previous case manager from FY 2019 was certified but left the agency. The PATH case manager is assisting with traditional methods of applying for SSI/SSDI.

b. Any gaps that exist in the current service systems:

Locally, lack of affordable low-income housing continues to be the major barrier for the PATH identified consumers. There is not enough affordable and/or subsidized housing for low income individuals. Portsmouth continues to have an extensive waiting list for Section 8 vouchers and the wait list for low income housing is long. The Shelter Plus Care Program is currently at capacity. Additionally, many PATH clients have histories of legal problems, outstanding utility bills, and poor credit which are barriers to accessing housing. If background checks of past living arrangements and/or housekeeping skills are not satisfactory, clients are often denied housing. Although the jail system is improving with placements of individuals leaving the legal system, there continues to be a gap in services for these individuals when they return to the community in Portsmouth. Often, in addition to the above, the consumer's legal issues and inconsistent employment history make placements difficult. The PATH case manager continues to submit letters and advocate for reasonable accommodations on behalf of hard to place individuals. DBHS is identifying and removing barriers by developing relationships with landlords and providing supportive services that assist consumers

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

Consumers presenting with mental illness or co-occurring disorders go through PDBHS Central Intake/Same Day Access where they receive a screening and intake in the same day and are referred to need based, appropriate services. The PDBHS Intake staff are Licensed Mental Health Professionals and experienced in working with individuals with mental health/co-occurring disorders. Case reviews, involving all programs at PDBHS, are held weekly so that appropriate treatment for all consumers is monitored. The PATH case manager attends this meeting and has input regarding PATH suitable individuals. PDBHS staff receives training in evidence based best practices such as Mental Health First Aid, Applied Suicide Intervention Skills Training, REVIVE training to address Opioid Use and Overdose with the administration of NARCAN, and other training that will provide them with up to date information. PDBHS offers a Women's Outpatient Program, HIV/AIDS information and Recovery Houses for women with co-occurring disorders.

Outreach:
The full time PATH case manager will continue to provide outreach and assessment at various locations around the city where homeless individuals congregate in order to offer services and distribute information regarding homeless services and activities such as Homeless Connect, which the PATH case manager participates in. Pamphlets and business cards have been created and are distributed to various locations where homeless congregate.

Screening:
PDBHS offers screening and assessment services for PATH consumers to determine the clinical and service needs of the individual. All persons are triaged in Central Intake/Same Day Access, which is the starting point for services with PDBHS. No appointment is required; Central Intake is available Monday – Thursday, 8:30 a.m. to 2:30 p.m. for Portsmouth citizens.

Clinical Assessment:
The PATH case manager will continue to make referrals to PDBHS services through central intake/same day access. The case manager facilitates making appointments and provides transportation to these appointments. Intake assessments are provided by a combination of licensed and unlicensed professionals. Unlicensed professionals gather basic demographic information, and Licensed Mental Health Professionals complete a psychosocial assessment, mental status exam, determine medical necessity for treatment, document diagnosis, and determine functional impairments in daily living skills and community living skills order to make a determination of Severe Mental Illness for PATH enrolled individuals.

Habilitation and Rehabilitation:
PATH consumers may be referred to one or more services, which are designed to promote recovery, independence, maximum functioning and a sense of wellbeing. Opportunity House, a psychosocial day program for adults with serious mental illness or co-occurring disorders serves more than 60 individuals and is open Monday through Friday. The Women's Center provides numerous services for women experiencing substance use or co-occurring conditions. Mental Health Skill Building Services are available to assist with training individuals with increasing their daily living skills and psycho-social functioning.

Community Mental Health Services:
The PATH case manager will refer most PATH clients who are eligible for services to PDBHS for assessment and evaluation. Services can include case management, medication management, individual therapy, co-occurring services and/or psychosocial rehabilitation, PACT, Department of Aging and Rehabilitative Services or HIV/AIDS education. If PATH clients have health insurance PATH case manager will assist clients with finding an outside provider if that is the client's preference.

Substance Use Treatment Services:
The PATH case manager makes referrals to Substance Abuse Outpatient Treatment Services. The referrals for services are presented at the multidisciplinary intensive treatment team meeting (ITT) for the appropriate levels of care. In addition, the PATH case manager links individuals to Crisis services for immediate access to inpatient Substance Use treatment/detox services. This is especially crucial given the high incidence of opiate use among PATH/DBHDS consumers.

Training of Community Provider Staff on PATH and its Consumers:
PATH has provided information to the general public at the annual Portsmouth Homeless Assist Day, the Portsmouth Homeless Action Committee's (PHAC) membership luncheon, the Portsmouth Behavioral Healthcare Services (PDBHS) Advisory Committee, Hope House Foundation and the Portsmouth Old Town Business Association. In addition PATH representatives have attended every bimonthly PHAC meeting, co-chaired the Point In Time count, 2x a month go to PCAN meetings and made presentations at various churches.

Case Management:
The PATH case manager utilizes a person-centered approach to treatment planning. Treatment plans address housing, entitlements, medical, food, shelter, clothing, budget and additional service needs. All service options or identified needs are documented in progress notes.

Residential Supportive Services:
The PATH case manager will lend supportive services to any PATH consumers who enter housing for their first 3 months or until another case manager is able to take over with meeting the consumers support needs.

Housing Eligibility Determination:
DBHS uses the HUD definition of "homeless," "homeless individual," and "homeless person" as defined by the December 5, 2011 Defining Homeless final rule to help determine PATH eligibility. Individuals are referred to the local CoC Homeless Hotline to register and begin the process of eligibility for any of the various housing programs in the city. The PATH case manager assists the consumer in completing the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) which is used to determine eligibility and priority of need for each consumer. The PATH case manager then refers the consumer to the PCAN which meets 2x a month. During this meeting, case managers for the various CoC funded housing programs in the city are in attendance. The case is presented and staffed and a plan developed for assisting with the most appropriate housing program.

Security Deposits:
Eligible consumers are assisted on a limited as needed basis.

One-time Rental Payments to Prevent Eviction:
This funding will provide assistance to PATH eligible consumers who are at eminent risk of becoming homeless by definition. The PATH case manager will assess the risk for homelessness to determine if the person(s) meet the criteria for this one time assistance to prevent eviction.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

DBHS uses the HUD definition of "homeless," "homeless individual," and "homeless person" as defined by the December 5, 2011 Defining Homeless final rule to help determine PATH eligibility. Individuals are referred to the local CoC Homeless Hotline to register and begin the process of eligibility for any of the

various housing programs in the city. The PATH case manager assists the consumer in completing the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) which is used to determine eligibility and priority of need for each consumer. The PATH case manager then refers the consumer to the PCAN which meets twice a month. During this meeting, case managers for the various CoC funded housing programs in the city are in attendance. The case is presented and staffed and a plan developed for assisting with the most appropriate housing program. All activities of the PATH case manager are documented in the DBHS HER and HMIS. PDBHS offers screening and assessment services for PATH consumers to determine the clinical and service needs of the individual. All persons are triaged in Central Intake/Same Day Access, which is the starting point for services with PDBHS. No appointment is required; Central Intake is available Monday – Thursday, 8:30 a.m. to 2:30 p.m. for Portsmouth citizens. At screening, a preliminary determination is made at to the individual's qualification for Severe Mental Illness status. Based on this screening, an intake with a LMHP is completed on the same day. The individual is then scheduled for recommended services such as case management, mental health or substance abuse counseling, psychosocial rehabilitation services, skill building services, psychiatric physician services. Some individuals may be referred to private providers in the community for services as requested by the individual or service availability.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

The Portsmouth PATH program has been utilizing HMIS for the last 3 years. DBHS established a work group to develop forms and methods migrating information from Credible to prevent duplication of data input. However, this has proven too costly to achieve. Portsmouth CoC uses and supports HMIS, and it is administered by the Norfolk CoC with the PARC program support. The Shelter Plus Care Program case managers use and are familiar with HMIS. The HMIS administrator for Portsmouth's CoC has been very supportive with training and technical advice. Using HMIS has had some frustrations: 1) we are continuing to report in 3 different locations, our I system, HMIS and on paper; 2) we have had difficulty gathering the data needed each reporting period; 3) often we cannot see records placed in HMIS by other organizations; 4) our program data is not yet accurately reflected in HMIS. The PATH case manager and supervisory staff would benefit from training on running data reports from HMIS.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

The PATH Case Manager is on location (as cited in 4a) in order to assist with referrals and linking the homeless with resources and information. Assistance is provided with placement in local housing programs (as cited in 2 and 3).

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

The PATH case manager receives training available in motivational interviewing techniques, cultural sensitivity and diversity, human rights, client rights, informed consent, provider choice, aging and ethical issues encountered in dealing with the homeless populations and all consumers of Portsmouth DBHS. The PATH case manager's ability to work with a diverse population is displayed through dignity, respect for differences, empathy and knowledge of available resources to meet specific needs and/or interests. The

PATH case manager is sensitive to age, gender, disability, lesbian, gay, bisexual, transgender, racial/ethnic and differences of all clients. The PATH case manager is required to complete cultural diversity awareness and sensitivity training on an annual basis.

The PATH case manager is newly hired with Portsmouth DBHS since October 2019. He is an African American male who has resided in Portsmouth for many years and is also a disabled veteran. He is very familiar with the Portsmouth community and its unique demographics.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

PATH staff receive training, as available, on cultural diversity through City of Portsmouth/DPHS, fair housing and other training resources. The PATH case manager is required to complete cultural competency training on an annual basis.

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

a. Projected number of adult consumers to be contacted with PATH funds: 110
b. Projected number of adult consumers to be enrolled using PATH funds: 80
c. Percentage of adult consumers projected to be Literally Homeless: 70%
d. Demographics: The targeted population is single adults with mental illness. Per the 2018 census the Portsmouth population is made up of 52% African Americans, 38% Caucasians, 4% Hispanic, 1% Asian, 3% Other. The PATH case manager attends cultural competency workshops offered through City of Portsmouth/PDBHS and has worked with a diverse population for many years. On 1/23/19, Point In Time (PIT) count was 119. 3 of those were identified as having mental health issues, 4 were identified with chronic substance use, 15 were reported Veterans, 2 identified with HIV/AIDS, 14 were identified as victims of domestic violence, 3 were parenting youth age 18-24, 5 were children of parenting use. The numbers for mental health and substance use disorders appear very low, this may be due to stigma associated with MH/SA issues when self-reporting. The PIT count also revealed that 41 were female, 78 were male, with no reports of transgender or gender non-conforming, 103 were Black/African American, 15 were White and 1 Multi-Race.

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

Portsmouth is one of three designated communities in the Commonwealth of Virginia working with the Zero: 2016 campaign to end homelessness in the veteran population. The Portsmouth CoC is working with the Veterans Affairs and other organizations working to find homes for veterans. The PATH case manager works with and receives referrals from, all of these agencies. One barrier for veterans is some do not met criteria for VA services or established programs due to receiving less than honorable discharges. These are very difficult to place as they are not eligible to receive benefits but often cannot hold a job. Portsmouth DBHS collaborates with the Veterans Affairs and Western Tidewater CSB Orders Home Program that is a Peer Group that focuses on transitioning service members, reservists, national guard, veterans and military connected family members with empowerment, support and goal setting. This serves as a transition and integration peer support program.

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

Currently there is one consumer serving on PDBHS Advisory Board. There are also two formerly homeless consumers on the PHAC board. One of our Shelter Plus Care consumers, who was once in PATH, continues to volunteer when available to work with PATH program for outreach to homeless individuals. The Department of Behavioral Healthcare Services partners with NAMI and sponsors a Family to Family program on site. PATH consumers are also involved in that organization. DBHS also is beginning a Family and Friends Group which is open to the general public. Consumers with Portsmouth DBHS to include PATH are goal directed to become Peer Support Specialist who have lived experience with mental health/substance use and homelessness.

Consumers are involved in person centered planning of their care and services to include family members. Consumers participate is discharge planning at the onset of admission. PATH staff complete annual training on assessments, person centered planning, goal setting and treatment planning, and documentation. All consumers complete an informed consent acknowledgement at the onset of services that explain benefits and risks of services/treatment, making a voluntary decision to participate in treatment with the ability to end treatment at any time. Consumers are given a provider choice agreement to obtain services at where they want. Consumers are given a right to appeal acknowledgment for any services that may be increased/decreased, added or denied. Consumers are given a Human Rights Acknowledgement that explains disclosure agreements, treatment decisions, respect and non-discrimination information, confidentiality of healthcare information/HIPAA, grievance procedures and appeals process, consumer responsibilities. Consumers are also given information for Portsmouth DBHS Human Rights Advocate and HPR 5 Human Rights Advocate. Consumer satisfaction surveys are available to complete to evaluate satisfaction and/or dissatisfaction with agency services.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

The budget will enable the agency to remove the preliminary barriers that have been long standing problems to accessing mental health and co-occurring, case management services, housing and employment services, prevent homelessness for those persons at risk, provide financial assistance and support for newly housed persons with minimal resources, and close some of the gaps in the services delivery system. Having resources such as case management services to link the homeless person to financial entitlements and obtain the necessary documents such as birth certificates/identification, pay deposits, purchase household items, procure temporary housing and bus tickets, will lead to the rapid housing of homeless persons and long term housing/stability

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

Portsmouth is one of three designated communities in the Commonwealth of Virginia working with the Zero: 2016 campaign to end homelessness in the veteran population. The Portsmouth CoC is working with the Veterans Affairs and other organizations working to find homes for veterans. The PATH case manager works with and receives referrals from, all of these agencies. One barrier for veterans is some do not met criteria for VA services or established programs due to receiving less than honorable discharges. These are very difficult to place as they are not eligible to receive benefits but often cannot hold a job. Portsmouth DBHS collaborates with the Veterans Affairs and Western Tidewater CSB Orders Home Program that is a Peer

Group that focuses on transitioning service members, reservists, national guard, veterans and military connected family members with empowerment, support and goal setting. This serves as a transition and integration peer support program.

Prince William County Community Services
15941 Donald Curtis Drive
Woodbridge, VA 22191
Contact: Lynn Fritts

Provider Type: Community mental health center
PDX ID: VA-012
State Provider ID:
Contact Phone #: 703-792-7947

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**86,204.00**	**10,244.00**	**96,448.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Outreach worker	17,308.00	50.00 %	0.41	7,064.00	10,244.00	17,308.00	PT
Other (Describe in Comments)	79,140.00	80.00 %	1.00	79,140.00	0.00	79,140.00	PATH Therapist

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0.00**	**$ 27,553.00**	**$ 27,553.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 1,000.00**	**$ 1,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Conference Registration Fee	$ 0.00	$ 1,000.00	$ 1,000.00	

d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

e. Supplies	**$ 450.00**	**$ 160.00**	**$ 610.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 450.00	$ 60.00	$ 510.00	
Office: Supplies	$ 0.00	$ 100.00	$ 100.00	

f. Contractual	**$ 125.00**	**$ 0.00**	**$ 125.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments

Other (Describe in Comments)	$ 125.00	$ 0.00	$ 125.00	Cell Phone Service Fee

g. Housing	**$ 500.00**	**$ 42.00**	**$ 542.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 300.00	$ 42.00	$ 342.00	Rental Assistamce
Other (Describe in Comments)	$ 200.00	$ 0.00	$ 200.00	Housing Move-In Costs

h. Construction (non-allowable)

i. Other	**$ 788.00**	**$ 140.00**	**$ 928.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 400.00	$ 0.00	$ 400.00	
Client: Other (Describe in Comments)	$ 200.00	$ 0.00	$ 200.00	Identification Purchase
Client: Other (Describe in Comments)	$ 188.00	$ 140.00	$ 328.00	Medication Assistance

j. Total Direct Charges (Sum of a-i)	$ 88,067.00	$ 39,139.00	$ 127,206.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 88,067.00	$ 39,139.00	$ 127,206.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 150

Estimated Number of Persons to be Enrolled: 50

Estimated Number of Persons to be Contacted who are Literally Homeless: 146

Number staff trained in SOAR in grant year ending in 2019: 0

Number of PATH-funded consumers assisted through SOAR: 0

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Prince William Community Services

1. Description of Provider Organization:

A. Name: Prince William Community Services
B. Organization Type: Community Mental Health Center
C. Description: The Prince William County Community Services (CS) is the umbrella agency for the area PATH program. CS provides mental health, developmental disability, substance abuse, and early intervention programs as well as emergency services for children and adults. The PATH program is placed within the organization under the MH Supported Living Services (SLS). The MH SLS provides community-based services for individuals with serious mental illness (SMI) and/or co-occurring SMI and substance use disorders (SUD). These services include outreach, active case management, support services, and supported housing.
D. Region Served: The Prince William County Community Services serves Prince William County, the Cities of Manassas and Manassas Park.
E. Amount of federal PATH funds requested: $88,067
F. Primary Point of Contact: Lynn M. Fritts

Phone: office 703-792-7947; cell 571-436-1021
Email: lfritts@pwcgov.org

2. Collaboration with HUD Continuum of Care (COC) Program *Describe the organization's participation with local HUD Continuum of Care (COC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities*.

Community Services (CS) was involved with the Continuum of Care (COC) prior to the inception of the PATH program in the Prince William County (PWC) area. A PATH therapist has served on the COC since 1999. The Continuum of Care Network (COCN), formally known as the Homeless Services Network Council, is the group of area agencies that the PWC Board of County Supervisors tasked with coordinating and promoting homeless services in the Prince William County Area. Public and private non-profit agencies, such as local emergency shelters, transitional and permanent housing programs, and emergency assistance programs are members. The Prince William Area Departments of Social Services (including City of Manassas and Manassas Park), the county Office of Housing and Community Development, and the Community Services all participate in COC. Currently a PATH therapist, in addition to the COC monthly meeting, actively participates in various sub-committees, including the Point-In-Time (PIT), Data and Needs Analysis, Permanent Supportive Housing, and Outreach committees. The PATH therapist facilitates monthly PWC Homeless Case Management meetings, designed to support front line staff through trainings, resource exchange and case consultation. This PATH therapist also co-facilitates the COC's outreach efforts for the PIT count, including mapping the locations and the organizing teams to ensure all known campsites and popular congregation spots (libraries, coffee shops, etc.) have been accessed. The PATH therapist provides training to PIT survey takers related to conducting the survey in a safe manner that elicits valid information and is respectful of the individual's time and living space. PATH services are the only services available to the target SMI / homeless population in the PWC area. Many more consumers are connected to mental health services, mainstream resources, assisted in obtaining SSI/SSDI (through the SOAR model), medical benefits and housing than would be served without a PATH Program. PATH clinicians have developed and maintain an ongoing professional relationship with the intake personnel at PWC CS Same Day Access unit, making the process of community mental health referrals as seamless as possible for individuals being served in the PATH program. The PWC

Coordinated Entry Program (CE) is coordinated by staff at the Bill Mehr Drop-In Center. PATH has an established schedule to be onsite at Drop-In Center five days per week, making access to CE as easy as walking down the hallway.

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

The PATH staff work closely with community providers to assist consumers.

Outreach Teams: PATH clinicians maintain a collaborative relationship with multiple secular and faith-based outreach groups working with the unsheltered homeless in PWC.

- Streetlight Community Outreach Ministries, in addition to operating the year-round Overnight Shelter and Permanent Supported Housing programs, conducts street outreach. Streetlight alerts PATH staff about concerns regarding individuals encountered during outreach who may be demonstrating behaviors related to mental illness. PATH then coordinates with Streetlight to develop a plan for outreach.
- Manassas Hope for the Homeless, in addition to street outreach, utilizes the Manassas Baptist Church as a hypothermia shelter when temperatures are forecast 25 degrees or below and provide showers on Fridays. PATH provides an in-service on mental illness and substance use issues (as both relate to individuals in a congregate setting) for shelter volunteers at the beginning of the winter season. PATH receives referrals from staff operating the hypothermia and shower program. PATH staff will provide onsite outreach services on Fridays at regular intervals.
- Manassas Hunger and Homeless Outreach (MHHO) provides outreach and meal services every Sunday. Volunteers with MHHO alerts PATH staff regarding individuals encountered as well as trends within the unsheltered community in the Manassas area. A former PATH clinician is now a volunteer with MHHO providing outreach.
- Feeding Friends, based out of Gainesville United Methodist Church utilizing a commercial food truck, provides meals and outreach to the homeless in the Manassas area two times per week. As with the other outreach efforts Feeding Friends also communicates concerns to PATH clinician. PATH clinician accompanied Feeding Friends on an outreach effort in FY 2020 and will continue throughout FY 2021.
- PATH clinicians routinely receive phone calls or emails from individuals not associated with any outreach group but nonetheless conducting outreach as a solo effort. PATH clinicians collaborate as much as permissible, understanding an ROI has not been obtained, with the referral source and will act on the information to provide general guidance or extend the outreach effort as a PATH clinician.

Primary Health Care: PATH clinicians maintain a collaborative relationship with local health care providers.

- Sentara Northern Virginia Medical Center in Eastern PWC and Novant Health UVA Medical Center in Western PWC (PATH eligible consumers typically access medical service through the Emergency Departments). PATH therapists work effectively with hospital medical discharge planners, especially in outreach efforts for patients leaving against medical advice.
- The PWC Area Free Clinic and Mother of Mercy Medical Clinic (via Catholic Charities) provides

medical care to uninsured, indigent consumers. PATH referrals to these clinics would include uninsured individuals who do not meet the criteria for Virginia Medicaid or Medicare (i.e. undocumented immigrants).

- The Sentara Northern Virginia Medical Center Mobile Health Care Vans also provide medical care to indigent and uninsured individuals and are located at scattered sites in the County, including the Bill Mehr Drop-In Center (DIC). PATH maintain a presence at the DIC Monday through Friday and will coordinate referrals as needed.
- The Greater Prince William Community Health Center (GPWCHC) operates facilities in three locations covering a large area of county. Most notable in this expansion has been the decision to provide medical care for an acute medical issue that can be addressed in an outpatient setting, thus preventing a visit to the local emergency room. This service is free of charge, for individuals who are homeless, without income or insurance. Individuals who do not qualify for Medicaid expansion can receive treatment at GPWCHC. PATH therapists have established and will maintain a collaborative relationship with the PWC area free clinics and GPWCHC.
- The Virginia General Assembly's 2019 decision to expand Medicaid eligibility has opened many doors for PATH consumers establishing a primary care physician. PATH clinicians assist clients with online Medicaid applications. PATH clinicians encourage individuals to sign a consent to release information (ROI) allowing the clinician to better coordinate medical care.

Mental Health (MH) and Substance Use Disorder (SUD) Treatment: PATH clinicians provide information related to treatment options within CS to individuals during the outreach and engagement phases of PATH contact.

- Same Day Access (SDA): PWC CS implemented SDA in July 2018. PATH clinicians carry wallet-size information cards with details on SDA and distribute to individuals considering CS as a treatment resource. PATH clinicians explain the SDA process and provide practical information (such as showing up when the office opens at 8 AM to ensure being seen that day). PATH clinicians work with SDA staff to address unpaid balances from previous services that may act as a barrier to obtaining current treatment. This may include completing forms requesting a fee waiver. After obtaining an ROI, PATH clinicians work to obtain medical records from previous providers. These records are scanned into the electronic health record prior to the client's meeting with SDA, allowing SDA clinicians an opportunity to review medical information before and during the assessment process.
- Outpatient Treatment: PWC CS provides outpatient MH, SUD and co-occurring treatment, psychiatric, medication management and case management services. Substance Use Services utilizes Medication Assisted Treatment, prescribing or dispensing Antabuse, Naloxone and Suboxone. Because PATH is housed within CS, referrals are easily coordinated and relationships are collaborative. PATH therapists work closely staff from Emergency Services, Adult Services and Adult Substance Use Services. A PATH clinician also has a permanent full time position with PWC CS Emergency Services.
- Residential Substance Use and Co-Occurring Treatment: Prince William County does not have a residential substance use/co-occurring treatment program but through contracts and relationships regularly refer out to other residential substance use/co-occurring treatment facilities in other areas, including Boxwood Treatment Center in Culpepper, Fairfax and Alexandria detox centers. Individuals who would like to participate in residential, spiritually based programs are referred to other programs, including The Salvation Army and Teen Challenge, both of which have multiple locations in Virginia. As of April 1, 2017, most Virginia Medicaid coverage plans will pay for residential SUD and Co-occurring treatment.
- Residential Withdrawal Management (Social and Sub-Acute Medical Detox Services): Through contracts and relationships with other Virginia CSB's, Prince William County CS regularly refers

out to residential withdrawal management programs in other counties, including Rappahannock-Rapidan CSB at Boxwood Treatment Center in Culpepper, Virginia, Fairfax County ADS, and City of Alexandria CSB. All of these are social detox units, not medical. As of April 1, 2017, most Virginia Medicaid coverage plans will pay for residential withdrawal management.

- Inpatient Withdrawal Management (Medical Detox Services): Medically managed, inpatient services for alcohol withdrawal is available through Novant Health Prince William Medical Center or any other local hospital. Medically managed, inpatient services for withdrawal are also available in local Northern Virginia hospital units for clients with Medicare and/or Medicaid.

Housing: Housing is expensive and affordable housing is difficult to find in the Prince William County area.

- Shelters: Prince William County utilizes three emergency shelter facilities (SERVE, Hilda Barg Homeless Prevention Center and Beverly Warren Emergency Homeless Shelter) for the homeless, providing a total of 140 beds. ACTS operates an emergency domestic violence shelter. PWC DSS, contracting with Streetlight, operates the year-round Overnight Shelter and has a capacity for 48 beds. The PATH therapists work very closely with the staff at all these shelters, providing consultation, MH services, training and as a liaison with CS. The shelter staff is more comfortable accepting consumers with mental illnesses and/or substance use when they have a PATH staff to follow the consumer. The PATH workers go to the shelter to see the consumer rather than requiring the consumer come to the CS office.
- Transitional Living: Following HUDs decision to de-emphasize transitional housing projects PWC has experienced a decrease in the number of transitional housing over the years. PATH does maintain a working relationship with the two remaining providers: St. Margaret of Cortona (via Catholic Charities) and Dawson Beach (via PWC Office of Housing and Community Development).
- Permanent Supportive Housing (PSH): The CS Community Mental Health Program, parent organization to PWC PATH, has multiple housing sites for CS consumers with a serious mental illness. The CS also provides on-site mental health treatment and supportive services to 20 consumers who live in the Community Apartments (previously developed by a non-profit community provider through a HUD 811 grant). The CS Community Mental Health Program partners with The Good Shepherd Housing Foundation to provide permanent supportive housing for 16 SMI consumers, four of whom must be homeless at entry. As a PSH program, Good Shepherd Leasing utilizes the continuum of care and the partnership between Good Shepherd and Community Services to house an additional ten, SMI homeless consumers. PATH staff have referred and advocated for PATH consumers (all chronic homeless) to be among those housed through this program. Streetlight Community Outreach Ministries offers a total of 25 beds for the chronically homeless including six PSH beds for medically fragile clients. Pathways Homes, Inc. allocated 10 PSH slots to PWC in March 2016, and added nine more slots in FY 2018. Pathways was awarded an additional 12 slots in FY 20 which are in the process of being procured. PWC will have a total of 31 single unit apartments for homeless clients through the partnership with Pathways. PATH clients who have transitioned into mainstream services will continue to be referred. PATH therapists work collaboratively with the PSH programs.
- PWC Office of Housing and Community Development: The Housing Choice Voucher Program through the Office of Housing and Community Development (OHCD) last opened their Wait List December 2010 for two weeks. During the two-week enrollment period, 8000 names were added to the wait list. The wait list is not expected to open again during the proposed grant year. Currently there are less than 800 families on the Wait List. On average about 100 people are called from the wait list each year. The County this year applied for additional funding to assists low-income families. OHCD was approved this year for funding for Family Self-Sufficiency (FSS),

Veteran Affairs Supportive Housing (VASH) and Mainstream Vouchers for persons who are non-elderly but disabled. OHCD currently serves on average 1,860 families per year with the average cost per person for the Housing Choice Voucher Program is $1,173 per month. The Mainstream Vouchers awarded to OHCD will begin to lease up effective July 2020. With the funding allocation it is anticipated that 60 households will be served from the Housing Choice Voucher Wait List.

Bill Mehr Homeless Drop-In Center: The Cooperative Council of Ministries (CCOM), in partnership with Prince William County Department of Social Services, operates a year-round Drop-In Center, working with many of the chronically homeless individuals. The Drop-In Center facility underwent a total reconstruction in 2016-17, now providing private meeting rooms for PATH staff to meet with individuals. PATH staff coordinate with other entities (Rapid Rehousing, PWC Employment Services, Computer Assistance programs and Veterans groups) providing services to Drop-In participants. The PATH staff work closely with the Drop-In-Center and local churches (e.g., St. Paul's United Methodist and Vineyard Christian Fellowship's Streetlight Ministries) to assist PATH consumers to use this service. PATH staff maintains an established schedule at Drop-In, providing the opportunity for direct contact between the therapist and the SMI, homeless individual on a consistent and reliable basis.

Employment: The Department of Aging and Rehabilitative Services (DARS) in connection with the Supported Employment Program (SEP) provides employment assistance. SEP is part of CS. PATH therapists make referrals and coordinate with these programs. In addition, many of the PATH consumers work with day labor employers. The PATH therapists help with coordinating transportation, provide bus tokens, and work with the consumer on managing symptoms in various settings, including making least harmful choices about substance use. The PATH therapist disseminates information related to specific hiring events and free re-employment workshops directly to PATH consumers, members of the PW COC, and staff at the Homeless Drop-In Center and PWC Community Services. Staff from Virginia Career Works SkillSource Center, including a veteran's specialist, are also members of the PWC COC. The PATH therapist has provided outreach to staff at the SkillSource Center related to barriers to employment experienced by PATH consumers. These barriers include not only homelessness and mental illness but co-existing problems such as criminal background, co-occurring medical and substance use conditions, and lack of job skills relative to the burgeoning emphasis on computer related positions. SkillSource has responded by inviting PATH clients to participate in all activities at the Center.

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

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing.

The PWC PATH program utilizes PATH clinicians for the purpose of outreach, engagement and case management activities. The PWC PATH program will demonstrate an increased street presence, specifically targeting campsites, public libraries, municipal parks, and sandwich and coffee shop establishments, locations frequented by the homeless population on a regular basis. Comprehensive treatment plans are developed for every PATH Enrolled client. Components to that plan include housing, mental health and/or substance use services, income and entitlements, and linking to community based medical care. PWC PATH staff has considerable experience providing case management, therapeutic

and/or emergency services. The result is a projected increase in the number of consumers outreached, engaged and targeted for case management.

b. Any gaps that exist in the current service systems?
Housing: The primary gap for PWC is affordable housing. PATH consumers, as well as many others in the community, have difficulty obtaining safe and affordable housing. The PWC area does not have Single Room Occupancy (SRO) facilities or Safe Havens and has a very limited number of Assisted Living Facility (ALF) auxiliary grant beds. PATH therapists coordinate with Veterans Administration and Operation Renewed Hope Foundation outreach staff to be certain that veterans outreached or enrolled in PATH submit applications for special housing vouchers (e.g. VASH vouchers) for homeless veterans. PATH therapists also coordinate with PWC OHCD as Housing Choice Vouchers are disseminated to PATH Enrolled consumers. PATH clinicians assist clients with applications (online or hard copy) for multiple locations under the Housing Choice Voucher program throughout Virginia, West Virginia and North Carolina.

Entitlements: The most significant issue continues to be the length of time it takes to process applications, wait for determinations, and, at times, appeal denial determinations for entitlement programs (e.g., Supplemental Security Income, Social Security Disability Insurance). Most emergency shelters will not allow a three to six month stay while the consumer's application is initially reviewed. When a consumer has a serious mental illness, complicated by a medical condition that is disabling, it can be very dangerous for that person to be unsheltered. Finding housing and consistent medical support while waiting for the determination is difficult. In addition, many consumers need to be accompanied to Social Security, Social Services, etc. to apply for benefits. PATH addresses this gap by having a near-perfect record in Social Security claims being approved based on the initial application. A normal Social Security determination can take three months to two years. PWC PATH is successful in getting most Social Security benefits approved in three to six months. PATH therapists have received extensive training in applying for Social Security benefits. One of the PATH therapists completed the training of trainers program for SOAR (SSI/SSDI Outreach, Access and Recovery) and now trains fellow CS clinicians on the SOAR model.

c. A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder.
The Prince William County Community Services has provided services to individuals who are homeless or at risk for homelessness and have a Serious Mental Illness and/or a co-occurring Substance Use Disorder for more than 30 years. Please refer to Section 3 of this application as it explains in detail services available to clients with a SMI and co-occurring substance use disorder.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
PATH enrollment is determined by three components: 1) the individual has Serious Mental Illness (SMI) defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities; 2) is homeless or at risk for being homeless; and 3) willing to work with a PATH clinician. Enrollment occurs when the PATH clinician determines the individuals meets the criteria and both clinician and individual mutually agrees the prospective PATH client would benefit from PATH involvement. Eligibility criteria, as it pertains to the individual, is documented in the electronic health record.

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

plans to complete HMIS implementation.

The PWC PATH Program fully implemented the HMIS data reporting on July 1, 2016, utilizing Bowman Systems – Service Point. PWC CS utilizes Credible Behavioral Electronic Health Record (EHR). The two primary PWC PATH therapists will have sole responsibility for record maintenance within HMIS. PWC CS PATH identify PATH specific data elements in Credible and load them into HMIS on an individual / client basis. PWC PATH will perform this task as a matter of a routine / daily basis to ensure data entry is both timely and of high quality. An ongoing challenge for PWC PATH is the double entry aspect of recording the information in two separate systems. The PATH supervisor will continue to reinforce the importance of timely documentation into Credible and HMIS to ensure contacts, services and referrals are accurate and not missed.

6. Housing *Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualifying residents*.

Most available housing for PATH clients is provided through the PWC CSB Mental Health SLS Program, Good Shepherd Housing Foundation (GSHF), Streetlight Community Outreach Ministries and Pathways Homes. The GSHF, Streetlight and Pathways have multiple HUD grants through the Continuum of Care which include permanent supportive housing for low income and disabled and Housing First units. As previously noted, PATH clinicians assist clients with applications for Housing Choice Voucher programs throughout Virginia, West Virginia and North Carolina. Clients also seek housing in Oxford Houses. PATH therapists search for individually rented rooms and other shared housing opportunities through known websites sites such as Trulia. The PATH supervisor works closely with the COC to advocate for and obtain more affordable housing for the chronically homeless. The PWC Continuum of Care 10 Year Plan to End Homelessness includes Affordable Housing Strategies as one of the four areas addressed in the plan. Both an increase in Affordable Dwelling Units (ADU) and Housing First units are identified strategies in the plan.

The PATH staff support and coordinate with other homeless services programs, emergency shelters, Drop-In-Center, and churches. At various times all the homeless service providers are involved with referrals, often through word of mouth and networking. Finding financial supports for individual consumers and developing resources is a full-time task. This work is performed in coordination with the various providers, both at a programmatic and an individual case manager level. The PATH program refers, advocates and coordinates with the CS Community Mental Health Program for PATH consumers. The PATH therapists often continue to stay involved with the consumer while they develop a relationship with their Community Mental Health therapist/case manager. The PATH program proposes, and when needed, finds financial support for housing programs for people who have a serious mental illness and are homeless.

The PATH lead therapist / supervisor is an active member of the PWC Continuum of Care (COC) PSH Admission's Committee. The PWA PSH Admission's Committee (AC) has been established to review and make final admission decisions regarding households that have been referred to PSH. The AC has the following responsibilities: 1) establish the criteria upon which all chronically homeless persons will be evaluated, scored, and ranked. The ranking will determine which household should secure the next available unit; 2) review COC PSH referrals to determine which households will be placed in PSH; 3) meet when there are program vacancies to determine how to prioritize the PSH pool to fill those vacancies.

7. Staff Information

a. Describe how staff providing services to the population of focus will be sensitive to age, gender,

disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

The PATH therapists have a long history in treating people with Serious Mental Illness with a variety of backgrounds, races, ages and disabilities. PATH staff, through a CS contract with Voiance, has access to face-to-face and telephonic translation, for consumers who are hearing impaired, or whose primary language is something other than English. PATH therapists have completed graduate level courses in Assessment and Treatment of Diverse Populations; Multicultural Counseling; Counseling Diverse Populations; Clinical Social Work in Relation to Chronic Mental Illness with a focus on the interplay between diversity and serious mental illness; Mental Health and Social Policy with a focus on systemic discrimination; and Planning of Health Education Programs which addressed designing culturally appropriate intervention strategies. Post graduate trainings include Broaching Race in Counseling; Culture and Its Effect on Communication; Cultural Awareness in Therapeutic Settings: How Oppression Impacts the Recovery Process in Mental Health and Substance Abuse; and Mental Health: Culture, Race and Ethnicity. CS staff in general exemplifies diversity relative to their work, extending beyond race and gender.

b. Describe the extent to which staff receives periodic training in cultural competence and health disparities.

For a comprehensive list of courses and trainings PATH staff has had relative to cultural competence, note the information as stated above (7.a.). PWC University provides classroom and online training opportunities to all CS staff on multiple subjects, including Cultural Diversity. PATH staff participates in online and classroom trainings designed to provide quality services for special populations beyond the general areas of race and ethnicity. This includes trauma survivors, military veterans, individuals with an Intellectual or Developmental Disability, traumatic brain injuries, individuals adjudicated Not Guilty by Reason of Insanity (NGRI), and those experiencing generational poverty. PATH staff will participate in trainings, such as "Integrating Primary Care with Behavioral Healthcare" to better serve individuals experiencing co-occurring physical health issues.

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

a. Demographics of Target Population:

Race / Ethnicity of PATH Enrolled	**% PATH Enrolled**		**Age Parameters**	**% PATH Enrolled**
American Indian or Alaskan Native	3		18-23	6
Asian	3		24-30	16
Black or African American	38		31-40	26
Native Hawaiian or Pacific Islander	.7		41-50	23
White	54		51-61	28
Hispanic / Latino	8		62+	1
Gender of PATH Enrolled			**Veteran Status**	
Female	52		Veteran	7
Male	47		Non-Veteran	93
Transgender Male to Female	1			
Transgender Female to Male			**Co-Occurring SUD**	
Gender Non-Conforming			Co-Occurring SUD	29

			No Co-Occurring SUD	71
			Chronically Homeless	
			Yes	31
			No	69

b. *Projected number of adult consumers to be contacted with PATH funds:* The PWC PATH program projects to outreach at least 150 individuals during FY 2021.

c. *Projected number of adult consumers to be enrolled using PATH funds*: The PWC PATH program projects to enroll at least 50 individuals during FY 2021.

d. *The percentage of adult clients to be served using PATH funds who are literally homeless*: The PWC PATH program projects to serve at least 97% determined to be literally homeless during FY 2021.

9. **Veterans** *Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be COC-level coordination demonstrating effectiveness in serving this population.*

PATH therapists provide direct active outreach services to veterans in the local homeless Drop-In Center and local church congregate meal sites, on the street, at campsites, and in the woods. PATH therapists receive referrals from other homeless service providers or veterans volunteering their time in the community, often not part of an organization but simply to help a peer. Assessment of veteran status is normally completed at the first or second contact during the outreach phase of engagement. As the veteran becomes an enrolled PATH client, an assessment is completed identifying needs, such as untreated mental illness, health issues, lack of income and housing. PATH therapists link clients directly with mainstream services for issues exposed in the needs assessment. Services available to veterans include mental health, substance abuse, primary health, case management, employment, education and housing as identified in Section four of this application. PATH therapists directly link clients with services available to only veterans, such as the US Department of Veterans Affairs (VA) Medical Center in Washington, DC; the VA Healthcare for Homeless Veterans; and the VA case manager responsible for HUD VASH vouchers. Within the last three years, Friendship Place and Operation Renewed Hope Foundation have begun working with the PWC COC to identify veterans for housing opportunities. As the VA is designed to provide housing for honorably discharged veterans only, Friendship Place and Operation Renewed Hope Foundation can house veterans under any discharge status that is not dishonorable, thus opening the door for more overall veteran eligibility. In keeping with the emphasis to house all veterans by the end of 2015, PWC placed great emphasis on outreaching to the unsheltered homeless population to identify veterans to begin the process of securing housing.

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

The PWC CS has a proven track record of involving mental health consumers and their family members in program administration, planning, implementation, and evaluation. The PWC CS involves and solicits input from consumers and their family members through both formal and informal processes. For example, consumers and/or their family members have and do serve as members of the Community

Services Board directing the mental health, intellectual disability, and substance abuse services for Prince William County. PATH, as a program of the CS, receives oversight from this same Board. Additionally, in recent years Prince William County has been fortunate to see an increase in consumer advocacy and consumer-run services and to have established processes for collaboration and communication. For example, quarterly meetings are held with professional and community stakeholders including 1) representatives of consumer organizations (e.g., Trillium – a consumer run drop in center), 2) the president of the local chapter of the National Alliance for the Mentally Ill, 3) CSB Executive Director and, 5) managers from CS Emergency Services, Adult Services, Community Mental Health, and Vocational Service programs. The purpose of these meetings is to share information, seek input, and facilitate overall collaboration between consumers and provider programs within the CS. Because of the level of need and numbers of homeless encountered through programs such as Trillium consumer input and collaboration with PATH is frequent. Issues specific to serving individuals who are homeless and have an SMI and/or co-occurring SMI/SUD are frequent topics. Consumer input also is obtained through surveys throughout the year. CS is committed to maintaining and further developing formal and informal processes to receive input from its consumers and to use the information to inform continuing service improvements.

11. **Budget Narrative** *Provide a budget narrative that includes your local plan for the use of PATH funds.*

A brief narrative describing the items in the attached budget:

- Provides for a 0.8 FTE position as PATH Therapist – East and West. This equals 30 hours per week. Includes fringe benefits.
- Provides for 0.5 FTE position as PATH outreach Therapist(s) – East and West. Therapist(s) will serve on a part-time basis providing outreach, engagement and case management.
- Costs for trainings and conferences.
- Office supplies for PATH staff.
- Outreach supplies to assist the homeless. This includes sleeping bags, inclement weather gear and other necessities for those who are literally homeless.
- Cost for medication assistance
- Identification related costs (birth certificates, etc.)
- Rental assistance costs
- Bus tokens
- Cab vouchers
- Housing Move-In costs (linens, dishes, etc.)

12. Programmatic and Financial *Oversight* *Describe your agency's method of providing programmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.*

PWC PATH supervisor will keep abreast of changes, updates and instructional guides for the PATH program by participating in PATH Learning Community webinars sponsored by SAMHSA and other training sites endorsed by SAMHSA or state PATH contact at DBHDS. PWC CS PATH supervisor provides support and supervision to PATH staff on a regular schedule. During FY 2021 PATH clinicians will meet monthly to staff cases, review trends, receive instruction or updates, and explore resources. The PATH supervisor will conduct weekly records review of PATH clients HMIS and electronic health records for quality assurance. PATH supervisor also receives supervision and/or consultation from immediate supervisor, program manager, and division manager related to PATH program implementation to ensure PATH standards are maintained. Oversight of PATH funds begins at the fiscal management division of PWC CS. The PATH supervisor and CS fiscal management analyst develop a budget identifying

acceptable expenses, such as outreach supplies, bus tokens, medication, rental assistance. The request is reviewed by supervisors prior to purchase to ensure expenses are eligible under PATH guideline. The PATH supervisor has been issued a PWC purchase credit card with limitations on items that can be purchased as well.

Rappahannock Area Community Services Board
600 Jackson Street
Fredericksburg, VA 22401
Contact: Jason McIntosh

Provider Type: Community mental health center
PDX ID: VA-013
State Provider ID:
Contact Phone #: 540-479-4116

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**39,435.00**	**14,030.00**	**53,465.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	53,465.00	100.00 %	0.74	39,435.00	14,030.00	53,465.00	

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**28.03 %**	**$ 14,984.00**	**$ 0.00**	**$ 14,984.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 371.00**	**$ 0.00**	**$ 371.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Mileage Reimbursement	$ 371.00	$ 0.00	$ 371.00	

d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

e. Supplies	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

f. Contractual	**$ 42,854.00**	**$ 18,685.00**	**$ 61,539.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 41,754.00	$ 18,685.00	$ 60,439.00	Contract with Micah Ecumenical Ministries for PATH outreach and SOAR services
Other (Describe in Comments)	$ 1,100.00	$ 0.00	$ 1,100.00	Cell Phone Service Fee

g. Housing	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

h. Construction (non-allowable)

i. Other	**$ 500.00**	**$ 0.00**	**$ 500.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Other (Describe in Comments)	$ 500.00	$ 0.00	$ 500.00	Medication Assistance

j. Total Direct Charges (Sum of a-i)	$ 98,144.00	$ 32,715.00	$ 130,859.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 98,144.00	$ 32,715.00	$ 130,859.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 270

Estimated Number of Persons to be Enrolled: 130

Estimated Number of Persons to be Contacted who are Literally Homeless: 230

Number staff trained in SOAR in grant year ending in 2019: 1

Number of PATH-funded consumers assisted through SOAR: 31

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Rappahannock Area Community Services Board

1. Description of Provider Organization:

A. Name: Rappahannock Area Community Services Board
B. Type of Organization: Community Mental Health Center
C. Description: The Rappahannock Area Community Service Board (RACSB) is the leading public mental health, intellectual disability and substance abuse provider for Planning District 16. RACSB is committed to improving the quality of life for individuals residing in Planning District 16 with mental health, intellectual disabilities and substance abuse concerns as well as providing education and prevention services to our community. We do this through an integrated community-based system of care that is responsive to consumer needs and choices. We respect and promote dignity, rights and full participation of individuals and their families.
D. Region Served: The City of Fredericksburg and Caroline, King George, Spotsylvania and Stafford Counties
E. Amount of PATH Funds: $98,144
F. Primary Contact: Jason McIntosh, jmcintosh@rappahannockareacsb.org, (540) 479.4116 ext.17

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

RACSB and its PATH program works closely with the Fredericksburg Regional Continuum of Care (CoC) and also with the area agencies who serve the homeless and at-risk population. The Fredericksburg Regional CoC is the network of community organizations working together to prevent and end homelessness within the Fredericksburg region. The CoC is led and staffed by the George Washington Regional Commission and serves the City of Fredericksburg and the counties of Caroline, King George, Spotsylvania, and Stafford. Information is shared through Homeless Management Information System (HMIS) to ensure the coordination and quality of services to the individual. RACSB is an active member of the CoC, which is comprised of nearly 50 agencies serving Planning District 16 (PD16). Its goal is reducing the number of people experiencing homelessness, reducing returns to homelessness, and reducing the number of people who become homeless. RACSB, including staff from PATH, Jail Diversion and residential programs, attend CoC meetings each quarter and collaborate with the partner agencies there to identify gaps in services which may lead to homelessness. In addition, the PATH Outreach Worker actively participates with interfaith groups and churches within the planning district by providing mental health and other referral services for individuals/families identified as resistant to accessing services. PATH also participates in weekly discharge planning meetings with MH Inpatient programs such as Snowden at Fredericksburg and with the Behavioral Health Unit of Spotsylvania Regional Hospital. In addition, the Outreach Worker meets with staff and

individuals at the Rappahannock Regional Jail prior to release to homelessness when they are identified as having a serious mental illness.

The Fredericksburg Area CoC provides a single point of entry. Individuals who are at risk of homelessness are referred to the COC's Homelessness Helpline, which assesses the need and connects the household/individual to necessary resources that will keep them from becoming homeless. Through our point of entry household/individuals are referred to prevention or an appropriate member of the COC based on their assessment (Micah, Thurman Brisben Homeless Center (TBC) and Loisann's Hope House). Services are available 24 hours a day with Hope House, Micah and TBC provide screening and referral during normal business hours and TBC continues after hours. The most appropriate service is determined through a common screening tool that is incorporated in each agency's intake process. Empower House serves those fleeing domestic violence; Hope House assists families; Mary's Shelter helps pregnant women; Thurman Brisben shelters lower barrier singles and families and Micah serves individuals who don't fit into another organization.

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.

In our community, homeless individuals and families are served by the Thurman Brisben Homeless Center and Micah Ecumenical Ministries. In addition, Hope House is an emergency shelter serving families who are homeless and need assistance with childcare, job training and in establishing more permanent housing. Empowerhouse, sponsors a shelter for people fleeing domestic violence. Mary's Shelter also takes women who are homeless and pregnant. All of the above shelters serve individuals who may also have a diagnosis of a serious mental illness.

The PATH Outreach team consists of one PATH Outreach Worker who leverages his resources and time by working closely with Micah and other CoC members, as well as maintaining effective communications with area hospitals, clinics, agencies and law enforcement which interact with homeless individuals and families. The PATH Outreach worker provides regular community presentations to staff at the Rappahannock Regional Jail, Thurman Brisben Center, area Social Services, the Virginia Employment Commission and Workforce Development, local churches, and maintains a presence at the VA and VFW Stand Down where the focus is on homeless veterans.

The PATH program's unique relationship with Micah Ministries also positions it to influence the overall homeless service system to better serve individuals experiencing serious mental illness. Being a part of Micah gives the PATH program legitimacy as it develops working relationships in the greater community. As a result, the program has formed working relationships with five local Department of Social Services, three hospitals and Snowden of Fredericksburg, the Moss Free Clinic, the Central Virginia Housing Coalition, the Salvation Army, the Veteran's Administration, DMV and Fredericksburg Area HIV/AIDS Support Services (FAHASS). These relationships offer a unique opportunity to streamline access to services for many individuals who may be experiencing increased stressors, anxiety, depression or paranoia.

As an integral part of Micah's program, the PATH Outreach Worker also has the unique ability to refer individuals through Micah's co-located services. For example, individuals needing to enroll in Moss Clinic or apply for Medicaid can complete the eligibility process while they are visiting the PATH Outreach Worker in Micah's office. PATH individuals can also access Micah's income program, which includes trial work

experiences, placement in jobs within the community and access to SOAR services when employment is ruled out as an option.

The PATH Outreach Worker utilizing local resources regularly refers individuals to area churches for assistance, such as food, clothing, shoes, sleeping bags, quilts, and various sundry items. Micah provides showers, clothes and brown-bag lunches for the street homeless, including PATH-eligible persons five days per week. Micah also supports a coordinated group of organizations in the downtown area to provide and host a free community dinner and breakfast 365 days a year, which is open and welcoming to the homeless and PATH-eligible persons.

Several churches and ministries have volunteers who deliver food and supplies to locations in the city of Fredericksburg as well as Stafford and Spotsylvania counties. The PATH Outreach Worker accompanies these volunteers and meets with individuals in non-traditional locations for the purpose of assessing need, building rapport, and providing information on resources and referrals.

RACSB's permanent supportive housing program (PSH) which works with its Program for Assertive Community Treatment (PACT), providing psychiatric treatment, medication management, housing assistance, employment assistance and more to individuals in their homes. The PSH program also accepts referrals for individuals enrolled in PATH.

PATH may provide individuals with a one-time assistance for rent of security deposits and often utilizes and leverages assistance from other members of the COC and community. RACSB or Micah links individuals to payee services if appropriate. RACSB Case Management and Residential Services may also utilize Section 8 vouchers when appropriate. Individuals enrolled in Residential Services with RACSB are offered assistance with budgeting and bill paying.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

PATH Outreach services staff conducts a high degree of active outreach and in-reach. Staff conducts outreach within the community at high traffic areas such as Thurman Brisben Homeless Center, Empowerhouse, the library, area parks, free community dinners and other sites frequented by homeless individuals for direct, face-to-face interactions. Staff utilizes strategies targeted at engaging individuals into the needed array of service, including identification of individuals in need, development of rapport, offering support and referrals to appropriate resources. This results in increased access to community services by individuals experiencing homelessness. The PATH outreach worker also maintains an office at the Micah Ministries Hospitality Center, where PATH-eligible individuals frequent five days per week, seeking basic needs and case management. Through targeted outreach and in-reach during community breakfasts and dinners hosted by the Veterans of Foreign Wars as well as veteran Stand Down Events the PATH Outreach Worker has multiple referral and outreach opportunities. Additionally the PATH Outreach Worker is in regular contact with the staff and leadership of the Virginia Veterans and Family Support and through the Micah Hospitality Center, where the PATH Outreach Worker meets weekly with the VA representative.

b. Any gaps that exist in the current service systems:

PATH attempts to bridge the Gaps in service by providing one-time assistance with rent to prevent evictions as well as security deposits to secure housing and prescription coverage in order to obtain medications at the time of discharge from the hospital, in order to enter into additional treatment programs and to maintain stability while awaiting insurance approval. Many times, individuals struggle to get to appointments and/or employment, therefore PATH provides transportation assistance through direct assistance and local bus tickets. At times, individuals are assisted with bus tickets to return to their homes or families outside of our area. PATH has also been able to assist individuals with car repairs in order for them to maintain employment and at times shelter.

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

PATH staff will provide initial screening and assessment to determine general needs and mental health and co-occurring issues that need to be addressed. The individual will then be referred to RACSB's substance abuse therapist for evaluation and treatment. As appropriate, RACSB uses multiple statewide inpatient treatment centers, but no PATH funds are used for this purpose. PATH program participants are encouraged to follow up with outpatient treatment and supported with transportation assistance and sundry items, as incentives for following up. Information about AA and NA meetings in the local community is also provided. RACSB has also worked extensively with community partners, including homeless service providers, to offer training in Narcan administration.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

Individuals are met through outreach where there are opportunities for direct communication and observation. Generally, individuals will self-disclose their mental health history after conversing with the outreach worker. Other times after a period of communication the outreach worker reintroduces himself and asks the individual to disclose if they have ever been diagnosed with a serious mental illness or if they have ever been hospitalized for mental illness. Other times the individual is referred to the outreach worker by hospital staff or other homeless service agents in the area and the worker begins communication with the individual. Documentation of their SMI can be obtained from self-disclosure and/or hospital discharge papers prior to enrollment. Staff has a high degree of active outreach and in-reach. Staff continues to maintain office hours at Micah's Hospitality Center and conducts outreach and in-reach at area hospitals and behavioral health units, Thurman Brisben Homeless Shelter, Salvation Army, N/A and AA meetings, the library, Hurkamp Park, free community dinners and other sites frequented by homeless people for direct, face-to-face interactions. Staff utilizes targeted strategies aimed at engaging and steering individuals into the needed array of services, including identification of individuals in need, screening, development of rapport, offering support and referrals to appropriate resources. This has resulted in increased access to and utilization of community services by individuals with SMI experiencing homelessness. Brief screenings are completed to determine need for referral to comprehensive clinical assessments. Following the PATH intake, clients can be referred to RACSB for further assessments and treatment.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

PATH and Micah are fully compliant and have transitioned into HMIS Data Integration. All agencies within the CoC of Planning District 16 are utilizing HMIS/Servicepoint. As a participant in HMIS, the RACSB

PATH/SOAR staff can use what has already been entered into the system by each of the providers, rather than start from scratch. RACSB completed its integration of Electronic Health Records 2014. The Commonwealth of Virginia continues to require RACSB to use two systems with duplicating information requiring double entry of data. Entry into Avatar our EHR and CCS information systems is required by the Commonwealth in addition the state requires use of the HMIS system.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

Once an individual is identified as PATH-eligible, an intake appointment with an RACSB therapist is scheduled, if agreeable. Concurrently, the individual's immediate mainstream needs are assessed and the PATH worker initiates referrals for services, such as SNAP and Medicaid benefits, emergency shelter and immediate psychiatric screenings, in cases of crisis. As the individual works with the PATH outreach worker, the individual may be referred to Micah's re-housing staff who initiates efforts to place the person in permanent housing with grant funds, including PATH funds when no other funds are available and the financial need requires just one-time assistance. Sometimes the system works through multiple step downs. For example, a person may start at local in-patient MH services, discharge to RACSB's Crisis Stabilization program and transition to Micah's Residential Recovery Program. Other times an individual may be referred to the Thurman Brisben Center (singles homeless shelter) if the individual is accepting of this option and able to self- resolve. Additionally through the CoC prioritization lists, targeted assistance is provided and as an identified vulnerable population, PATH clients receive a high priority in accessing those resources and receiving housing placement. RACSB's PSH program has come online and PATH clients are being referred and placed.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

RACSB has 40+ years demonstrating cultural competencies sensitive to individuals with serious mental illness who are homeless. Through PATH funding we have expanded services to serious mentally ill persons for more than a decade. Attention is placed on staffing the individual with people familiar with the population and community. Material and products such as audio/visual materials, PSA's are gender/age/culturally appropriate and consistent with the population served. Annual updates in cultural diversity/sensitivity training are provided and required by the agency. PATH funded staff providing services to the target population will be sensitive to age, gender and racial/ethnic difference. Additionally, RACSB offers translation and interpretation through a telephone service. RACSB has a signing-therapist for individuals with hearing difficulties and several bilingual staff members that assist with translation.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

As part of a CARF accredited case management system, all staff are required to have training at least annually in the issues of cultural diversity. Staff are also responsible for demonstrating this competency in service planning and service delivery. In addition, PATH staff will be given the opportunity to attend training provided by or recommended by the state PATH program.

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

- Projected number of adult consumers to be contacted with PATH funds: 270
- Projected number of adult consumers to be enrolled using PATH funds: 130
- Percentage of adult consumers projected to be "Literally Homeless", and activities to maximize the use of PATH funds to serve adults who are literally homeless as a priority population: 85%

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

Through targeted outreach and in-reach during community breakfasts and dinners hosted by the Veterans of Foreign Wars as well as veteran Stand Down Events the PATH Outreach Worker has multiple referral and outreach opportunities. Additionally, the PATH Outreach Worker is in regular contact with the staff and leadership of the Virginia Veterans and Family Support and through the Micah Hospitality Center, where the PATH Outreach Worker meets weekly with the VA representative. RACSB staff have received training in military cultural competence and are prepared to provide any necessary services to any referrals made from the PATH Outreach Worker.

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

Micah employs multiple formerly homeless persons on its staff. These individuals range from the Housing Coordinator, Office Manager, Respite House Staff and Cold Weather Shelter Staff who provide perspective which might be overlooked in the planning, implementation and evaluation process of its programming. Additionally Micah employs through the Rappahannock Area Agency on Aging, PATH-eligible or previously PATH-eligible individuals. Micah sponsors a "Giving back" program, where guests are encouraged to volunteer in exchange for various incentives—bus tickets, meal cards, laundry privileges, etc. Once housed, PATH-eligible individuals also have the opportunity to serve in regular volunteer positions within agency programs.

Micah's Residential Recovery Program is supervised by a Health Services Advisory Committee, which invites a PATH-eligible homeless client to participate in each meeting. Additionally, Micah and PATH staff conduct quarterly meetings with the general homeless population to capture input into services provided and areas of improvement. When necessary, Micah and PATH staff will also serve as intermediary between families who wish to help PATH-eligible consumers—financially or emotionally—but cannot be directly involved in the individual's care.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

Approval of this grant will fund two staff, a PATH outreach worker and contracted SOAR Coordinator, who deliver PATH-eligible services to individuals who are homeless with a serious mental illness. The proposal also includes funds to support the travel and equipment needs of both positions, plus an allotment for basic

need assistance to individuals who are PATH eligible. Proposed budget items and costs were projected based on historical needs and use of funds during prior years.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The projected PATH Budget is developed annually to outline how the grant funds will be used. PATH Outreach Worker meets and communicates regularly with his supervisor, to discuss plans to cover medications, rental assistance and security deposits. A separate budget is also developed for the Micah contract. Proposed expenses are discussed with the PATH Outreach Worker and all invoices are reviewed upon receipt for accuracy.

Region Ten Community Services Board
505 Old Lynchburg Road
Charlottesville, VA 22903
Contact: Deidre Creasy-Quirindoongo

Provider Type: Community mental health center
PDX ID: VA-014
State Provider ID:
Contact Phone #: 434-972-1885

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**31,279.00**	**0.00**	**31,279.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	39,251.00	75.00 %	0.80	31,279.00	0.00	31,279.00	

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0.00**	**$ 6,731.00**	**$ 6,731.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 2,000.00**	**$ 2,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 2,000.00	$ 2,000.00	Use of Agency Vehicle

d. Equipment	**$ 1,000.00**	**$ 0.00**	**$ 1,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 1,000.00	$ 0.00	$ 1,000.00	cell phone

e. Supplies	**$ 3,062.00**	**$ 1,000.00**	**$ 4,062.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 2,000.00	$ 500.00	$ 2,500.00	
Office: Supplies	$ 1,062.00	$ 500.00	$ 1,562.00	

f. Contractual	**$ 25,611.00**	**$ 11,889.00**	**$ 37,500.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments

Other (Describe in Comments)	$ 25,611.00	$ 10,889.00	$ 36,500.00	Contract with On Our Own of Charlottesville, Inc., for a Peer Outreach Worker
Other (Describe in Comments)	$ 0.00	$ 1,000.00	$ 1,000.00	Cell Phone Service Fee

g. Housing	**$ 2,000.00**	**$ 0.00**	**$ 2,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 2,000.00	$ 0.00	$ 2,000.00	Initial Housing Costs

h. Construction (non-allowable)				
i. Other	**$ 1,910.00**	**$ 0.00**	**$ 1,910.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Other (Describe in Comments)	$ 1,910.00	$ 0.00	$ 1,910.00	medication assistance

j. Total Direct Charges (Sum of a-i)	$ 64,862.00	$ 21,620.00	$ 86,482.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 64,862.00	$ 21,620.00	$ 86,482.00	

Source(s) of Match Dollars for State Funds:

State and local general funds.

Estimated Number of Persons to be Contacted: 300

Estimated Number of Persons to be Enrolled: 130

Estimated Number of Persons to be Contacted who are Literally Homeless: 294

Number staff trained in SOAR in grant year ending in 2019: 0

Number of PATH-funded consumers assisted through SOAR: 0

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Region Ten Community Services Board

1. Description of Provider Organization:

A. **Name:** Region Ten Community Services Board

B. **Type of Organization:** Community Mental Health Center

C. **Description:** The Region Ten Community Services Board (CSB) is a public behavioral health care center located in Charlottesville, Virginia with satellite offices in five surrounding counties. Region Ten has a team of nearly 600 employees who provide services to over 9000 clients in the service area. The mission is to assess the need for services, and to create and provide accessible, cost-effective services of the highest quality for persons with behavioral health needs, so that they may achieve more independent, satisfying and productive lives. Region Ten has a long history of providing comprehensive mental health and substance abuse treatment services to homeless and at risk individuals. We work closely with community partners in creating housing opportunities with comprehensive supports and services in the city of Charlottesville.

D. **Region Served:** The City of Charlottesville and the Counties of Albemarle, Louisa, Fluvanna, Greene and Nelson

E. **Amount of PATH Funds:** $64,862

F. **Primary Contact:** Deidre Creasy-Quirindoongo, deidre.creasy-quirindoongo@regionten.org, (434) 972-1885

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

Region Ten has two HUD grants that target housing subsidies and support for homeless individuals. A Shelter Plus Care grant currently provides rental subsidies to a number of previously homeless individuals. In addition, a HUD Supportive Housing grant provides housing and supervision for up to 20 men enrolled in an intensive Dual Recovery Program. PATH completes coordinated entry on individuals using HMIS. Coordinated assessments are conducted with the Haven acting as a central intake. Individuals are encouraged to complete an assessment as soon as possible. The assessments score level of chronic homelessness and vulnerability

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 case manager is an active participant in the coordination of activities and policies across the local community organizations. The case manager attends the Service Provider Council for the Thomas Jefferson Coalition of the Homeless (TJACH). TJACH now has a community case review bi-monthly that the PATH case manager attends on the 1st, 3rd and 5th Wednesday of each month. This community collaboration includes the City of Charlottesville, PACEM seasonal shelter, On Our Own and the Haven as well as other agencies involved with individuals experiencing homelessness. The second PATH case manager is the

current Chair of SPC for the TJACH board. The PATH program manager attends all CIT meetings and meets periodically with other community partners.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

The vast majority of the consumers we serve are literally homeless. These consumers are in PACEM, Salvation Army, the Haven, soup kitchens, churches, libraries and on the streets. PATH case managers connect with individuals to work to obtain housing, mental health and substance abuse services, employment and SSI services. Case managers also provide bus passes, trainings and connections to other community resources as needed.

b. Any gaps that exist in the current service systems:

The biggest gap that exists in the current system is the availability of housing. Even when there is funding available this area struggles to find affordable units.

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

The PATH team offers Case Management that assists PATH participants in navigating the local CSB and private providers to obtain appropriate and affordable mental health and substance use services. PATH staff also provide transportation to and from the Haven, and to various appointments in the area such as: permanent supportive housing, Veteran Administration, DMV and medical appointments.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

PATH staff reach out to individuals experiencing homelessness or to those identified as experiencing homelessness to see if the participant has a history of a serious mental illness and what services the individual is needing. The participant is connected with the local continuum of care and completes an intake into the HMIS system. Individuals are enrolled in PATH no later than the same business week. PATH staff accompany individuals to Same Day Access at Region Ten where they receive a mental health assessment resulting in a determination of serious mental illness. If there is a serious mental illness, then a PATH enrollment is completed.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

PATH staff have met with HIMS officials and were trained by the local COC. Staff attend HMIS user quarterly meetings at the Haven and participate in HMIS webinars.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

Region Ten and other community partners strive to develop a wide range of affordable, supportive housing for persons with disabilities, including the PATH target population. Region Ten serves individuals with serious mental illness and those who are experiencing homelessness with an array of funding sources and housing types. Region Ten is an agent for VHDA's Housing Choice Voucher rental subsidy program and maintains collaborative relationships with more than 30 local landlords. The agency developed a housing developer corporation years ago that today owns and rents affordable apartments to persons served by the agency. The agency has also been successful with HUD Continuum of Care Grants: Shelter Plus Care and Supported Housing Programs for chronically homeless persons. In the past, the agency successfully obtained city funds to pilot a Housing-First project (Step-Up) that served 12 chronically homeless men and women. Virginia Supportive Housing also has an SRO in Charlottesville that has 30 beds available to the homeless population. Region Ten creatively extended Medicaid Mental Health Rehabilitation funding to field in-home support staff for more than 250 adults with serious mental illness. PATH staff also continue to participate in planning for services for eligible homeless individuals who frequent the Haven (multi-resource day shelter), PACEM seasonal shelter, First St. Church Day Haven and the Salvation.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

The PATH program has adopted a number of practices that assure services are provided in a manner that is sensitive to age, gender, disability, LGTBQIA, race and ethnic differences of the homeless individuals they serve. PATH annually evaluates its target demographics to review needed changes or goals in a variety of areas to remain responsive to the consumers. Region Ten maintains a roster of staff with multi-linguistic abilities and assures PATH staff have access to these staff and other resources for facilitating communications with PATH consumers.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

PATH staff is comprised of staff with significant mental health and engagement experience with chronically homeless individuals. PATH staff conduct informal meetings with PATH service recipients during the year to ascertain feedback about their efforts and work.

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

A. Demographics: Of the 191 PATH-enrolled consumers this past year, 42% were female, 58% were male. 37% were African American, 51% were Caucasian, 8% were of mixed races, 4% were unknown and 5% were of Hispanic Origin. 7% had a military history
B. The projected number of adult clients to be contacted: 300
C. The projected number of adults to be enrolled: 150
D. The percentage of adult clients to be served using PATH funds who are literally homeless: 98

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

PATH staff collaborate with the Haven's Wounded Warrior Program to ensure that Veteran's experiencing homelessness are served.

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

PATH activities are reviewed in weekly collaborative meetings with members of On Our Own who identify as peers or in many cases have experienced homelessness themselves. These participants plan individual and general program supports and services for PATH service recipients.
The agency has an active Peer Advocacy Committee (PAC) directly accessible to consumers. The PAC identifies opportunities for the agency and its programs, including the PATH service to be more responsive to client needs, concerns and preferences.

The agency has a comprehensive protocol for initial and ongoing notification of consumer rights and protection of consumer information.

The agency's Board of Directors has mandated positions for at least one consumer and multiple family members. Members of the agency's Board of Directors meet regularly with homeless participants in several of the agency's service programs to this population.

The agency has a demonstrated commitment to the recruitment and hiring of consumer staff. PATH-eligible consumers are assisted to apply and sustain jobs with the agency. The housekeeping and moving service is a frequent job source for some PATH consumers. The agency's Dual- Recovery Center Supportive Housing Program actively recruits homeless or formerly homeless individuals to work as staff. This Program's manager, assuring even greater tie-in by PATH service recipients to program jobs, directly supervises the PATH service.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

A. Staffing:
   1. Position – Path Case Manager/ Path Outreach Worker
      - Provide PATH Case Management to individuals who are experiencing homelessness.
      - Provide triage assessment and linkage with services to individuals experiencing homelessness.
      - Maintains PATH data reports as required by the PATH grant reporting to maintain the grant.
      - Provide support services to individuals with co-occurring or mental health disorders.
      - Attend TJACH meetings and other pertinent Community Coalition and team meeting as relevant to the PATH Program.
      - Provide support and education to family members.
      - Work collaboratively with case managers, treatment providers and other care providers in linking individuals directly to services and supports specified in the individual's treatment plan.

- Maintain contact with representatives of the various treatment programs involved in the care and rehabilitation; Arrange aftercare and follow up services for recovering individuals leaving the IOP or other treatment programs.
- Provide transportation to and from residential programs or to treatment from outlying counties.
- Maintain necessary casework records to document the provision of outreach services in Credible and HMIS.
- Attend required meetings and trainings as assigned.

2. Salary/Rate –Path Case Manager $31,279/ Contracted Path Outreach Worker 25,611
3. Percent of Time – Path Case Manager 75%/ Path Outreach Worker 80 %

B. Fringe Benefits: $6,000
C. Travel: Agency Vehicle $2,000
D. Supplies: $1062; Office and outreach supplies to include printing materials, postage and bus passes are needed for general operation of the project.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

Programmatic and fiscal oversight to ensure PATH funds are used on eligible expenses are closely monitored by the PATH Program Manager and Region Ten's Finance Department.

Richmond Behavioral Health Authority
107 S. 5th Street
Richmond, VA 23219
Contact: Theodora Appiah-Acheampong

Provider Type: Community mental health center
PDX ID: VA-015
State Provider ID:
Contact Phone #: 804-819-4017

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**114,520.00**	**16,547.00**	**131,067.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	50,166.00	100.00 %	1.00	50,166.00	0.00	50,166.00	
Case Manager	45,707.00	100.00 %	1.00	45,707.00	0.00	45,707.00	
Case Manager	37,294.00	50.00 %	0.50	18,647.00	0.00	18,647.00	
PATH Administrator	82,735.00	20.00 %	0.00	0.00	16,547.00	16,547.00	Program Manager

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**33.20 %**	**$ 43,518.00**	**$ 0.00**	**$ 43,518.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 800.00**	**$ 27,000.00**	**$ 27,800.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Conference Registration Fee	$ 500.00	$ 7,000.00	$ 7,500.00	RAHTF
Mileage Reimbursement	$ 300.00	$ 0.00	$ 300.00	staff mileage reimbursement of travel
Other (Describe in Comments)	$ 0.00	$ 20,000.00	$ 20,000.00	Use of agency vehicles

d. Equipment	**$ 0.00**	**$ 3,300.00**	**$ 3,300.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Computer Lease/Purchase	$ 0.00	$ 3,000.00	$ 3,000.00	
Other (Describe in Comments)	$ 0.00	$ 300.00	$ 300.00	cell phone purchase

e. Supplies	**$ 0.00**	**$ 8,000.00**	**$ 8,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 0.00	$ 6,000.00	$ 6,000.00	
Office: Supplies	$ 0.00	$ 2,000.00	$ 2,000.00	

f. Contractual	**$ 30,000.00**	**$ 2,620.00**	**$ 32,620.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 30,000.00	$ 0.00	$ 30,000.00	Virginia Housing Alliance Training for all VA PATH Providers
Other (Describe in Comments)	$ 0.00	$ 2,520.00	$ 2,520.00	Cell Phone Service Fee
Other (Describe in Comments)	$ 0.00	$ 100.00	$ 100.00	annual contract with furniture bank

g. Housing	**$ 12,772.00**	**$ 40,000.00**	**$ 52,772.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 10,272.00	$ 40,000.00	$ 50,272.00	rental assistance
Other (Describe in Comments)	$ 2,500.00	$ 0.00	$ 2,500.00	furniture bank fees

h. Construction (non-allowable)

i. Other	**$ 1,100.00**	**$ 24,500.00**	**$ 25,600.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 500.00	$ 0.00	$ 500.00	
Client: Other (Describe in Comments)	$ 500.00	$ 1,000.00	$ 1,500.00	identification fees
Client: Other (Describe in Comments)	$ 0.00	$ 22,000.00	$ 22,000.00	Emergency hotel
Office: Other (Describe in Comments)	$ 100.00	$ 1,000.00	$ 1,100.00	medication assistance
Staffing: Training/Education/Conference	$ 0.00	$ 500.00	$ 500.00	

j. Total Direct Charges (Sum of a-i)	$ 202,710.00	$ 121,967.00	$ 324,677.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 202,710.00	$ 121,967.00	$ 324,677.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 550

Estimated Number of Persons to be Enrolled: 150

Estimated Number of Persons to be Contacted who are Literally Homeless: 275

Number staff trained in SOAR in grant year ending in 2019: 2

Number of PATH-funded consumers assisted through SOAR: 15

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Richmond Behavioral Health Authority

1. Description of Provider Organization:

A. **Name:** Richmond Behavioral Health Authority (RBHA)

B. **Type of Organization:** Community Mental Health Center

C. **Description:** The Mission of the Richmond Behavioral Health Authority (RBHA) is to "enhance the quality of life for the people of Richmond by promoting and providing quality behavioral health and developmental services that are available, accessible, and cost-effective." RBHA is licensed by the Virginia Department of Behavioral Health and Developmental Services and is the statutorily established public entity responsible for providing mental health, intellectual disabilities, substance abuse, and prevention services to the citizens of the City of Richmond.

RBHA was established in July 1996 by resolutions of the City Council of the City of Richmond. Prior to that time, RBHA's services were included as part of City government.

RBHA is governed by a Board of Directors through the Chief Executive Officer. Board members are ordinarily appointed by City Council for three-year terms which can be renewed up to two times. Funding is received through fees from consumers, the Commonwealth of Virginia, local and state grants and the City of Richmond. RBHA provides crisis intervention, mental health, and intellectual disability and substance abuse services to residents of Richmond.

The Richmond Behavioral Health Authority is a RBHA has been providing outreach, case management, and crisis intervention services to individuals experiencing homeless and at-risk individuals even prior to its establishment as an Authority in 1996. For over two decades, services have been provided to this population via multiple channels, including: PATH, Community Development Block Grant (CDBG) funding, and funding from the United States Department of Housing and Urban Development. Individuals receiving all levels of mental health services, but especially those receiving intensive case management and PACT-level services, are also at-risk and frequently experience homelessness.

D. **Region Served:** The City of Richmond

E. **Amount of PATH Funds:** $202,710

F. **Primary Contact:** Katie Chlan, LCSW katie.chlan@rbha.org, (804) 819-4255

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

During the past eighteen months, the Greater Richmond Continuum of Care has seen notable changes in both the shelter referral process, as well as the prioritization process for rapid rehousing and permanent supportive housing. RBHA PATH workers, as well as the Program Manager, have been intimately involved in this redesign process and continue to participate in all the CoC on all levels.
While this new process of client prioritization for services is still evolving, RBHA PATH workers attend the regularly scheduled meetings and case conferencing where individuals are matched to housing resources.

While coordinated outreach has struggled in the CoC in recent years, there has been a renewed interest in this strategy, and RBHA's PATH workers are actively participating in this process.

The Program Manager is an active member of the CoC's System Policy and Process (SPP) committee, the CoC HMIS committee, the CoC Quality Improvement Leadership Committee, as well as the Veteran's workgroup. The SPP committee is charged by the CoC Board of Directors with redesigning the new prioritization for services process. The Program Manager also regularly attends the General Continuum of Care meetings.

RBHA's Director of Mental Health is a member of the CoC's Board of Directors. This governing body provides oversite and leadership to the Continuum as a whole.

Finally, Homeless Services staff consistently provides support with the biannual point-in-time count and the annual Project Homeless Connect event, taking the lead in coordinating the mental health/substance abuse triage area.

The recent public health crisis of Corona -19 has provided additional opportunity for collaboration with other providers within the CoC. PATH outreach workers, as well as the Program Manager attend daily check-ins with the CoC. The coordinated outreach team, including PATH outreach, is working on a daily basis to connect individuals to existing resources, as well as newly designed, heath crisis-focused resources. RBHA PATH has also been, and will continue to be involved in planning these new responses, as well as implementing them once appropriate.

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.

RBHA's three PATH workers diligently address clients' immediate and long-term needs in the most comprehensive manner possible, given available resources. The PATH team maintains a solid presence in the community, strengthening and expanding the scope of services and supports available to the vulnerable population they serve. They work to address the clients' comprehensive needs to include mental health and/or substance abuse services, shelter/housing, medical, clothing and food, job development/training services, and assistance with obtaining benefits. Some of the most effective collaborative relationships include: the Daily Planet, Commonwealth Catholic Charities Outreach Services, the Richmond Police Department, and the Richmond Department of Social Services.

RBHA's PATH workers refer individuals that require mental health and or substance abuse services to RBHA's rapid access program where individuals are assessed and appropriately assigned to needed services. The rapid access program takes walk-in appointments daily. Individuals not meeting RBHA's criteria are referred to the Daily Planet for services. The Richmond Integrated Community Health (RICH) Clinic housed at RBHA provides primary medical care to individuals enrolled in the PATH program regardless of their benefit status. This grant funded program enables individuals to receive both behavioral care and medical care at RBHA. This one-stop shop has proven to be very valuable in the provision of services. PATH workers report that individuals are more willing to receive primary medical services provided in the on-site clinic.

The following table lists community organizations that the PATH staff utilize on a regular basis. Please note that the list is not exhaustive. Also, please note that these referrals and processes look very different right now, due to the public health crisis.

Agency Name	Service(s) Provided	Referral Process
Richmond Behavioral Health Authority	mental health, substance abuse, crisis services, crisis stabilization, CIT, medical clinic, PSH	triage appointment followed by regular intake/assessment process
Richmond City Justice Center	temporary detainment	worker accepts referrals, identifies service needs, coordinates care
RBHA North Campus	inpatient substance abuse treatment, outpatient	worker completes referral
Assisted Living Facilities	24/7 board and care	Worker completes UAI
Daily Planet	medical, dental and mental health care, case management	referral from worker for clinic; for all services, must complete agency intake; employment services
CARITAS Furniture Bank	furniture/household goods	worker assists with referral process, "shopping" for furniture, and loading/moving
Community Emergency Shelters	Shelter (temporary, emergency).	Referral to Housing Crisis Line and assistance with linkage
Virginia Supportive Housing	SRO housing, HIV/AIDS house, SSVF	Worker assists with referral, completing applications, supports in program interviews for veterans
Department of Social Services	SNAP benefits, Medicaid, General Relief, outreach partner	worker assists with applications; links with DSS workers
Richmond Police Department HOPE Unit	law enforcement, specialized outreach, linkage with community providers	workers respond to requests for help with potential PATH clients; collaborative outreach
OAR of Richmond	services for ex-offenders	staff assists with referral and linkage
2nd Presbyterian, St. Peter's, United Centenary, AME Bethel	daily meals programs	worker outreaches at various locations
Virginia Employment Commission Region IV	Employment supports for all Virginians. For veterans, the Disabled Veteran Outreach Program (DVOP) representatives also provide intensive case management for	PATH- will provide linkages to DVOPs for homeless veterans when appropriate.

	veteran's homeless or disabled veterans	
St. Paul's Church	meal program, financial assistance for security deposits, utilities, etc.	worker outreaches at lunch site; assists with direct referral for financial support
Social Security Administration	SSI/DI, social security cards	staff assists with accessing services, applying for benefits
Hilltop Promises	Clothing, mailing address, computer access, staff support	worker completes referral
Virginia Veteran and Family Support	veteran's services (for VA and non-VA eligible) –mental health and substance abuse treatment linkage, support groups, and veteran specific homeless and housing services linkages	worker collaborates with onsite staff (including housing resource specialist) and makes appropriate referrals
Veterans Administration	medical and behavioral health services	Worker assists with linkage, collaborates with treatment team. In addition, the Path-Vet will work specifically with the Healthcare for Homeless Veterans and HUD VASH programs
Va. Dept of Veterans Services	VA benefits assistance, and employment and transition assistance for Virginia Veterans.	PATH-Vet will provide linkage to VVFS (a program of DVS) and additional DVS support services as needed.
Hospitals (MCV, Tucker's, St. Mary's, RCH, CSH)	medical and psychiatric care (acute care and long-term)	worker accepts referrals from hospitals; links clients to hospital, facilitates admission and discharge
Health Brigade	Specialized medical care and limited case management services.	Worker accepts referrals
Senior Connections	Provides community resources for seniors	Worker accepts and provides services for referrals

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness

who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

The Richmond Behavioral Health Authority (RBHA) is a public agency providing mental health, intellectual disability, substance abuse, prevention, and children's services. The RBHA provides the following non-exhaustive list of services either directly or through contracts with community providers: crisis intervention, crisis stabilization, psychiatric evaluations, nursing and pharmacy services, case management, in-home support services, psychiatric rehabilitation programs, youth day treatment programs, various short- and long-term residential programs, primary care, homeless services including permanent supportive housing, and PACT. Services are provided to persons meeting the various admission criteria, but predominantly to those identified as Seriously Emotionally Disturbed, Seriously Mentally Ill, diagnosed with an Intellectual Disability, and/or a Substance Use or Dependence disorder.

Below is a list of services, as well as a brief description of these services, that are being provided by RBHA PATH:

Outreach - Outreach remains a core service of RBHA's PATH program. On a weekly basis, PATH staff outreach at any of the following locations: RBHA crisis and crisis stabilization units, Daily Planet, Commonwealth Catholic Charities, emergency shelters, overflow shelter (seasonal), the Department of Social Services, churches and other meal sites, Medical Respite, and various parks and other sites frequented by individuals experiencing homelessness.

Periodically, city officials and concerned members of the community will reach out to RBHA for immediate assistance outreaching a homeless individual who is displaying concerning behaviors. PATH responds immediately in these cases to identify, assess, and offer services to the identified individual.

Finally, PATH has been at the table organizing meetings among community outreach workers, so that regular information sharing and communication takes place to best serve homeless individuals on the streets. Participation with the Community Outreach Committee has facilitated numerous placements for individuals who are chronically homeless.

Screening - The PATH workers conduct a basic mental status exam for all outreached individuals to assess for immediate needs. If persons are presenting in an agitated, suicidal, homicidal, or otherwise decompensated state, then the PATH worker, will work with RHBA Crisis services to ensure that a certified pre-screener may initiate a Temporary Detention Order.

When individuals express a willingness to be assisted through the program, PATH staff will conduct a face-to-face interview utilizing a simple diagnostic tool, the "Street Sheet", to document a client's basic demographics and requested services. The Street Sheet asks about basic PATH program eligibility; current housing situation and homeless history; behavioral and medical health treatment and information; benefits and other sources of income and support; and other pertinent information shared during the interview. The Street Sheet becomes a part of the PATH record. The Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT 2.0) is an additional tool being used by PATH staff to prescreen single adults. PATH staff together with other community partners (VSH, VA, VVFS, Daily Planet) who are part of the Community Outreach Team utilize this tool in prioritizing who gets housed first depending on the scores retrieved from the VI-SPDAT 2.0 at their regularly scheduled meetings.

PATH staff also regularly completes triage and intake/assessment forms for mental health and substance abuse services at RBHA and the Daily Planet, for Crisis Stabilization Unit services, and Assisted Living

Facility placements. In addition, the PATH-Vet CM assists with any eligibility and treatment information needed for the VA veteran crisis line, and the McGuire VA Medical center services.

Clinical Assessment - RBHA PATH workers utilizes Rapid Access for individuals seeking assessment and mental health and/or substance use disorder services. Rapid Access clinicians complete a diagnostic assessment and educate individuals on services that may be offered. Individuals that go through the Rapid Access process are given an option to see a psychiatrist on the same day for medication management. A case manager is also assigned to the individual on the same day.

Habilitation and Rehabilitation - The PATH workers provide supportive counseling and assist individuals with problem-solving with the goal of helping program participants reach their maximum level of independence in a community-based setting. Because PATH staff works under the same service umbrella as the Mental Health Support Services team, there has been an opportunity to support referrals and linkage to this service once clients have been formally opened to agency services.

Community Mental Health Services - Individuals presenting in a psychiatrically distressed state are immediately referred to Crisis Services, including Crisis Stabilization, at the RBHA and assisted through the prescreening process by the crisis unit. The PATH worker collaborates with the Crisis/Intake team and the Case Management units to provide background and supporting documentation that may help determine the best course of treatment for the individual. Other community mental health resources accessed by the PATH workers include the Daily Planet Clinic, the Virginia Commonwealth University Medical Center, and private MHSS providers.

Substance Use Treatment Services - Individuals presenting with substance use disorders are encouraged to participate in treatment. The PATH workers assist clients with referrals to RBHA, The Healing Place, RBHA North Campus (the former Rubicon) the Salvation Army, the Daily Planet's co-occurring disorders group, and community AA/NA meetings, as appropriate.

Training of Community Provider Staff on PATH and its Consumers - PATH staff continue to be available on a formal and informal basis to provide training to RBHA case managers and area providers with learning about and accessing resources for their clients. More formal settings include sharing among community providers and with various RBHA teams. Most information-sharing occurs informally through collaboration with hospitals, social services, veteran's services, jails, shelters, landlords, service agencies for offenders and the like.

The PATH Outreach Worker has been a member of the community's Crisis Intervention Team, a model program that trains police officers how to recognize, support, and respond appropriately to persons who may be having a behavioral health crisis. PATH staff, together with housing specialists have provided agency wide trainings on PSH. They have also provided trainings on the application process and how to document one's homelessness to community partners including Central State Hospital.

Case Management - PATH staff is actively engaged in providing traditional and non-traditional case management services to enrolled individuals. Staff assesses individual's needs, refers to a variety of services including social services, employment services, medical and behavioral health care, and actively links to emergency shelter placements, permanent housing, doctor appointments, intake appointments and more as they seek to provide opportunities for individuals to make a more stable life for themselves. Individuals receiving SOAR services are also supported at appointments with attorneys, during consultative exams, and at SSA hearings.

Staff goes above and beyond their case management duties by helping individuals develop resumes, finding employment resources, working with shelter providers to extend shelter days, escorting individuals to the emergency room for treatment, and collaborating with the local jail. They are regularly seen dressing for the day to move a truckload of furniture into an individual's new home. The PATH workers provide brief follow-along services to those placed in permanent housing and assist them with maintaining contact with mainstream services. The workers document progress via informal service plans and case notes for each enrolled PATH client in HMIS.

Residential Supportive Services - PATH workers provide support in a number of ways. They may problem-solve with a client and housing provider to prevent a pending eviction, mediate a roommate conflict, collaborate with medical and behavioral health staff while an individual is housed in short- and long-term shelter, medical respite, inpatient substance use treatment, crisis stabilization and similar. Staff also take an active role in supporting individuals through the process of enrolling in various housing programs, including Section 8 housing, SRO housing, and PSH. Support may include helping with service referrals, with completing forms and applications, and meeting with staff at other provider agencies.

Housing Moving Assistance - PATH staff evaluates an individual's financial resources, his/her housing wants and needs, and available housing-related resources in the community as a part of the services offered through the existing PATH program. The PATH program's partnership with the CARITAS furniture bank has been a successful one, again with a high demand. Since accessing affordable household furnishings is identified as a service gap, the PATH program again proposes to utilize a portion of its funding to assist a limited number of clients with purchasing furniture vouchers.

Housing Eligibility Determination - Homeless service providers within the Greater Richmond Continuum of Care utilize a coordinated process for assigning all mainstream housing resources including emergency shelter, RRH, and PSH. While these process and priorities are still being tweaked, RHBA PATH workers are active in this process and advocate for the individuals they are serving to receive these housing resources. PATH staff utilize the VI-SPDAT 2.0 to determine housing eligibility for other housing options. PATH staff utilize this tool, in addition to the individual's finances, to determine if an individual may self-resolve or be eligible for main stream housing placement.

Security Deposits - PATH staff assists individuals with accessing funds for security deposits and other initial housing expenses via community partners, as resources are available. This is an invaluable resource that is always in short supply and high demand and, as such, the RBHA PATH program will again propose to devote a portion of program funding to support PATH clients with security deposits and housing start-up.

One-time Rental Payments to Prevent Eviction - The PATH team has occasionally provided financial assistance to individuals to prevent eviction. Individuals must have a plan on how to sustain after receiving assistance.

b. Any gaps that exist in the current service systems:

While historically, there have been very few gaps identified, it is believed that the current public health crisis will expose gaps in both PATH eligible services, as well as the homeless services system as a whole.

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

Individuals enrolled in RBHA for services have access to and are encouraged to participate in Dual Recovery Program groups. The Daily Planet also offers its own co-occurring disorders group, led weekly by a staff

clinician. The VVFS Region IV team also offers a veteran peer support group for veterans in mental health recovery that will be open to veterans identified by the PATH program. Veterans who are homeless with SMI have access to clinical assessment through the VA or community treatment options.

PATH clients may also access or come in contact with the jail team liaison, crisis stabilization, and/or the medical clinic for persons who are uninsured or underinsured.

PATH staff assists clients with the referral, triage, and intake process for these programs. With the close partnership between the Daily Planet, PATH staff is able to complete the intake paperwork and make direct referrals to the various programs, helping individuals by-pass some of the initial intake processes.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

When a PATH worker is conducting outreach with a new individual, clinical impressions of SMI are initially used to determine eligibility. Once the PATH worker is able, they will check RBHA's electronic records system to see if the individual has been a past recipient of services at RBHA, and if the individual has a recent documented diagnosis on file. If this is the case, then this diagnosis is utilized for enrollment purposes. If the PATH worker is not able to locate historical documentation of diagnosis, the worker will attempt, when appropriate, to connect the individual with RBHA's Rapid Access so he/she can be assessed by a licensed clinician and have disability documented at this time. In addition, the PATH worker may get a signed Release of Information to contact other community mental health providers (the Daily Planet, other CSBs, private skill builders, for example) to obtain documentation of diagnosis. If these options are not effective and the individual continues to require ongoing PATH services, the Program Manager, a professional who holds a license form the Department of Health Professions, may meet with the individual to document disability.
Each and every attempt at obtaining documentation will be documented in the individual's file, and every effort will be made to obtain appropriate documentation of SMI as quickly as possible.

PATH workers have the ability to document homeless status on their own, and do so as appropriate during the initial engagement period.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

RBHA's PATH program began entering client level data into HMIS is October of 2011, and SOAR data into HMIS in May of 2012. The First Annual Performance Report (APR) was generated and submitted from HMIS in the fall of 2017.

New PATH hires are immediately connected with Homeward, the CoC's HMIS administrator, for training. Homeward has remained current on PATH regulations as they relate to PATH, as they do differ slightly. The PATH Program Manager is a part of the CoC HMIS and SPP committees to ensure that PATH HMIS regulations are acknowledged. Ongoing technical assistance is needed to ensure success with data entry, including training from Homeward to ensure proper use of HMIS; training on report writing; assistance modifying PATH pages to ensure data captured meets all stakeholder requirements and support from DBHDS with regard to assistance working with Homeward on writing PATH-specific reports.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

RBHA's PATH Program is able to provide a wide array of housing and services targeted to PATH-eligible consumers including:

- Maintain a service-rich program by continuing to staff the program with 2.5 FTE PATH Case Managers, who are all registered Qualified Mental Health Professionals or Certified Peer Recovery Specialists.
- Advocate for PATH consumers and connect them to the newly designed regional shelter system
- Focus service delivery on comprehensive community outreach in those places where individuals experiencing homelessness are known to live or congregate
- Provide intensive case management for PATH-enrolled consumers
- collaborate and follow-through with a wide variety of providers, stakeholders, businesses; providing SOAR services
- Utilize limited funding to purchase goods and services that incentivize PATH-eligible individuals to engage in services
- assist in accessing birth certificates, photo identification cards, prescription medications
- Support best practices around rapid re-housing by providing limited funding for security deposits, first month rent payments, and furniture vouchers
- Serve in both supportive and leadership roles in the community around finding solutions to end homelessness.
- Complete Home Connect (RBHA PSH) applications for individuals who may be appropriate for this resource
- Assist RBHA Case Managers with completing Home Connect applications for appropriate individuals

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

All RBHA staff participates in a half-day diversity awareness seminar led by trained Human Resources staff. PATH staff provides person-centered services and do so in a consistently professional, respectful, and empathetic manner for some of the most difficult-to-serve persons. The three PATH workers are "people"-persons and regularly go above and beyond for all of their clients, regardless of age, gender, race/ethnicity, or level of disability. The staff understands that it takes building a foundation of trust to develop a working relationship with most persons experiencing homeless and recognize the need to be sensitive to privacy issues, hygiene concerns, personal belongings, and readiness to accept treatment for presenting problems.

In addition, in the past year, RBHA's PATH team added a Certified Peer Recovery Specialist. This individual has lived experience in both substance abuse as well as homelessness. In addition, he has received specialized training in how to use that personal experience in working with others. He is also WRAP and WHAM trained, allowing him to facilitate groups that are sensitive to the needs of those we serve.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

PATH staff are strongly encouraged to attend at least one cultural competence training yearly, as provided by RBHA through external trainers, its online continuing education courses, and/or as offered in the community. A sampling of trainings that staff participated in includes: Various PSH trainings through VHDA, Statewide SOAR training and the local Homeward best practices conference annually. Additionally, all of RBHA staff participated in a multi-day Person Centered Services Training.

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

A. Demographics: The January 2019 point in time count of people experiencing homelessness reported by Homeward for Metro Richmond include: 497 total homeless individuals were counted. This includes 68 children. 152 of these individuals reported being unsheltered on the night of the count. 68.4% of adults are males, and 31% are females. A majority of persons report that they are African-American (61.4%), followed by White (28.4%). 11.7% indicated that they are Hispanic. The majority (64.9%) served some time in jail and/or prison. 28.4% report having a problem with alcohol sometime in their lifetime. 50.2% report receiving some type of treatment for a mental health problem at some point in their lifetime. 27.5% were employed.
B. The projected number of adult clients to be contacted: 550
C. The projected number of adults to be enrolled: 150
D. The percentage of adult clients to be served using PATH funds who are literally homeless: At least 50%

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

In past years, RBHA PATH had a PATH specific position to connect veterans experiencing homelessness to veteran appropriate resources. After that funding was eliminated, those tasks became a part of all PATH outreach staff. PATH staff work closely with CoC partners including the local Veterans Administration Medical Center Homeless Services Team, Virginia Department of Veterans Services, Virginia Veteran and Family Support, Virginia Supportive Housing, Homeless Point of Entry, Daily Planet, Department of Social Services, Richmond Behavioral Health Mental Health Services Division, and Homeward. Coordination of veteran services occurs on a case-by-case basis. In addition, all RBHA staff, including PATH outreach workers, will have completed Veteran/Military specific competency training by 6/30/2020.

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

There are a number of meaningful ways in which consumers and family members are involved at the RBHA. RBHA employs 15-20 self-identified consumers in support service and professional capacities. The SOAR worker consistently involves family members in a consumer's disability case, with the permission of the individual, in order to improve outcomes. When possible, PATH staff involves family members in the treatment planning process for PATH enrollees.

The RBHA has consumer and family representation on its Board of Directors. The Adult Mental Health Division continues its efforts to transform the service delivery system into a more consumer-driven one, and has planned for staff and consumer training opportunities and employment opportunities for consumers.

There is a current Certified Peer Recovery Specialist working on the PATH team. He adds her perspective as a former consumer of services on a regular basis.

Recovery is also supported through regularly scheduled Wellness Recovery Action Plan (WRAP) groups via the psychiatric rehabilitation programs and the crisis stabilization program. Finally, there are regular opportunities for consumers to provide feedback about existing and proposed programs and services at RBHA through a variety of surveys administered throughout the year and through suggestions boxes located in several areas of the agency.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

The submitted Budget Form details the planned program expenditures and the changes in how the funds will be distributed for the coming year. All match funds, totaling $121,967, will be made available on July 1, 2020.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The PATH program operates as part of the agency's Homeless Services programs and as one of many programs under the Adult Mental Health Division at RBHA. All programs and staff function under written policies, procedures, and licensing guidelines of the RBHA. The RBHA's Administration Division is responsible for the financial, auditing, and information systems, processes, and procedures.

When PATH staff request funds, the Program Manger signs off on each request, ensuring that the request meets PATH guidelines. The Program Manager also received a monthly report from finance to review and verify compliance with grant requirements.

Valley Community Services Board
85 Sangers Lane
Staunton, VA 24401
Contact: Lydia Campbell

Provider Type: Community mental health center
PDX ID: VA-020
State Provider ID:
Contact Phone #: 540-887-3200

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**41,147.00**	**20,941.00**	**62,088.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Outreach worker	43,260.00	100.00 %	0.95	41,147.00	12,781.00	53,928.00	
PATH Administrator	14,920.00	10.00 %	0.00	0.00	8,160.00	8,160.00	

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0.00**	**$ 0.00**	**$ 0.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 7,520.00**	**$ 7,520.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Car Rental	$ 0.00	$ 7,520.00	$ 7,520.00	Vehicle lease

d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

e. Supplies	**$ 0.00**	**$ 12,500.00**	**$ 12,500.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 0.00	$ 10,000.00	$ 10,000.00	
Office: Supplies	$ 0.00	$ 2,500.00	$ 2,500.00	

f. Contractual	**$ 0.00**	**$ 1,200.00**	**$ 1,200.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments

Other (Describe in Comments)	$ 0.00	$ 1,200.00	$ 1,200.00	cell phone service fee

g. Housing	**$ 0.00**	**$ 2,000.00**	**$ 2,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 2,000.00	$ 2,000.00	Rental Assistance

h. Construction (non-allowable)

i. Other	**$ 0.00**	**$ 1,150.00**	**$ 1,150.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 0.00	$ 300.00	$ 300.00	
Client: Other (Describe in Comments)	$ 0.00	$ 400.00	$ 400.00	Medication Assistance
Client: Other (Describe in Comments)	$ 0.00	$ 200.00	$ 200.00	Identification Purchase
Staffing: Training/Education/Conference	$ 0.00	$ 250.00	$ 250.00	

j. Total Direct Charges (Sum of a-i)	$ 41,147.00	$ 45,311.00	$ 86,458.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 41,147.00	$ 45,311.00	$ 86,458.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 125

Estimated Number of Persons to be Enrolled: 75

Estimated Number of Persons to be Contacted who are Literally Homeless: 125

Number staff trained in SOAR in grant year ending in 2019: 1

Number of PATH-funded consumers assisted through SOAR: 0

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
Valley Community Services Board

1. Description of Provider Organization:

A. **Name:** Valley Community Services Board

B. **Type of Organization:** Community Mental Health Center

C. **Description:** Valley Community Services Board (VCSB) provides comprehensive mental health, intellectual disability, developmental disability, and substance use services through a wide array of treatment, residential, and rehabilitation services. VCSB provides 24-hour emergency services, intake assessments, case management, residential, outpatient counseling, and substance use treatment, program of assertive community treatment, children's therapeutic day treatment, juvenile detention program, jail services including re-entry services, ICF/ID and ID group homes, and infant/toddler services. VCSB provides psychiatric and nursing services to children and adult populations and is the coordinator for the local Crisis Intervention Team Program for law enforcement officers.

D. **Region Served:** The Cities of Staunton and Waynesboro and the Counties of Augusta and Highland

E. **Amount of PATH Funds:** $41,147

F. **Primary Contact:** Lydia Campbell, Adult MHCM Supervisor, lcampbell@vcsb.org, 540-887-3200 ext. 7602

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do. Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

VCSB is part of the Valley Homeless Connection, a local planning group (LPG) that is part of the Balance of State Continuum of Care. VCSB serves as the lead agency for this LPG and has participated in this group since its formation in 1999. VCSB currently manages the community's coordinated entry system by way of a homeless services phone line, as well as manages the community's emergency shelter bed waiting list, and administers the community's homelessness prevention, rapid rehousing, and permanent supportive housing programs. VCSB was selected as new grantee during HUD's FY19 CoC application and was awarded funds for Rapid Rehousing (RRH) and Permanent Supportive Housing (PSH).

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.

VCSB is partnered with Augusta Health, who provides Healthcare for the Homeless community clinics; Valley Mission and Waynesboro Area Refuge Ministry (WARM), who provide emergency shelter for those experiencing homelessness; Veteran's Affairs (VA) and Supportive Services for Veteran Families (SSVF), who provide veterans with an array of services including rental assistance, medical services, and employment services; and Waynesboro Public Library, who provides a day time location for those experiencing homelessness to meet with service providers, and search for employment and housing. PATH outreach worker ensures access to employment services through DARS and VEC. PATH outreach worker links clients

to mental health and substance use treatment at VCSB or private providers as the client prefers, with transportation provided as needed to remove potential barriers to treatment. VCSB's PATH outreach worker is the community's sole primary outreach worker at this time and can often be found following up on community reports of unsheltered individuals. Our PATH outreach worker partners with WARM's part-time outreach worker in the summer months to cover more geographical area.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

The PATH outreach worker is a vital part of our LPG's case conferencing activities and is often the first point of contact for individuals experiencing homelessness. We have found that the need for services for those experiencing literal homelessness and SMI or SUD is so great that our PATH program has not served individuals who are at risk of homelessness in the last two years. Our PATH program is strongly partnered with VA and SSVF services to address the housing needs of veterans and provides linkages to MH/SU treatment while supporting clients through their access of those treatments. PATH outreach worker completes a universal intake form for immediate referral to PSH and RRH, addition to the community by name list, and entry into HMIS thus beginning case conferencing. The by name list and case conferencing system ensure that our community's limited resources are targeted to the most vulnerable individuals experiencing homelessness as the by name list is prioritized by veterans and chronicity. When a PATH eligible client is linked to treatment at VCSB, they are also eligible for MHCM services. Clients are open to both services for at least 90 days for the PATH outreach worker to support the client through the transfer of services.

b. Any gaps that exist in the current service systems:

Gaps in the current system include available on-going rental assistance for eligible participants. PHAs rarely have their waiting lists open and even if they do, the wait is several months long. Even if a client is able to obtain employment, they may not be able to maintain it because the public transportation system in our community, though significantly improved, remains inadequate to utilize for employment purposes.

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

The PATH outreach worker does not directly provide mental health or substance use treatment however links clients to these services through Open Access at VCSB. Services that are available include but are not limited to: case management – mental health or substance use, medication management, outpatient therapy, office based opioid treatment, assertive community treatment, permanent supportive housing, rapid rehousing, crisis support services, and emergency services.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

While establishing rapport with unsheltered and sheltered individuals experiencing homelessness, the PATH outreach worker is developing a diagnostic impression of the presence of serious mental illness or co-occurring disorder. Once rapport is established, the PATH outreach worker inquires about having a diagnosed

SMI or history of mental health treatment and offers linkages to such treatment. If the client reports a diagnosed SMI or states willingness to participate in PATH service, the client is then enrolled in PATH. Clients are quickly connected to evaluations by LMHP-types through Open Access at VCSB. One PATH specific slot is reserved each week for these intake evaluations. Verification of SMI is documented in the client's EHR at VCSB. If the client reports diagnosed SMI but is not currently receiving treatment, the previous process applies. If the client reports currently receiving treatment, PATH outreach worker coordinates continued treatment with the provider and client and requests diagnosis documentation from the provider, however we have found this scenario to be rare.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

VCSB serves as the lead agency for Homeless Management Information System (HMIS) as well and utilizes the Balance of State chosen HMIS provider, Homeward. PATH outreach worker and supervisor have attended SAMHSA HMIS Learning Community (LC) webinars and annual Homeward HMIS refresher training. All new staff will complete Homeward HMIS new user training and will be encouraged to attend LC webinars as they are available.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

Identification as an individual experiencing homeless during outreach activities results in placement on the community's by name list regardless of whether or not the individual is determined to be PATH eligible. It is extremely likely that PATH eligible individuals meet criteria for subcategories of veteran or chronically homeless, which results in a full team approach during case conferencing to move the client into permanent housing as quickly as possible. Housing opportunities may be available through VCSB PSH for SMI, rapid rehousing, local LIHTC properties, or private landlords with inexpensive apartments. Unfortunately, the two PHAs that serve our catchment area are not involved with the LPG and the PATH outreach worker can only support PATH enrolled clients through the standard application process for income-based housing.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

VCSB operates from a fundamentally person-centered approach. PATH staff are sensitive to and aware of differences that may lend to individuals being less trusting initially of a white male in his forties, particularly in our rural community. PATH staff works diligently to establish trust and rapport with individuals experiencing homelessness inclusive of these differences.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

PATH staff have training in cultural awareness provided by VCSB as a part of their agency orientation with refresher training annually. PATH staff have not had training in health disparities however supervisor will locate opportunities for such training.

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

A. Demographics:
The demographics of the target population:
Female: 47%
Male: 53%

Age Summary:
18-23 10%
24-30 23%
31-50 47%
51-61 17%
65+ 3%

Race Summary:
American Indian or Alaska Native 5%
Asian 2%
Black or African American 27%
Native Hawaiian or Other Pacific Islander 2%
White 63%

Ethnicity Summary
Hispanic/ Latino 3%
Non-Hispanic/ Latino 97%

Veteran Status
Veteran 10%
Non-Veteran 90%

B. The projected number of adult clients to be contacted: 125
C. The projected number of adults to be enrolled: 75
D. The percentage of adult clients to be served using PATH funds who are literally homeless: 100

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

When an individual accesses any homeless service in our community, a universal intake is completed which collects HMIS data points. Upon identification of individuals with veteran status, PATH outreach worker provides linkage to Veteran's Administration (VA) and Supportive Services for Veteran Families (SSVF) for housing resources and medical resources as needed and if the client is willing. The client is added to the by name list and is part of the subcategories focused on in case conferencing.

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

Clients and their family members are encouraged to be active participants in all components of VCSB service delivery to enhance and reinforce treatment options that are provided. VCSB has made efforts to include clients and their family members on the Board of Directors and a family member currently serves on the Board of Directors, though not in the role of family member. Client have been encouraged to attend VCSB Consumer Advisory Council meetings, the annual goal planning meetings, and to make suggestion or recommendation for additional services or improvements to treatment rehabilitation services offered by VCSB. Clients are made aware of their rights and informed at entry to services. Valley Homeless Connection, the LPG, is in process of adding a formerly homeless individual to our governance structure. The PATH supervisor is also a VCSB client family member.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

CSB is requesting funding for .7 of an FTE to carry out the work of the PATH program. Additional costs include vehicle leases and gas for trip between our location and homeless sites as well as to our partner's, Valley Mission, location. One cell phone service plan is included in the budget. Supplies of $12,500 included in the budget as part of our match include the costs of tents, sleeping bags, personal items (i.e. shampoo, feminine products, toothpaste, etc.), food packages and other supplies that an individual experiencing homelessness may need. Other costs include cost of training, program supplies, rental assistance and similar.

Program match is provided by Valley Mission, our partner, by VCSB, and by other community grants that will be requested for program supplies.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The PATH program is overseen by Lydia Campbell, our Adult Mental Health Case Management Supervisor who actively participates in assisting our PATH Outreach Worker to achieve the goals of this program. Lydia reports to our Mental Health Case Management Manager who reports to our Director of Behavioral Health. VCSB also has a Quality Assurance program which assists programs with compliance and adherence to state and federal regulations. VCSB accounting department is comprised of a CFO, Payroll Administrator, Accountant, Payable Account, Representative payee and Billing staff. VCSB receives more than $750,000 in Federal funds; therefore, VCSB has an annual fiscal audit and submits it to the Federal Audit Clearinghouse. Currently the annual fiscal audit is done by PBMares. VCSB reports to a Board of Directors and provides them with regular program and financial updates.

Virginia Beach Department of Human Services, Community Support Services Division
3143 Magic Hollow Blvd.
Virginia Beach, VA
Contact: Kathleen Brooks-Johnson

Provider Type: Community mental health center
PDX ID: VA-016
State Provider ID:
Contact Phone #: 757-385-0672

- **Local Provider Description** – Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the amount of PATH funds the organization will receive.
- **Collaboration with HUD Continuum of Care (CoC) Program** – Describe the organization's participation with local HUD Continuum of Care (CoC) recipient(s) and other local planning activities and program coordination initiatives, such as coordinated entry activities. If the organization is not currently working with the Continuum(s) of Care, briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
- **Collaboration with Local Community Organizations** – Provide a brief description of partnerships and activities with local community organizations that provide key services (e.g., outreach teams, primary health, mental health, substance use disorder, housing, employment) to PATH-eligible clients, and describe the coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.
- **Service Provision** – Describe the organization's plan to provide coordinated and comprehensive services to PATH-eligible clients, including:
  - How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing;
  - Any gaps that exist in the current service systems;
  - A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
  - A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.
- **Data** – Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.
- **Housing** – Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency).
- **Staff Information** – Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients. Describe the extent to which staff receive periodic training in cultural competence and health disparities.
- **Client Information** – Describe the demographics of the client population, the projected number of adult clients to be contacted and enrolled, and the percentage of adult clients to be served using PATH funds who are literally homeless.
- **Consumer Involvement** – Describe how individuals who experience homelessness and have serious mental illnesses, and family members will be meaningfully involved at the organizational level in the planning, implementation, and evaluation of PATH-funded services. For example, indicate whether individuals who are PATH-eligible are employed as staff or volunteers or serve on governing or formal advisory boards.
- **Budget Narrative** – Provide a budget narrative that includes the local-area provider's use of PATH funds.

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

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**83,312.00**	**55,541.00**	**138,853.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	64,667.00	100.00 %	0.60	38,800.00	25,867.00	64,667.00	Clinician III
Other (Describe in Comments)	37,461.00	100.00 %	0.60	22,477.00	14,984.00	37,461.00	PATH Clinician I
Other (Describe in Comments)	36,725.00	75.00 %	0.60	22,035.00	14,690.00	36,725.00	Clinican I

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**21.08 %**	**$ 29,277.00**	**$ 19,518.00**	**$ 48,795.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 1,478.00**	**$ 0.00**	**$ 1,478.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Conference Registration Fee	$ 853.00	$ 0.00	$ 853.00	
Mileage Reimbursement	$ 625.00	$ 0.00	$ 625.00	staff travel reimbursement

d. Equipment	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

e. Supplies	**$ 213.00**	**$ 716.00**	**$ 929.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 0.00	$ 716.00	$ 716.00	
Office: Supplies	$ 213.00	$ 0.00	$ 213.00	

f. Contractual	**$ 3,436.00**	**$ 2,988.00**	**$ 6,424.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 2,400.00	$ 0.00	$ 2,400.00	HMIS Licensing Fees
Other (Describe in Comments)	$ 1,036.00	$ 0.00	$ 1,036.00	Cell Phone Service Fee
Other (Describe in Comments)	$ 0.00	$ 2,951.00	$ 2,951.00	Lease/Rent of Equipment - Copier fees
Other (Describe in Comments)	$ 0.00	$ 37.00	$ 37.00	Rentention Services

g. Housing	**$ 7,689.00**	**$ 1,949.00**	**$ 9,638.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 7,689.00	$ 1,949.00	$ 9,638.00	Rental Assistance

h. Construction (non-allowable)

i. Other	**$ 1,544.00**	**$ 958.00**	**$ 2,502.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 1,245.00	$ 0.00	$ 1,245.00	
Client: Other (Describe in Comments)	$ 299.00	$ 0.00	$ 299.00	Identification Purchase
Staffing: Other (Describe in Comments)	$ 0.00	$ 958.00	$ 958.00	Risk Management

j. Total Direct Charges (Sum of a-i)	$ 126,949.00	$ 81,670.00	$ 208,619.00	

Category	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
k. Indirect Costs (Administrative Costs)	**$ 0.00**	**$ 0.00**	**$ 0.00**	
l. Grand Total (Sum of j and k)	$ 126,949.00	$ 81,670.00	$ 208,619.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 200

Estimated Number of Persons to be Enrolled: 110

Estimated Number of Persons to be Contacted who are Literally Homeless: 190

Number staff trained in SOAR in grant year ending in 2019: 1

Number of PATH-funded consumers assisted through SOAR: 5

Virginia PATH Local Intended Use Plan, FFY 2021
PATH Program Year 2020-2021
City of Virginia Beach, Department of Human Services Behavioral Health Division

1) Description of Provider Organization:

A. **Name:** City of Virginia Beach, Department of Human Services Behavioral Health Division

B. **Type of Organization:** Community Mental Health Center

C. **Description:** Virginia Beach Department of Human Services (DHS) is a comprehensive public human services agency for the City of Virginia Beach. The Behavioral Health (BH) Division provides a full range of services including medication management, case management, emergency services, crisis stabilization and detoxification, prevention, day treatment, psychosocial rehabilitation, mental health support services with support residential services properties and child and youth treatment programs. Virginia Beach DHS BH PATH program focus is providing individuals (including Veterans) with a serious mental illness (SMI) experiencing homelessness or imminent danger of becoming homeless, services that assist in their transition from homelessness. There are numerous evidence-based practices, such as, persistent outreach and engagement, frequent visits to encampments, being visible in the community and connecting with stakeholders, using community resources and local churches to provide options to this vulnerable population. The objective is to increase engagement and enrollment, which promotes the connection needed to encourage participation in BH services, such as, medication management, mental health supportive services and case management services, etc. PATH aids support for individuals to their screening and diagnostic treatment appointments at Adult Outpatient Services (AOS) for Same Day Access (SDA) and PATH supports individuals to connections for habilitation and rehabilitation services, as well as, linking Veterans to the Veteran Administration and Veterans' Crisis Housing Hotline. PATH connects individuals to the Regional Housing Crisis Hotline to begin their transition from homelessness and to the Department of Social Services at the Housing Resource Center (HRC) to apply for entitlements and services, for example, SNAP, Employment Services, Medicaid and Integrated Services Team to monitor and ensure each individual gains access to services needed. Working at the HRC with a multitude of agencies and services, affords PATH to be in a unique position to directly link individuals with the Department of Housing and Neighborhood Preservation (DNHP) Outreach Team and to jointly assess their needs and have individuals promptly documented as ready for housing opportunities. PATH has access to meet with individuals at the HRC shelter and day program daily to stay engaged and encourage continued participation. PATH connects co-occurring individuals directly to a Substance Use Disorder (SUD) Peer Recovery Support Specialists to access options for treatment services including alcohol or drug treatment services. PATH has a newly acquired resource, ***Clean Slate*** that specializes in treatment for those addicted to opiates.

D. **Region Served:** The City of Virginia Beach

E. **Amount of PATH Funds:** $126,949

F. **Primary Contact:** Kathleen Brooks Johnson, KYBJohns@vbgov.com, (757) 385-0672

2. Collaboration with HUD Continuum of Care (CoC): Describe your PATH program's participation in the local CoC and any other local planning, coordinating or assessment activities. If the PATH program does not collaborate directly with the CoC, please describe other staff or programs within the organization that do.

Also, describe your CoC's efforts at implementing the Coordinated Assessment process as described by HUD.

The PATH Team Leader represents the VBDHS BH Division as an active member of Bringing an End to All City Homelessness (BEACH) committee. BEACH is an advocacy organization consisting of faith-based, governmental, and nonprofit organizations. DNHP also coordinates the CoC for Virginia Beach. The Team Leader represents the Virginia Beach DHS BH Division on the Coordinated Assessment Committee, Service Prioritization Assistance Meeting (SPAM) and the Performance Measures Committee. Coordinated Assessment utilizes the Service Prioritization Decision Assistance Tool (SPDAT) to establish the Vulnerability Index of literally homeless families and individuals while referring them to available housing according to their vulnerability status. Individuals are referred for housing via the Prioritization List. The PATH Team Leader (or designee) participates in the selection of candidates for available housing slots weekly at the SPAM meeting.

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.

PATH ensures that homeless individuals sign a Release of Information (ROI) for organizations that provide services. Individuals are provided services with dignity and respect and they are provided information regarding their rights and services. PATH works directly with DNHP and their Outreach team to jointly outreach individuals and families. This relationship allows PATH to assist individuals in contacting the Regional Housing Crisis Hotline to start the process for housing and be referred to Virginia Beach Coordinated Entry & Assessment regardless of criminal history. If appropriate, a SPDAT will be recorded and placed in the Homeless Management Information System (HMIS). Coordinated Entry & Assessment refers to shelter, transitional housing, permanent supportive housing, and rapid re-housing for individuals with a criminal history unless it is a charge that places the individual on the sex offender registry. In the event a consumer is on the registry, PATH works closely with Probation and Parole to assist the individual in remaining compliant and ending their homelessness and/or unemployment as quickly as possible. PATH collaborates with private landlords and applicable probation officers and jail services to mitigate criminal history barriers consumers may encounter. The PATH program provides employment opportunity information to individuals that may benefit or be eligible for supported employment due to their respective disabilities through employers and supported employment agencies, such as, Community Alternatives Inc., Department for Aging and Rehabilitative Services (DARS), Didlake, Eggleston and Goodwill Industries. PATH eligible consumers unwilling to integrate into Adult Outpatient Services and/or Department of Social Services employment services will be monitored closely and PATH will continue engagements using motivational interviewing modalities. PATH works towards minimizing the challenges and fosters support by making referrals to private providers. PATH mitigates the barriers to accessing insurance for private providers by arranging for services and Medicaid Expansion providers for individuals experiencing SMI and/or co-occurring disorders.

PATH has ongoing relationships with various community resources. PATH attends the Oceanfront Coalition meeting facilitated by People in Need (PIN) ministries to address stakeholder concerns and develop campaigns to involve more businesses and churches to meet the needs of the homeless population. PATH outreaches individuals weekly at the local libraries, Potter's house, Star of the Sea and PIN ministries to ensure they have access to services that will promote transition from homelessness. PATH provides information on community organizations that are providing meals, financial assistance, showers and laundry services, such as, PIN, Potter's House, Faith in Action and Star of the Sea. PATH staff frequents local businesses to include 7-11's, Walmart and Wawa and provides information on resources and our contact

information to ensure that individuals may be outreach immediately to assess the individuals' needs. PATH connects individuals in need of medical services and assists them with making appointments with the Virginia Beach Family Medical Center, Beach Clinic and HRC medical clinic which are primary health care centers that have a sliding scale fee. PATH provides some funding for medical services, but when needed, we first work to identify and exhaust alternate funding resources. PATH makes direct referral to Pathways for those in need of crisis stabilization due to mental health symptoms and/or substance use disorders. PATH provides transportation to individuals that need services provided by the Department of Social Services at HRC to apply for entitlements to include SNAP, Medicaid and employment services.

4. Service Provision: Describe the plan to provide coordinated and comprehensive services to PATH-eligible clients, including:

a. How the services to be provided using PATH funds will align with PATH goals and maximize serving the most vulnerable adults who are literally and chronically homeless, including those with serious mental illness who are veterans and experiencing homelessness, to obtain housing and mental/substance use disorder treatment services and community recovery supports necessary to assure success in long-term housing:

Outreach workers contact homeless individuals where they sleep by going into `various campsites, boardwalk area and engaging individuals who may be panhandling. PATH services are provided routinely, and we check in with local churches. PATH staff attend homeless support groups to offer assistance and education. They strive to build trust and solid relationships with the homeless population, a stepping-stone to engagement and recovery.

PATH utilizes a person-centered/recovery-oriented outreach approach which places the emphasis on the individual's willingness and ability to move in a positive direction. Motivational Interviewing is the primary interviewing tool used during outreach and in-reach activities. Scheduled outreach occurs at the areas where the homeless tend to frequent. These areas include the Oceanfront boardwalk, numerous local churches that provide resources, local libraries and other key business areas throughout the City of Virginia Beach. The churches that provide weekly resources are the Star of the Sea (SOS), Virginia Beach United Methodist Church/Potters House and People In Need Ministries (PIN). PATH provides outreach services and responds to calls and referrals from the shelters, concerned citizens, businesses, stakeholders, such as, Virginia Beach Police Department and any inter-agencies of Virginia Beach. PATH staff perform occasional outreach efforts in partnership with local police to ensure camp site safety and resolution of citizen concerns from property and business owners. In-reach is utilized at the local shelters and Housing Resource Center (HRC): Judeo Christian Outreach Center (JCOC) and Department of Housing and Neighborhood Preservation (DNHP), JCOC's and DHNP's Day Support Center, PATH offices and Virginia Beach Public Libraries. PATH Continues to work with the DHNP Outreach team to enhance our ability to reach more homeless individuals.

b. Any gaps that exist in the current service systems:

The program has had success by connecting individuals to the Regional Housing Crisis Hotline. Shelter housing durations at HRC range from 6 months to 1+ years. The longer stays, while they may provide an individual with overall stability that supports independent living success, it does add to shortages in available established sheltering options.

Furthermore, the lack of long-term affordable housing options impedes or significantly delay individuals' objectives.

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

The following service areas are available to support individuals' needs and PATH staff provide linkage as needed:

PATH and HRC Case Management provide services at the HRC and in the community through the BH Division. Behavioral Health programs are now a part of an integrated service delivery system designed to provide housing, shelter, mental health, substance use treatment, benefits acquisition and medical services at one location.

Case Management serves individuals with diagnoses of mental illness and/or substance use disorders who need assistance to identify and use resources that will promote their highest level of functioning. Supports include access to needed medical, psychiatric, mental health, substance abuse, social, educational, vocational services and other supports essential to meeting basic needs and improve their quality of life.

Project LINK is a program that provides intensive case management services to pregnant, post-partum and parenting women whose lives have been affected by substance use and/or a co-occurring disorder by reducing barriers that may prevent them from seeking appropriate treatment.

Adult Day Treatment services are provided five days a week. Group therapy and education are provided for persons with moderate to severe levels of mental illness, substance use, or co-occurring disorders.

Adult Outpatient Services are located at Pembroke 6 and Magic Hollow and their services focus on individuals with serious mental health issues and significant substance use disorders. Services include psychiatric evaluations, medication management, group therapy and limited individual and family counseling.

Community Based Crisis Stabilization – This service provides direct mental health care to adult individuals experiencing an acute psychiatric crisis that may jeopardize their current community living situations.

Residential Crisis Stabilization Units (CSU) – There are three CSU programs located in Virginia Beach, Norfolk and in Hampton. These facilities are sub-acute short-term crisis stabilization programs used to prevent further destabilization and avoid hospitalization for the PATH individuals. Our Pathways Center in Virginia Beach also has a Medically Monitoring Detox service within their program. All three CSU programs accept indigent and Medicaid participants.

Program of Assertive Community Treatment (PACT) – Services are correlated to the individuals' assessed clinical needs, functional ability, and level of motivation. These services are designed for those who demonstrate a higher level of supportive care and would not be able to maintain their mental health stability.

Beach House Psychosocial Day Program provides individuals with daily living skills and socialization skills. They assist individuals with Temporary Employment Program (TEP) to promote their independence.

Opioid Treatment and Recovery Services provides funding for individuals with an opioid use disorder (OUD) to receive medication assisted treatment (MAT) for their addiction. OUD recovery support groups, as well as, support by Peer Recovery Specialist that manage our Warmline are available resources.

Adult Correctional Services is engaged when a PATH enrolled individual is incarcerated to continue their medication management and supportive services while incarcerated. Coordinated discharge planning is provided.

Emergency Services provides a 24/ emergency crisis response to all individuals in the City of Virginia Beach experiencing a mental health, substance use or co-occurring disorder crisis episode.

Supportive Residential Services provides a continuum of supportive and supervised affordable residential options for adults who have active cases with the Virginia Beach BH Division to include transitional and supportive housing, adult foster care, assisted living facilities, and affordable housing with in-home support.

Clean Slate is an outpatient treatment program that focuses on opiate addiction which provides alternative to methadone.

d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients:

PATH screens for eligibility at intake according to criteria using the individual's expressed need. PATH's Qualified Mental Health Professional (QMHP) will complete a Diagnostic Review with the individual and based upon symptoms reported, will complete the form with an unspecified diagnosis review for the Pembroke Six licensed clinician to update the diagnosis to a SMI, as appropriate, during their intake. The homelessness and at-risk status are determined by a lack of residency of the individual.

The enrollment criteria are as follows:

- The individual is determined to be PATH eligible, and
- The individual and the PATH provider have reached a point of engagement where there is a mutual agreement that services will be provided, and
- The PATH provider starts the individual file that includes;
  Basic demographic information for reporting purposes,
  Documentation by the Provider of PATH eligibility determination,
  Documentation by the provider of the mutual agreement for the provision of services,
  Services and referrals provided.

The PATH enrolled individual can access any PATH funded services, assistance, or provision of resources that the individual is willing to accept. This includes mutual work that the individual identifies as important in their recovery, stability, or well-being. PATH providers are expected to document any and all needs, services, and outcomes in the required individual Electronic Health Records (EHR).

All eligibility documentation can be found in the EHR and file attachment feature in HMIS that staff uploads for everyone served.

5. Data: Describe the provider's participation in HMIS and describe plans for continued training and how providers will support new staff:

PATH has fully implemented HMIS into daily activities for PATH documentation and reporting purposes. PATH is in close communication and collaboration with our local HMIS Administrator for data quality, literacy, training, and questions related to the program utilization. The program is audited for data content and collection quality by the HMIS Administrator annually and the Program Team Leader submits monthly progress reports for data quality review. Data is collected utilizing worksheet templates provided by HUD and they are completed at each intake for consumers. To ensure accurate reporting, the VB PATH staff reviews individual electronic HMIS records prior to each closure. PATH receives and responds to referrals

from homeless providers participating with HMIS to accurately capture services, contacts, and engagements with potential PATH eligible consumers.

Every contact must be logged into both of our electronic health records, HMIS and Cerner. To ensure accuracy, we have incorporating the new HMIS data requirements in the intake packet, plus, staff are using tablets in the community to complete collaborative documentation. PATH staff also maintains individual service logs to input services within 24 hours. All actions promote efficiencies in this process.

6. Housing: Indicate the strategies that will be used for making suitable housing available for PATH clients (i.e., indicate the type of housing provided and the name of the agency). Describe how PATH is implemented in collaboration with the local housing department/office responsible for providing housing to qualify residents:

Virginia Beach DHNP offer a list of affordable housing options and is the administrator of housing vouchers. PATH also provides this list for individuals and families found ineligible for these types of vouchers and educates individuals in housing searches, information and eligibility determination. When appropriate, PATH staff will assist individuals in accessing these types of housing resources in application assistance, getting documents ready and advocating for their housing placement to eliminate barriers to housing.

PATH assists individuals in contacting the Regional Housing Crisis Hotline to start the process for housing and be referred to Virginia Beach Coordinated Entry & Assessment. If appropriate, a SPDAT will be recorded and placed in HMIS. When necessary, PATH assists in the completion of the SPDAT. Coordinated Entry & Assessment refers to emergency shelter, transitional housing, Permanent Supportive Housing (PSH) and Rapid Re-housing (RR) programs. PATH supports the Coordinated Entry & Assessment team in the coordination of consumers entering PSH, resources from the Lesbian, Gay, Bisexual and Transgender (LGBT) Life Center, Community Alternative Management Group (CAMG), Virginia Supportive Housing (VSH) and the City of Virginia Beach. Virginia Beach Community Development Corporation (VBCDC) provides permanent housing for veterans and families with mental illness, substance use and co-occurring disorders. Virginia Supportive Housing (VSH) is a regional program and currently manages six Single Residential Occupancy (SRO) accessible to PATH consumers. PATH supports consumers by completing SRO applications. PATH initiates referrals to VBDHS BH Division Supportive Residential Services upon enrollment into services to access housing options through the PSH & RR program as well as supportive residential facilities.

7. Staff information:

a. Describe how staff providing services to the population of focus will be sensitive to age, gender, disability, lesbian, gay, bisexual, and transgender, racial/ethnic, and differences of clients.

The VBDHS BH Division provides annual cultural diversity trainings to ensure staff provide services and support to anyone regardless of their age, gender, race, national origin, religion, sexual orientation, disability and/or ability to pay for services. PATH complies with the City of Virginia Beach's strategic Cultural Competency and Diversity Plan. Our mission is that everyone is treated with dignity and respect, that services are accessible and that individuals served are provided their rights and information pertained to service recommendations. Staff are trained to respect and to have a strong working knowledge of person-centered treatment that is voluntary. Staff will also connect individuals to community resources that specifically cater to an individual's needs.

b. Describe the extent to which staff receive periodic training in cultural competence and health disparities.

PATH workers receive annual cultural diversity training provided by the City of Virginia Beach. PATH complies with the City of Virginia Beach's strategic Cultural Competency and Diversity Plan. PATH has access to and distributes Public Service Announcements (e.g. VBDHS Office of Consumer Affairs, CDC & VDH, etc.) and printed material that is in English and Spanish to distribute to the homeless population and can access translated material in other languages as needed through the Regional Language Bank. PATH staff are also responsible for completing annual Ethics, Human Rights, Blood Borne Pathogen and Pandemic Flu trainings.

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

A. Demographics:

RACE/ETHNICITY (201)	Percentage
American Indian	.1%
Asian	0%
Black/African American	33%
Hispanic/Latino	4.5%
White/Caucasian	39%
Multi-Racial	5%

AGE (201)	Percentage
0 – 17	.1%
18 – 24	3.5%
25 – 34	18%
35 – 44	19%
45 – 54	20%
55 – Up	20%

GENDER (161)	Percentage
Male	59%
Female	39%
Transgender	.62%

B. The projected number of adult clients to be contacted: 200
C. The projected number of adults to be enrolled: 110
D. The percentage of adult clients to be served using PATH funds who are literally homeless: 95

9. Veterans: Describe how your PATH program serves veterans experiencing homelessness. Included in the response could be CoC-level coordination demonstrating effectiveness in serving this population.

PATH assessing individuals and families with veteran status. If the veteran is not currently connected or participating in VA services, they are assisted in registering at the Hampton VA Center. If they do not qualify for VA services, the individual is assisted in contacting the BH Services Pre Registration to schedule an appointment for services. We assist Veterans that are eligible by helping them become document ready for housing. We also assist in finding financial resources for those that may need help with deposit and first month rent.

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

Virginia Beach BH Services Mission Statement: To promote recovery for Virginia Beach citizens and their families, with or at risk of mental health, substance use or co-occurring disorders, through an array of coordinated services offering prevention, treatment and community collaboration delivered in a climate of dignity and respect.

- All PATH consumers are assessed for suitability of services. At that time, everyone is informed of their individual rights and they voluntarily sign consent forms for services and fees (based on income). Once individuals are admitted into on-going treatment, they sign other documents notifying them of their rights and choices and well as consents for medications prescribed.

- The Office of Consumer and Family Affairs (OCFA) provides opportunities for individuals (including PATH individuals), their families, and members of the community to participate in educational activities, learn about and be linked with community resources. They learn about how to become involved in advocacy initiatives. Programs offered include *Friends and Family* which is a 6 week series of classes that offers understanding and help for friends and families affected by substance use and *Wellness Recovery Action Plans (WRAP)* is a 9 week series of classes that help individuals learn how to write a recovery plan focused on their goals for wellness. The individuals can also attend *Peer-to-Peer* which is a 9-week class that is taught by mentors and helps individuals with severe mental illness prepare their own recovery and relapse prevention.

Currently, PATH staff do not self-identify as having mental illness or a history of homelessness, however, many PATH consumers have volunteered to participate in the *Point-in-Time* count and participate in the annual Homeless Connect event. One previous PATH consumer is now on the board of the BEACH committee. PATH encourages individuals to support and participate in public hearings and open planning meetings.

11. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.

A. Staffing:

1. Position – Provide the title of the position and an explanation of the roles and responsibilities of the position as it relates to the objectives of the award supported project under the comment section. The position must be relevant and allowable under the project.

   The VBCSB PATH program operates with 2.75 FTEs, a FT Clinician III, a Behavioral Health Assistant and a PT Clinician I.

   - The Clinician III serves as the Program Team Leader and coordinates staff activities, staff oversight, data tracking, reports financial performance and ensures program target objectives and State Performance measures are met. The PTL serves as the primary point for coordination of services and continue outreach efforts. The PTL serves as a liaison between the DHS, homeless service providers, city stakeholders and churches. The PTL serves as the representative for the VBDHS BH Division PATH program at the Virginia Beach Homeless Advocacy and Resource Partnership, Bringing an End to All City Homelessness, Performance Measures Committee, SPAM and DNHP meeting and links weekly with their Outreach Team.

   - The BH Assistant will provides outreach and in-reach responsibilities to consumers that are homeless or at risk of homelessness and have SMI or co-occurring disorders. The BH Assistant provides linkage of individuals with resources, such as, Same Day Access (SDA), referrals to Supportive Residential Services, case management and this person develops individualized service plans to help our individuals to maintain stability in the community. The BH Assistant will visit homeless encampments, approach individuals on streets that are homeless, and they will connect with homeless people in other areas where homeless persons are known to frequent. They are responsible for cconducting face-to-face Motivational interviews and for collecting information on individuals who are suspected to have a SMI or co-occurring illness.

   - The Clinician I provide outreach services to individuals with SMI, or co-occurring disorder. Coordinates and prepares SOAR cases for SSDI/SSI, Medicaid and other benefit applications for seriously mentally ill and co-occurring PATH individuals. The Clinician I obtains clinical documentation and assures that all filing for SSI, SSDI, Medicaid and other benefits are done accurately and within the time frame required. The Clinician I establishes contacts within Social Security Administration, Department of Social Services and Disability determination Services for individuals served. Required to submit service logs within 24 hours of service being provided and update both Electronic Health Records to include HMIS and Cerner. The Clinician I meets with everyone at a minimum of once a month and provides collateral contacts weekly. Clinician I assists with completing application forms, recertification forms, etc. These forms could include Social Services applications (which includes Medicaid, SNAP, and TANF) and Social Security Card applications.

2. Salary/Rate – The estimated annual salary. a. Salaries should be comparable to those within your organization. b. If the position is not being charged to the Federal award, but the individual is working on the project identify the salary/rate as an “in-kind” cost.

   Salaries for staff supporting program operations total $187,649 of which $48,796 ties to benefits. PATH funding will cover 60% of salaries and benefits and the remaining balance will be covered by local match.

3. Percent of Time − The percentage of time that the position contributes to the project. Personnel cannot exceed 100% of their time on all active projects (including other Federal awards).

   All three positions are 100% dedicated to providing PATH service provisions.

B. Fringe Benefits**:** Fringe benefits are allowances and services provided to employees as compensation in addition to regular salaries and wages. City positions are eligible for benefits as described by Department of Labor regulations. City full time and benefits eligible part time positions have access to other benefits which include life insurance and health Insurance selection and VRS contribution. These positions are also receiving Holiday and Leave pay.

C. Travel: Funds requested in the travel category should be only for project staff. Travel for consultants and contractors should be shown in the "Contract" cost category along with consultant/contractor fees. Because these costs are associated with contract-related work, they must be billed under the "Contract" cost category. Travel costs associated with community outreach efforts $625, conference training costs $853.

D. Supplies: Supplies are items costing less than $5,000 per unit (federal definition), often having one-time use.

12. Programmatic and Financial Oversight: Describe your agency's method of providing pragmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The program uses an eligibility check list to determine that individuals meet the criteria for PATH services. We work within budgeted categories to provide supports to eligible individuals and link those who require additional supports beyond the grant's ability. This may be accomplished through other CSB service areas or via linkage to external partners. The program ensures individuals' supports are provided in accordance with grant requirements and reconciles monthly with review of expenditures in the financial system. The Clinical Services Administrator (CSA) reviews and final approves purchases in support of individuals served in PATH. The CSA completes an overall review of PATH program for compliance for clinical and financial compliance. Finance works with the program to review expenditures and processes as needed, but not less than monthly. The program is subject to departmental and/or city audits as well as state-initiated reviews.

III. State Level Information

A. Operational Definitions

Term	Definition
Individual Experiencing Homelessness:	Virginia's operational definition for determining who is homeless is derived from the federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act. The term "homeless" includes persons who lack a fixed regular and adequate nighttime residence. It also includes persons whose primary night-time residence is either a supervised public or private shelter designed to provide temporary living accommodations; an institution that provides temporary residence for individuals intended to be institutionalized; or a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings.
Imminent Risk of Becoming Homeless:	The term "imminent risk of becoming homeless" includes one or more of the following criteria: doubled -up living arrangement where the individual's name is not on the lease, living in a condemned building without a place to move, arrears in rent/utility payments, having received an eviction notice without a place to move, living in temporary or transitional housing that carries time limits, being discharged from a health care or criminal justice institution without a place to live. In addition to the criteria above, persons who live in substandard conditions are by definition at risk of homelessness, due to local code enforcement, police action, voluntary action by the person, or inducements by service providers to go to alternatives like short-term shelters whose residents are considered to be homeless. There is not a recommended time-frame for imminence as individual eviction processes, formal or informal, vary.
Serious Mental Illness:	Refers to individuals who have at least one serious mental illness and a substance use disorder, where the mental disorder and substance use disorder can be diagnosed independently of each other.
Co-occurring Disorders:	PATH providers use the DBHDS criteria for assessing the presence of a serious mental illness. The major components of the criteria include (1) adult age, (2) diagnosis of a major mental disorder, including the presence of a co-occurring substance use or intellectual/developmental disorder, (3) significant functional impairments, (4) expectation that the condition is of a long-term nature.

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

III. State Level Information

B. Collaboration

Narrative Question:

Describe how the state will implement a collaborative relationship with the department/office responsible for providing housing to qualifying residents. Describe how PATH funds supporting care and treatment of the homeless or marginally housed seriously mentally ill population will be served such that there is coordination of service provision to address needs impacted by serious mental illness and provision of permanent housing for those being served with grant funds is prioritized and assured.

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Footnotes:

Collaboration

DBHDS leadership including the Director of the Office of Community Housing (OCH) are members of the Housing and Supportive Services Interagency Leadership Team (executive leadership) and permanent supportive housing (PSH) Steering Committee, both of which include key stakeholders from eight state agencies. Through budget language, the 2017 General Assembly charged the Department of Housing and Community Development (DHCD) with developing and implementing strategies to increase PSH for individuals with serious mental illness (SMI). The General Assembly indicated that strategies could potentially include Medicaid financing and directed DHCD to include other agencies in the development of strategies, naming the Virginia Housing Development Authority (VHDA), Department of Behavioral Health and Developmental Services (DBHDS), Department for Aging and Rehabilitative Services (DARS), Department of Medical Assistance Services (DMAS), and Department of Social Services (DSS). Further, the General Assembly required DHCD to include stakeholders whose constituents have an interest in expanding supportive housing for individuals with SMI, naming the National Alliance on Mental Illness of Virginia, the Virginia Housing Alliance and the Virginia Sheriff's Association. Finally, the General Assembly required DHCD to provide an annual report on such strategies and the progress on implementation to the Chairmen of the House Appropriations and Senate Finance Committees. These agencies have developed and are implementing a multi-strategy Housing Action Plan for individuals with SMI.

The OCH houses both PATH and a $17.3 million state funded PSH program for individuals with SMI. DBHDS PSH is intended to address high priority issues for individuals with SMI: homelessness and institutionalization. Virginia's state psychiatric facilities are experiencing a census crisis due to "bed of last resort" legislation which has driven individuals under temporary detention orders into state hospital beds and exacerbated the list of individuals with Extraordinary Barriers to discharge. Due to a number of factors, PSH is acknowledged as an underutilized resource to address the census crisis. Additionally, in the last ten years Virginia has worked to positively impact the number of individuals experiencing homeless, resulting in dramatic reductions of homeless households in every sub-population. While there were 24% fewer individuals with SMI identified in Virginia's 2019 Homeless Point-In-Time Count in comparison to the 2011 count, this sub-population is still over-represented among people experiencing homelessness, and homeless reductions have been less dramatic for individuals with SMI than for almost every other sub-population. DBHDS seeks to positively impact homelessness among individuals with SMI through use of its PSH resources.

Nine of the fourteen of the DBHDS PATH providers are also DBHDS providers of DBHDS PSH for adults with SMI. We ensure our PSH is prioritized through operating guidance for individuals with SMI who are homeless or leaving institutions. Providers are required to work with their local Continuum of Care to identify vulnerable homeless individuals with SMI. We monitor adherence to prioritization and review collaboration with PATH and PSH, and we provide training and technical assistance on CoC collaboration, PATH-PSH collaboration, and best practices in supporting the PATH population in PSH. We monitor PATH, as well, including exits to permanent housing and provide training & technical assistance to improve outcomes.

III. State Level Information

C. Veterans

Narrative Question:

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

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Virginia PATH Services for Veterans

Population

According to the most recent data from the National Center for Veterans Analysis and Statistics (2017) an estimated 725,028 veterans of all eras of service are living in the Commonwealth of Virginia. This comprises approximately 11% of Virginia's total adult population. Twenty-six (26) percent, or 190,201, of those veterans received disability compensation. Areas in which PATH services are provided include a number of Virginia jurisdictions with significant veteran populations:

Tidewater/Southeastern Virginia Area: This area includes several large military installations, and as such, veterans comprise a significant percentage of area residents. The population of veterans as a percentage of the entire adult population in the PATH site areas of the Tidewater region are Portsmouth 16.1%; Newport News 17.3%; Norfolk 16.2%; Hampton 18.4%, and Virginia Beach 17.5%. These areas have high percentages of Gulf War veterans and those who served in Iraq and Afghanistan, and PATH sites report seeing an increasing number of young veterans from Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF).

Northern Virginia Area: PATH sites in this area serve several communities with a moderate veteran population. The highest concentration of veterans is in Prince William County, with a 12.6% veteran population (US Census Bureau, 2018). Approximately 7% of the population of the Northern Virginia jurisdictions are veterans.

Central Virginia Area: PATH service areas in the central Virginia area include the City of Richmond, which has a small veteran population at 5.6%, and Region Ten CSB, whose catchment area includes cities and counties with a total veteran percentage of 7.2%.

Western Area: Blue Ridge Behavioral Health covers city/county areas with veteran populations around 10%, and Valley CSB's catchment area has a similar population of veterans (9%).

Homelessness among Virginia Veterans

Virginia was the first state to announce a functional end to Veteran homelessness as defined and approved by the United States Interagency Council on Homelessness (USICH) and continues to have the lowest proportion of homeless Veterans of any state. That said, the Commonwealth continues to identify homeless veterans every day and some changes in the counts of veterans in the Point in Time data from 2018 – 2019 demonstrate that there is much more work to be done. From 2018 to 2019 the counts of homeless Virginia veterans showed that while there was an 8.4% decrease in the total number of homeless veterans (from 488 to 447), there was an 8.2% increase in unsheltered homeless veterans (from 85 to 92).

The Virginia Department of Veterans Services and the Governor's Coordinating Council on Homelessness continues to address issues in lower performing communities and works to leverage all available resources, including HUD VASH, to serve this population. Virginia's

State PATH Contact (SPC) is an active member of the Governor's Coordinating Council on Homelessness.

Coordination of Services for Veterans

PATH sites are expected to approach services for veterans in the way that is the most effective for their area. In some cases it works best to coordinate services with the local U.S. Department of Veterans Affairs (VA) outreach representative, who can provide them with quicker access to care, flexible service delivery, assistance with VA and SSI benefits, and can provide additional housing and supportive recovery options. Many times PATH workers assist the person in making a good connection with the VA representative and tracking the progress that the person is making. If the connection is not successful, the PATH worker can pick the client back up on their caseload and assist them in moving into mainstream services on the civilian side. PATH providers also continue to watch for changes in the services available to veterans and adjust their outreach strategies accordingly.

PATH sites are encouraged to have a working relationship with either their closest VA Medical Center or the VA Outreach worker for their area. As a result, PATH has noticed a solidifying of relationships with the veteran's service organizations. The increased presence of VA representatives on local HUD Continuum of Care committees and state level homeless coordination teams is also expected to have a positive impact.

Virginia Veteran and Family Support Program

In addition to services provided to homeless veterans by our PATH programs, the Virginia Department of Veterans Services (VDVS), in collaboration with DBHDS and other state human service agencies, operates the Virginia Veteran and Family Support Program (VVFS), formerly known as the Virginia Wounded Warrior Program. Supported by State general funds since 2009, VVFS provides behavioral health and rehabilitative services to military personnel, including active duty military and members of the National Guard and Reserve services returning from combat in Iraq and Afghanistan and their families. The program is operated on a regional basis, and one CSB in the five VVFS geographical service regions is contracted to be as the regional coordination site and fiscal agent for program funds. PATH services are available in some part of all five VVFS regions, as follows:

VVFS Region	**PATH Communities**	**PATH Providers**
Central Virginia	City of Richmond and surrounding jurisdictions	Richmond Behavioral Health Authority
	Charlottesville and surrounding jurisdictions	Region Ten CSB
Northern Virginia	City of Alexandria	Alexandria CSB
	Arlington County	Arlington CSB
	Fairfax County	Fairfax-Falls Church CSB
	Loudoun County	Loudoun County CSB

VVFS Region	PATH Communities	PATH Providers
	Prince William County	Prince William CSB
Northwestern	City of Fredericksburg and surrounding jurisdictions	Rappahannock Area CSB
Southwestern	City of Roanoke and surrounding jurisdictions	Blue Ridge Behavioral Health
Tidewater	Cities of Hampton and Newport News	Hampton-Newport News CSB
	City of Norfolk	Norfolk CSB
	City of Portsmouth	Portsmouth Department of Behavioral Health
	Virginia Beach	Virginia Beach CSB

The needs of homeless veterans meeting the program's eligibility requirements will be addressed by VVFS, and Virginia's PATH programs work collaboratively with VVFS in their areas of service. VVFS staff includes two state-level Homeless Veterans Coordinators who are working with communities across the state to help build local coalitions and care continuums to improve veterans' access to available resources, including housing vouchers, employment support, and social services. Virginia's PATH programs work with these coordinators to improve veterans' services in their local communities. Additional collaboration around the needs of service members and their families is accomplished through the Virginia Service Members and Veterans Coordinating Council, a state-level steering committee that is comprised of representatives of state agencies, military-specific entities such as the three Veterans Affairs Veterans Integrated Service Networks (VISNs) operating in Virginia; the Virginia National Guard; specific military branches such as the Army and Navy; veterans service organizations operating in Virginia, and other similar groups.

Again, the SPC serves on the Governor's Coordinating Council on Homelessness Veteran's Committee which is the body that was instrumental in coordinating statewide efforts to successfully achieve a functional end to Veteran homelessness in the Commonwealth in 2016 and continues to work to address homelessness in this population.

PATH Efforts to Assist Veterans

The table below summarizes each of our current sites' veteran services plans as proposed for FFY 2020.

PATH Site	Description of Services Provided to Veterans
Alexandria CSB	HOPC works closely with the shelters drop in center, meal programs, detox and DCHS mental health centralized intake at identifying homeless Veterans. The HOPC developed connections with the VA's Homeless Outreach Social Worker and collaborated to link veterans to health care, food and personal identification. HOPC has developed relationships with members of the VA's MHCM Team and is familiar in navigating the VA hospital system in support of meeting the needs of Veterans with SMI.

PATH Site	Description of Services Provided to Veterans
	DCHS Center for Economic Support's Office of Community Services took the lead in coordinating the efforts to end veteran homelessness. It is a city-wide collaboration between local homeless service providers, veteran service providers, the Office of Veteran Affairs and DCHS's PATH program. The group also included members familiar with veterans and their experiences, including a retired Air Force colonel and an administrative assistant in the Community Services Program whose husband is active duty Army. The City of Alexandria was able to attain "Functional Zero" status in December 2015.
Arlington CSB	As of the year 2016, Arlington County has successfully accomplished the goal of housing all veterans with a dual diagnosis, to include SMI. TOW/PATH employees continuously work in conjunction with nonprofit agencies and an array of community partners to continue to maintain this goal and work towards the housing of all homeless individual in the county. TOW/PATH clinicians also work in conjunction with these agencies as part of the Zero-2016 Initiative to end homelessness and house veterans and chronically homeless individual.
Blue Ridge Behavioral Health	The PATH worker visits area overnight shelters, day shelters and the HAT team office on a regular basis. When a homeless veteran is identified, the PATH worker educates the veteran on all resources including those specific to veterans such as the VA medical center and Trust House. The PATH worker makes referrals to the VA homeless outreach worker. The homeless Veteran decides where to receive their services. Representatives from the VA Medical Center participate in the Blue Ridge Continuum of Care and the Blue Ridge Interagency Council on Homelessness and service collaboration occurs at these meetings. The Blue Ridge Continuum of Care actively participated in the Veteran's Initiative and was successful in bringing veteran's homelessness to a functional zero.
Fairfax Falls Church	As part of our routine outreach, PATH staff engages homeless veterans. PATH staff will work closely with the Veterans affairs outreach workers with the focus of assisting homeless veterans to access needed services. PATH staff also participate in meetings with the COC and the Veterans Affairs dedicated solely to assist homeless veterans in accessing housing and services.
Hampton Newport News	The HNNCSB PATH team interfaces and treats homeless veterans with SMI the same as all other PATH clients. Many area veterans are already connected to services, since the large VA hospital is located in Hampton, so they are often ineligible for PATH services. The HNNCSB PATH team still assists them with resource identification, location, and linkages. For those who are eligible, the team works to connect them to required and requested services including but not limited to the VA, Wounded Warrior, HNNCSB, and other community programs. The HNNCSB staff works extensively with the veteran service continuum in the area through the Continuum of Care, the regional VA, and the local Military Affairs Committee. The HNNCSB worked successfully with the CoC and VA on Ending Veteran Homelessness Campaign as the Peninsula was one of the 5 Virginia teams that ended functional veteran's homelessness, allowing Virginia to claim the first state to have achieved that title. The resource development specialist attended and

PATH Site	Description of Services Provided to Veterans
	participated in the planning process and the Director of Property and Resource management was on the state leadership team. During the 100 day challenge, the region housed 136 homeless veterans, some of them located and referred to housing by the PATH team. The HNNCSB PATH team and homeless services department continues its effort to outreach and identify homeless veterans with SMI, several of whom were referred to and accepted into the Road2Home housing program operated by HNNCSB.
Loudoun	PATH Outreach Workers screen every individual for possible veteran status. If the veteran does not have possession of his or her DD214 then they receive assistance in getting this vital document. Depending on the needs and desires of the person, referrals are made to the VA Medical Center (WVA) and Friendship Place (DC). PATH has established a good rapport with the VA Medical Center. VOA, Chesapeake operates a Supportive Services for Veteran Families Program and applicable individuals are referred to that program. Loudoun County has a new Virginia Department of Veteran's Services, the Loudoun Benefits Office in Ashburn as well as a new Department of Veteran's Affairs Vet Center Community Access Center in Leesburg. PATH has established working relationships with both of these organizations and has successfully referred applicable individuals.
Norfolk	PATH staff works in collaboration with the Virginia Veteran and Family Support as well as the VA outreach workers. Once a homeless veteran is identified by PATH the linkage is immediately made for VA services. If the client is not eligible for VA services, then PATH continues to assess the individual for PATH eligibility. If the individual is not PATH eligible then linkage to other outreach services happens.
Portsmouth	Portsmouth is one of three designated communities in the Commonwealth of Virginia working with the Zero: 2016 campaign to end homelessness in the veteran population. The Portsmouth CoC is working with the VA and other organizations working to find homes for veterans. The PATH case manager works with, and receives referrals from, all of these agencies. The PATH case manager is finding that she is working more with the vets who do not met criteria for some of the established programs due to receiving less than honorable discharges. These are very difficult to place as they are not eligible to receive benefits but often cannot hold a job.
Prince William	PATH therapists provides direct active outreach services to veterans in the local homeless Drop-In Center and local church congregate meal sites, on the street, at campsites, and in the woods. PATH therapists receive referrals from other homeless service providers or veterans volunteering their time in the community, often not part of an organization but simply as a way to help a peer. Assessment of veteran status is normally completed at the first or second contact during the outreach phase of engagement. As the veteran becomes an enrolled PATH client, an assessment is completed identifying needs, such as untreated mental illness, health issues, lack of income and housing. PATH therapists link clients directly with mainstream services for issues exposed in the needs assessment. Services available to veterans include mental health, substance abuse, primary health, case management, employment, education and housing as identified in Section four of this application. PATH therapists directly link clients with services available to

PATH Site	Description of Services Provided to Veterans
	only veterans, such as the US Department of Veterans Affairs (VA) Medical Center in Washington, DC; the VA Healthcare for Homeless Veterans; and the VA case manager responsible for HUD VASH vouchers. Within the last three years, Friendship Place and Operation Renewed Hope Foundation have begun working with the PWC COC to identify veterans for housing opportunities. As the VA is designed to provide housing for honorably discharged veterans only, Friendship Place and Operation Renewed Hope Foundation can house veterans under any discharge status that is not dishonorable, thus opening the door for more overall veteran eligibility. In keeping with the emphasis to functionally end Veteran homelessness, PWC placed great emphasis on outreaching to the unsheltered homeless population to identify veterans to begin the process of securing housing.
Rappahannock Area	Through outreach and in-reach during community breakfast and dinner hosted by the Veterans of Foreign Wars and their veteran Stand Down Events the PATH Outreach Worker has multiple referral and outreach opportunities. Additionally the PATH Outreach Worker is in regular contact with the staff and leadership of the Virginia Veterans and Family Support, based at RACSB and through the Micah Hospitality Center, the PATH Outreach Worker meets weekly with the VA Representative.
Region Ten	PATH workers collaborate with The Haven's Virginia Wounded Warrior Program to ensure that Veterans experiencing homelessness are served through PATH. In addition, the Veterans Administration is represented on the Thomas Jefferson Area Coalition for the Homeless Continuum of Care committee.
Richmond	In past years, RBHA PATH had a PATH specific position to connect veterans experiencing homelessness to veteran appropriate resources. After that funding was eliminated, those tasks became a part of all PATH outreach staff. PATH staff work closely with CoC partners including the local Veterans Administration Medical Center Homeless Services Team, Virginia Department of Veterans Services, Virginia Veteran and Family Support, Virginia Supportive Housing, Homeless Point of Entry, Daily Planet, Department of Social Services, Richmond Behavioral Health Mental Health Services Division, and Homeward. Coordination of veteran services occurs on a case-by-case basis. In addition, all RBHA staff, including PATH outreach workers, will have completed Veteran/Military specific competency training by 6/30/2020.
Valley CSB	Potential PATH clients are asked about their veteran status upon initial intake to identify homeless veterans with SMI. PATH also coordinates with local shelter programs who also gather initial information on residents' veteran status. PATH staff will work to coordinate housing resources to homeless veterans as needed. PATH staff have worked with the Supportive Services for Veteran Families via the Total Action for Progress (TAP) located in Roanoke, VA, whereby the program can provide rapid rehousing assistance for homeless veterans in the Augusta County catchment area. PATH staff also works to connect homeless veterans to the local Staunton CBOC so veterans can access medical and psychiatric care. PATH staff also coordinates services with CBOC staff as needed to assist individual veterans in accessing appropriate care and services for which they are eligible.

PATH Site	Description of Services Provided to Veterans
Virginia Beach	PATH is continuously assessing individuals and families for veteran status. If the veteran is not currently connected or participating in VA services, they are assisted in registering at the Hampton VA Center. If they do not qualify for VA services the individual is assisted in contacting the Behavioral Health Services Pre Registration to schedule an appointment for services. We assist Veterans that are VASH eligible by helping them become document ready for housing. We also assist in finding financial resources for those that may need help with deposit and first month rent.

III. State Level Information

D. Alignment with PATH Goals

Narrative Question:

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

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Alignment with PATH Goals

Adults with SMI who are literally homeless are the priority population served by Virginia's PATH providers. Of the estimated 1,609 individuals to be enrolled by Virginia PATH during FFY 2020, approximately 87% are anticipated to be literally homeless. Along with housing placement and connection to mental health services, street/shelter outreach and case management have been among the highest service priorities of Virginia's PATH program since its inception. Over the years, these expectations have been communicated consistently to our PATH sites. The majority of Virginia's PATH providers operate in urban or urban/suburban areas and spend a significant proportion of staff time conducting street and shelter outreach in order to identify and engage individuals who are literally homeless. In those PATH coverage areas that are more suburban or rural, staff seek out unsheltered individuals who are living in wooded areas or encampments and shelters (where they exist in rural areas) to offer services. Literally homeless individuals with serious mental illness often need high levels of case management services in order to access services and supports, and it is for this reason that case management is such a high priority in Virginia's PATH program. For FY 2019, Virginia PATH programs reported providing case management services to 73% of individuals enrolled, and our expectation that street outreach and case management are priority services for PATH consumers will not change in the coming year.

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.

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Alignment with the State Comprehensive Mental Health Services Plan

PATH services, state-level outcomes, progress in service delivery, and relationship with other state agencies and providers to improve access to housing are included in the Comprehensive State Plan for Virginia DBHDS (2016-2022). In addition, PATH services complement the goals and vision statements described in the Comprehensive State Plan for Behavioral Health and Developmental Services (previously-referenced current edition 2016-2022); for example:

- *Engage with state agency partners to develop a broad strategy for expanding housing options for public clients and partner with private organization or other public agencies to develop single resident occupancy options. (p. 23)*

  Several Virginia PATH sites, through their agencies or partner organizations, have embarked on opportunities to expand housing options for their consumers through Safe Havens, Housing First projects, CoC homeless programs, DBHDS PSH funding, and Single Resident Occupancy (SRO) housing. DBHDS promotes Fair Housing training and advocacy as a tool for both acquisition and retention improvement in the competitive markets and in specialized programs. As usual practice, PATH sites provide housing acquisition services for their consumers and have some capacity to provide follow-up supportive services to help stabilize them in this housing for a short period of time.

  State Support for Permanent Supportive Housing: As of July 1, 2020, DBHDS will have been allocated a total of $17.3 million in State General Funds, with which we anticipate securing an estimated 1280 units of PSH in high-need areas across the state. Those PSH programs are often co-located at CSB's with PATH programs. On average, the first 1,212 individuals housed through these PSH resources spent 49% of their nights literally homeless the six months prior to being housed in DBHDS PSH. Only 18% of individuals spent even one night in stable housing before moving into PSH. Overall, 72% of clients had at least one experience of homelessness and 34% had at least one stay in treatment in the six month prior to being housed. In close collaboration and coordination with PATH providers, DBHDS PSH provides rental assistance and housing stabilization services to individuals with SMI who are homeless, institutionalized, or cycling through criminal justice, health, and behavioral health settings.

III. State Level Information

F. Process for Providing Public Notice

Narrative Question:

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

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Process for Providing Public Notice

Each year, Virginia's annual PATH application is posted on the PATH section of the DBHDS Website for comment. The site is easy to access, the plan is easy to find, and there is a link next to the plan that sends comments directly to the State PATH Coordinator. Once DBHDS has finalized the application for this year, this plan will replace the one currently on the website and will be available for public comment. Any comments received will be taken into consideration for next year's PATH plan and recommendations for substantive changes will be reported to CMHS for review. The Virginia PATH Program's website can be navigated from the main Virginia DBHDS website at http://www.dbhds.virginia.gov.

III. State Level Information

G. Programmatic and Financial Oversight

Narrative Question:

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

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Programmatic and Financial Oversight

The PATH Program is administered by Virginia's SPC, whose position is sited in the DBHDS Office of Community Housing (OCH). Financial oversight is provided by the SPC in collaboration with the DBHDS Fiscal Office through a standard Performance Contract with CSBs. A Program Administrator, who reports to the SPC, also assist with PATH administration through coordination of SOAR, provider monitoring, and technical assistance. The SPC reviews program applications and annual reports; orients new PATH workers, supervisors and/or PATH sites to state and federal PATH policies and procedures; assists PATH sites with program development and transition; provides technical assistance by telephone, written correspondence, and on-site monitoring and technical assistance visits. The SPC also assists in inter-agency communications and network building; promotes program development that would benefit PATH consumers; assist in accessing housing development and supports funding; represents DBHDS on homeless services and permanent supportive housing coordinating bodies.

The two primary tools used by the SPC for programmatic oversight are site visits and quarterly performance monitoring. With the additional capacity provided by the new Program Administrator position, all sites will receive periodic on-site reviews and be rated on their compliance with expectations. In past years, Virginia's SPC was unable to conduct annual site visits with each program due to state budget cuts and downsizing in the DBHDS Central Office. However, now, on-site reviews will be conducted annually as well as needed when issues are identified, when a major change in program staff necessitates an on-site training and orientation session, or as part of regular monitoring and oversight activities which DBHDS undertakes annually with selected CSBs. If necessary, sites with significant performance issues would placed under a corrective action process and their continuance in the program is contingent on successful completion of corrective actions. Sites with less significant issues are provided with correspondence which includes recommendations for improvement and a request for evidence that these areas of improvement have been addressed. The SPC also works closely with the Federal Grants Manager to reconcile the overall PATH budget monthly.

III. State Level Information

H. Selection of PATH Local-Area Providers

Narrative Question:

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

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Selection of Local-Area Providers

Virginia's PATH funds historically have been allocated to sites using a formula that creates a need score for each of the PATH sites. That score combined the HUD Homeless Assistance Pro-rata for each community and the PATH-targeted disabled homeless subpopulations. The population estimations identified in the previous section also provide guidance for the targeting of need areas.

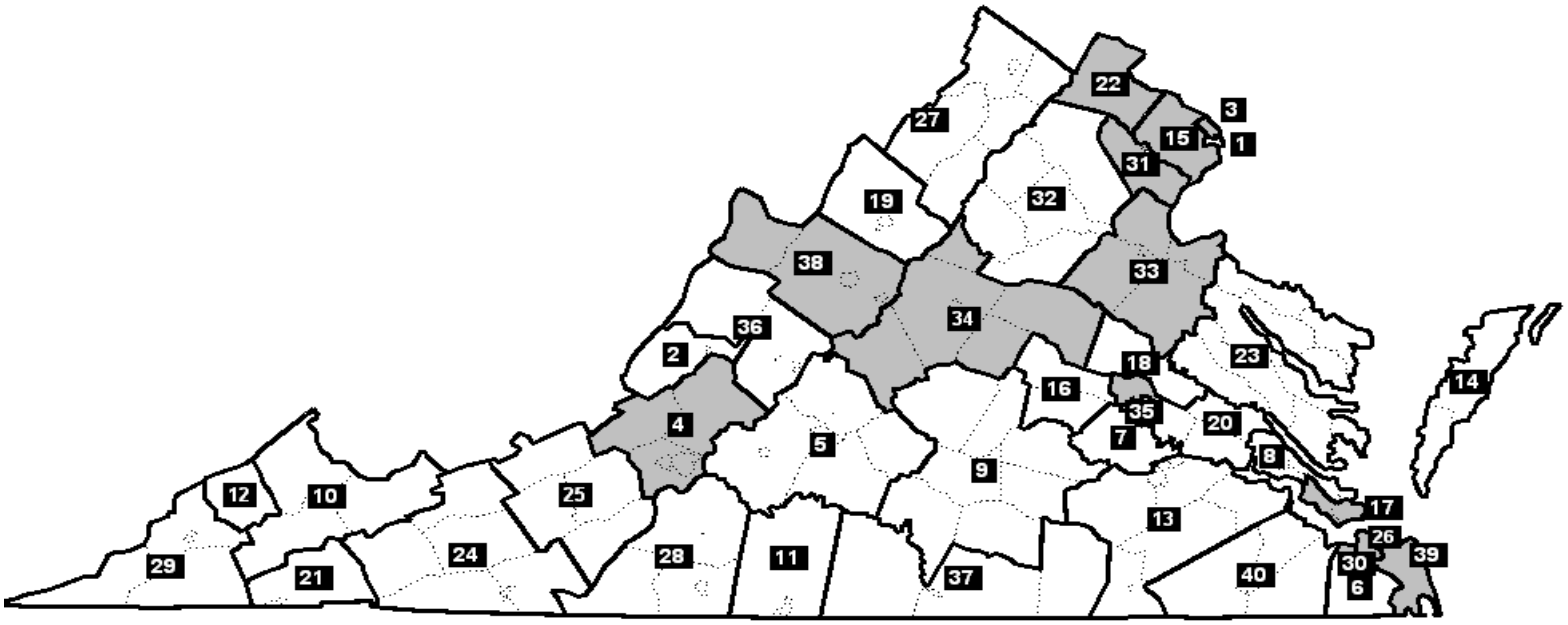
Currently, all Virginia PATH programs are sited in community mental health centers that receive their base funding through electronic warrants from DBHDS twice monthly from September through August. Current PATH sites include all major metropolitan areas, covering at least 56% of the estimated eligible population. There are four CSB service areas that have significant estimates of a homeless SMI population but are not current PATH sites (see chart, next page).

- Chesterfield and Henrico counties are suburbs of the City of Richmond, which reports serving persons from the suburbs as they come to Richmond to seek shelter and services. In FFY 2017, these jurisdictions received limited PATH services designed to identify homeless veterans as part of the PATH-Virginia Veteran and Family Support (VVFS) collaboration which is being implemented by jointly by Richmond Behavioral Health Authority and VVFS. Non-veteran homeless individuals with SMI identified during outreach efforts in those jurisdictions will be referred to appropriate services.

- The City of Chesapeake is adjacent to Norfolk, Portsmouth, and Virginia Beach. The Norfolk site serves a high portion of Chesapeake residents as limited shelter is available in Chesapeake and individuals often cross jurisdictional lines to seek shelter in Norfolk, which has a much larger number of shelter beds. In the winter, these three PATH site areas have winter shelter that accommodates persons from across the region.

- The New River Valley CSB catchment area is adjacent to the Blue Ridge/Roanoke and the Piedmont areas. Roanoke serves as the hub for homeless services in the western area of the state.

Virginia's FFY 2020 PATH Covered Service Regions



Community Service Board Service Area Identifications – Shaded Areas Indicate Current PATH Coverage Areas

1 Alexandria
2 Alleghany Highlands
3 Arlington
4 Blue Ridge
5 Central Virginia
6 Chesapeake
7 Chesterfield
8 Colonial
9 Crossroads
10 Cumberland Mountain
11 Danville-Pittsylvania
12 Dickenson
13 District 19
14 Eastern Shore
15 Fairfax-Falls Church
16 Goochland-Powhatan
17 Hampton-Newport News
18 Hanover
19 Harrisonburg-Rockingham
20 Henrico Area
21 Highlands
22 Loudoun
23 Middle Peninsula-Northern Neck
24 Mount Rogers
25 New River Valley
26 Norfolk
27 Northwestern
28 Piedmont
29 Planning District 1
30 Portsmouth
31 Prince William
32 Rappahannock-Rapidan
33 Rappahannock Area
34 Region Ten
35 Richmond
36 Rockbridge Area
37 Southside
38 Valley
39 Virginia Beach
40 Western Tidewater

III. State Level Information

I. 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.

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Location of Individuals with SMI who are Experiencing Homelessness

Current numbers of homeless persons with serious mental illness in Virginia is estimated to be 17,909 (method described below). Geographic regions for this report are identified by Community Service Board (CSB) service regions. There are 40 CSBs that cover the entire state. The estimate for each CSB service region is indicated on the table below; the geographic location and area is demonstrated on the map in Section G of the application. In both the table and the map, 14 current PATH service areas are indicated with shading. Note that one service area, that of the Charlottesville/Albemarle County area, also includes a sub-contracted consumer-run organization.

DBHDS compiles population estimates for each CSB service area and determines the estimated number of adults with SMI based in each area for the Comprehensive Plan. The estimate of the number of adults age 18 and over with serious mental illnesses was developed using the National Survey on Drug Use and Health's estimate of 4.2%. This percentage was applied to the Virginia 2019 Estimated Population data released by the University of Virginia's Weldon Cooper Center for Public Service to estimate that 3,58,178 adults in Virginia had a serious mental illness in 2019. The homeless/at-risk prevalence estimates are derived by calculating 5% percent of the SMI population (Task Force on Homelessness, 1992 and Blueprint for Change, 2003). The table on the following page represents the current estimates based on this methodology.

Estimates of Homeless Individuals with Serious Mental Illness

(Shaded Rows are PATH Communities)

CSB Name	2019 Adult Population Estimate	SMI Adult Population Estimate (4.2%)	Homeless/At-risk estimate (5% of SMI)	2019 PIT SMI Adults
Alexandria CSB	159,152	6,684	334	50
Alleghany Highlands CSB	20,646	867	43	
Arlington County CSB	242,152	10,170	509	75
Blue Ridge Behavioral Healthcare	257,118	10,799	540	28
Chesapeake Integrated Behavioral Healthcare	245,745	10,321	516	
Chesterfield CSB	350,760	14,732	737	
Colonial Behavioral Health	173,092	7,270	363	
Crossroads CSB	102,529	4,306	215	
Cumberland Mountain Community Serv.	89,457	3,757	188	
Danville-Pittsylvania Community Services	100,934	4,239	212	
Dickenson County Behavioral Health Serv.	14,299	601	30	
District 19 CSB	172,366	7,239	362	
Eastern Shore CSB	44,371	1,864	93	
Fairfax- Falls Church CSB	1,181,802	49,636	2,482	205
Goochland-Powhatan Community Services	53,339	2,240	112	
Hampton-Newport News CSB	316,753	13,304	665	48
Hanover County CSB	107,928	4,533	227	
Harrisonburg-Rockingham CSB	136,205	5,721	286	
Henrico Area Mental Health and Developmental Services	359,081	15,081	754	
Highlands Community Services	70,435	2,958	148	
Horizon Behavioral Health	262,428	11,022	551	
Loudoun County Dept. of MH, SA and Developmental Serv.	413,546	17,369	868	17
Middle Peninsula-Northern Neck CSB	145,750	6,122	306	
Mount Rogers CSB	116,046	4,874	244	
New River Valley Community Services	184,532	7,750	388	
Norfolk CSB	245,054	10,292	515	71
Northwestern Community Services	238,150	10,002	500	
Piedmont Community Services	137,346	5,769	288	
Planning District One Behavioral Health Services	87,333	3,668	183	
Portsmouth Department of Behavioral Healthcare	94,581	3,972	199	3
Prince William County CSB	523,891	22,003	1,100	38
Rappahannock Area CSB	372,270	15,635	782	26
Rappahannock-Rapidan CSB	166,971	7,013	351	
Region Ten CSB	257,452	10,813	541	24
Richmond Behavioral Health Authority	226,841	9,527	476	124
Rockbridge Area Community Services	40,704	1,710	85	
Southside CSB	81,538	3,425	171	
Valley CSB	125,231	5,260	263	39
Virginia Beach CSB	452,643	19,011	951	75
Western Tidewater CSB	157,590	6,619	331	
Population Sub-totals	**8,528,061**	**358,179**	**17,909**	**823**

* PIT (Point in Time) Count = total for larger CoC area, which may include jurisdictions not in the CSB catchment area.

1) Based on 2019 Population Estimates from the Weldon Cooper Center for Public Service at the UVA.
2) The SMI prevalence rate formula above is as described in the Virginia 2016-2022 Comprehensive State Plan.
3) Homeless/At Risk SMI numbers = 5% prevalence estimates (Blueprint for Change, 2003)

III. State Level Information

J. Matching Funds

Narrative Question:

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

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Matching Funds

Virginia's PATH programs are sited within Community Mental Health Centers, which are a component of our local-area CSBs. Their CMHC status provides a range of funding, including state general funds, local funds, Medicaid and other reimbursements, federal and state grants, fees paid by recipients, and other sources. Each provider is required to match its federal PATH award with a minimum of 33% of local resources, which include state general funds, local revenue sources, and in-kind contributions. All CSBs who are allocated PATH funds have identified the source of their local match, and provided assurance that required match funds will be available as of the start of the PATH program year on September 1, 2020. As is evident in our detailed program budget, a number of Virginia's PATH sites match at a higher percentage than the minimum; as a result, the Commonwealth's total match far exceeds the required 33%. Virginia's PATH match for FFY 2020 is 64% of our federal award total.

III. State Level Information

K. Other Designated Fundings

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.

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Other Designated Funding for PATH-Eligible Persons

As previously mentioned, the Office of Community Housing houses both PATH and a state funded PSH program for individuals with SMI. DBHDS PSH is intended to address high priority issues for individuals with SMI: homelessness and institutionalization. As of July 1, 2020, DBHDS will have been allocated a total of $17.3 million in State General Funds, with which we anticipate securing an estimated 1280 units of PSH in high-need areas across the state. Those PSH programs are often co-located at CSB's with PATH programs.

Furthermore, state funding can be used to provide direct services, housing supports, local match for HUD Continuum of Care projects, and other services for homeless consumers with serious mental illness. Community Service Boards use State general funds to match PATH program services in those areas that have PATH sites and they do support services to consumers who are identified and referred through PATH. In addition, approximately 75% of Virginia's annual Community Mental Health Services Block Grant (MHBG) award is allocated to CSBs to support services for adults with SMI. However, like State general funds, CSBs' MHBG allocations are not specifically designated for individuals with SMI who are homeless.

Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds are not generally used to fund PATH services. However, starting in SFY 2011, DHBDS has provided additional Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds to the City of Virginia Beach to address the needs of adults with substance use disorders who experience chronic homelessness. Due to the nature of the Virginia Beach community, which is a popular East Coast vacation spot with mild weather and a well-coordinated homeless service system, Virginia Beach has a large number of chronically homeless individuals with serious substance use disorders who are ineligible for PATH services because they do not have serious mental illness. In order to address the needs of this population, in March 2011, DBHDS began providing SAPTBG funds to the City of Virginia Beach to fund a "Substance Abuse PATH" project to operate in conjunction with the Virginia Beach PATH Program. Virginia Beach is using this SAPTBG award to fund an additional half-time "SA PATH" outreach worker who concentrates specifically on providing PATH-type services such as outreach, engagement and case management services to this population, and also to support the cost of substance abuse treatment, housing assistance and other needed services. Most of these individuals are originally identified by the Virginia Beach PATH Program during outreach activities, so PATH Program staff are able to make immediate referrals to the SA PATH worker when they determine that an individual is ineligible for formal PATH enrollment. In addition, the SA PATH worker is benefiting from the collaboration with Virginia Beach PATH staff in identifying services and resources for these consumers.

Lastly, the Virginia Department of Housing and Community Development (DHCD) administers the Virginia Homeless Solutions Program (VHSP) and VA Housing Trust Fund Homeless Reduction Grant which both constitute close to $18 million in state general funds to support the development and implementation of localized emergency crisis response systems with housing-focused, coordinated community-based activities. These activities are designed to reduce the overall length of homelessness in the community, the number of households becoming homeless and the overall rate of formerly homeless households returning to homelessness. PATH

providers are active members of their applicable Continuums of Care (CoC) responsible for locally administering the state general funding available through VA DHCD and the CoC's are tasked with ensuring the most vulnerable Virginians experiencing homelessness, including those with SMI, are prioritized for assistance.

III. State Level Information

L. Data

Narrative Question:

Describe the state's and providers' participation in HMIS and describe plans for continued training and how the state will support new local-area providers. For any providers not fully participating in HMIS, please include a transition plan with an accompanying timeline for collecting all PATH data in HMIS.

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

Data and PATH HMIS Implementation

At present, DBHDS is not involved in funding, utilizing or operating HMIS at the state or local level. The Virginia Department of Housing and Community Development (DHCD), the state agency which administers a continuum of state- and federally-funded homeless service programs to address housing and stabilization services for individuals and families at-risk of or experiencing homelessness in the commonwealth, is the only state agency with HMIS involvement. Communities receiving funds from those programs are required to utilize HMIS to report data, and DHCD contracts with Homeward, a Richmond-area organization that manages HMIS data collection and reporting for the Richmond and Fredericksburg Continuua of Care as well as the "Balance of State," which is comprised of those Virginia communities that do not have their own Public Housing Authority. Three PATH communities are represented in that HMIS data system, but Virginia has no consolidated statewide HMIS system which encompasses all areas served by PATH.

In order to meet SAMHSA's requirement that PATH annual report data be submitted through HMIS by the end of State Fiscal Year 2017, DBHDS and the 14 CSBs providing PATH services received joint technical assistance from the SAMHSA Homelessness Resource Network and the HUD technical assistance provider ICF International. This technical assistance effort was invaluable to the SPC and Virginia's PATH providers in assisting the state program as a whole to move to PATH HMIS data entry and reporting. As of June 2017, all Virginia PATH teams were entering PATH data into HMIS.

The SPC reviewed the PATH Data Collection Workflow, outlined in the PATH Program HMIS Manual, with all programs in an all-provider call to ensure that PATH providers and HMIS administrators know the expectation for data collection throughout the process of initial contact, engagement, enrollment, and project exit. This was coupled with the work done as a part of the State PATH Contact HMIS Data Collection Decision Tool and other data collection coordination practices (streets outreach policy, record-building protocols). DBHDS will continue to work with SAMHSA, HHRN, and PATH providers to improve the quality of PATH HMIS data.

DBHDS will continue to work with local providers and with Housing and Homelessness Resource Network (HHRN) HMIS experts to discuss HMIS reporting and to resolve issues, as necessary. DBHDS and local providers participate in the PATH HMIS Learning Collaboratives and the SPC relays information from these meetings to providers.

III. State Level Information

M. Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, 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. If the state does not use SOAR, describe state efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner.

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

SSI/SSDI Outreach, Access and Recovery (SOAR) Initiative

Virginia's SOAR efforts began in 2005, when three PATH sites began implementing the SOAR model through the Virginia PATH SSI Outreach Initiative. As of July 2019, there were fifteen active SOAR communities in Virginia, with 584 SOAR-trained workers across the Commonwealth, and 149 of those individuals are actively processing cases (at least two per year as required). Also through July 2019, twelve of the fourteen PATH providers had a total of twenty-one SOAR-trained staff; and, the other two providers without currently trained staff are receiving training in June 2020.

In 2011, DBHDS developed a State SOAR Coordinator (SSC) role to help strengthen the Virginia SOAR Program and increase successful benefits processing. The SSC position was designed to coordinate and strengthen the relationships and communication between the partners involved in the Virginia SOAR network with the goal of continually expanding Virginia's SOAR efforts. The SSC's responsibilities included providing SOAR-related training and technical assistance to existing and new SOAR sites, overseeing collection and reporting of SOAR outcome data to state and federal partners, and working with other state and community agencies to strengthen and expand SOAR services in Virginia. Since DBHDS created this position in September 2011, the SOAR project in Virginia has thrived and expanded. Virginia's SSC worked with the SOAR sites in existence at that time (all of which were PATH programs) to strengthen their data collection and reporting effort and improve collaboration with the Social Security Administration and Disability Determination Services (DDS). In addition, the SSC worked to expand SOAR to numerous other areas of the state where PATH services are not offered and has been collaborating with several local Continuum of Care to provide technical assistance on developing a SOAR initiative.

In May of 2017 the prior SSC left her position and DBHDS determined that, given the expansion of SOAR in the state and the fact that the SOAR Coordinator no longer manages SOAR data collection and reporting, there was no longer the need for a full-time position for SOAR in Virginia. The position was modified into the existing Housing and Benefits Coordinator role and Georgi Fisher was hired into this role in late February of 2018. The position focuses both on SOAR training and technical assistance and PATH and Permanent Supportive Housing (PSH) provider monitoring and support. This position meets the need for SOAR oversight in Virginia while also providing assistance to localities in expanding SOAR services as well as ensuring that PATH and PSH programs are monitored and supported.

Since Georgi's arrival in February 2018, the SOAR project, in collaboration with the Virginia Social Security Administration, has successfully developed a streamlined, standardized process for accepting and processing SOAR applications at local Social Security Field Offices. This new standardized processing addresses delayed processing times and lost applications, ensuring SOAR cases are identified, processed and approved within a 90-120 day window. Virginia SOAR collaborates with three SSA Regional Representatives, whose role is to ensure SOAR-assisted claims in each of their umbrella areas process through SSA within 14 days, are flagged appropriately, and are transferred to the DDS SOAR unit in the appropriate region. The SSA Regional Representatives also offer technical assistance, troubleshooting, and overall oversight to ensure SOAR-assisted applications move quickly through the application process. Virginia's

SOAR project also uses four Regional DDS Professional Relations Officers (PROs), whose role is to track submitted SOAR-assisted claims, assign them to SOAR analysts, and provide technical assistance. VA's SSA/DDS partners join in monthly regional meetings, gathering with SOAR workers to troubleshoot process and technical issues and also offer direct access to SOAR workers for immediate assistance.

Virginia SOAR saw a ten percent increase in the initial approval rate in the first year using this collaborative relationship. Where the state used to struggle with SOAR-assisted claims getting lost at a local office or an SSA-1696 not being associated with cases, the SSA Regional Representatives have reduced the barriers and delays associated with these issues. Claims are moving quickly through the process, being flagged appropriately as SOAR, and communication has greatly improved between SSA and SOAR workers. The DDS PROs have a collaborative relationship with the SOAR workers in their community. When a SOAR claim is submitted, the DDS PRO is notified. The PRO, in turn, tracks the case from SSA to ensure it lands in the SOAR unit and is assigned to a SOAR analyst for processing. Like the SSA Regional Representatives, they have eyes on the case from start to finish, which alerts them to delays or case processing issues. The PROs also offer in-depth technical assistance when a claim is heading toward denial, letting the worker know what evidence is needed to meet listing criteria, or where there is missing functional information. The collaborative project also includes regular contact with an assigned representative from the SSA Area Director's Office who is instrumental in helping us develop new systems and policies to assist in expedited and effective processing of SOAR-assisted claims. Continued quarterly meetings between the Local Leads, SSA Regional Representatives, DDS PROs, and the Area Director's Office allow us to continue to build the partnership to better serve the SOAR claimants.

Virginia's SOAR program implements a Local Lead structure and has trained fifteen Local Leads through the SAMHSA SOAR TA Center's Leadership Academy thereby providing local leadership and support for the SOAR initiative in regional communities. Monthly SOAR meetings are conducted in each of the five Community Services Board regions which brings together community SOAR workers, Community Services Board staff, and SSA/DDS representatives to continue strategic planning to improve SOAR outcomes across the state. In 2019, ten SOAR Course Certification Sessions were completed in the five regions certifying over 200 SOAR case managers, including planning, registration and follow-up for each training. Similarly, 584 individuals received the initial training for SOAR. As a result, the initial approval rate for SOAR in Virginia went from 67% in FFY 2018 to 76% in FFY 2019.

The first statewide SOAR Leadership Summit took place in 2019 which brought together SOAR Local Leads, SSA, DDS and national experts from SAMHSA to improve system coordination and planning for SOAR in the state in Virginia. In February 2020, Georgi presented at the National Alliance to End Homeless Conference on SOAR System Building and Partnerships and was selected in 2019 as a member of the SOAR Expert Panel, a selection of contracted subject matter experts from across the country under the SOAR National Technical Assistance Grant held by PRAI from through SAMHSA. Her expertise was also requested by the National Healthcare for the Homeless and she presented at their 2019 conference on SOAR Collaboration and Systems Planning.

Additionally, the SOAR project, in collaboration with the SOAR TA Center, DBHDS, and state psychiatric hospitals has begun development of a Pre-Release Process, focused on the implementation of Pre-Release Agreements between SSA and local state psychiatric hospitals, as well as SOAR training for all hospital-based benefits workers. This process addresses barriers to discharge for individuals with SMI and chronic homelessness, while also reducing census and the use of Discharge Assistance Planning (DAP) and increasing successful linkage to PSH programs.

This process has also crossed over to the implementation of the first Forensic Discharge Planning pilot project for the State of Virginia. DBHDS implemented a pilot project in two regions, pairing Discharge Planners in local and regional jails with a focus on pre-release linkage to housing and benefits. The Virginia SOAR Program has trained all twelve of the Forensic Discharge Planners (FDP) to utilize SOAR in pre-release applications. This process utilizes the same streamlined, expedited processing through Regional Representatives and Professional Relations Officers (PROs). In the first year of implementation, the FDP project has had an average approval rate of 80%, with an average processing time of 100 days. To date, they have also been successful in recouping $45,515 in back payments through SSA. Virginia will continue to expand the reach of this project as the program pilot project is expanded throughout the state.

These initiatives, along with continued outreach and technical assistance, have prompted Virginia as being identified as a SOAR Top 10 State in 2018 and, again, in 2019 for being in the top twenty percent of SOAR communities in the country for outcomes and processing times. Overall, Virginia’s state SOAR efforts have remained fruitful; Virginia continues to achieve a high approval rating, again, with a 76% initial approval rate for initial SOAR applications in 2019, well above the national average of 65%.

SOAR WORKS

SAMHSA
Substance Abuse and Mental Health Services Administration

2019 National Outcomes

2019 Outcomes

INITIAL APPLICATIONS

63% approval rate

4,273 initial approvals

108 days to decision on average

APPEALS

42% approval rate

667 appeals approvals

187 days to decision on average

Cumulative Outcomes

65% cumulative initial approval rate

43,486 cumulative initial approvals

6,591 cumulative appeal approvals

50,077 people receiving benefits because of SOAR

Financial Outcomes

$3,714 average back payment received by individuals (2,731 cases reporting)

$6,482 average Medicaid reimbursement per beneficiary (214 cases reporting)

$463M brought into the economies of the participating localities

Top States

81% approval rate

TOP 10 STATES*

Pennsylvania
Tennessee
Maryland
Arkansas
North Carolina
Oklahoma
Virginia
South Carolina
Nevada
Louisiana

The SSI/SSDI Outreach, Access, and Recovery (SOAR) Technical Assistance (TA) Center is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults and children who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder.

Contact SOAR: soar@prainc.com | (518) 439-7415 x2 | https://soarworks.prainc.com/

*Inclusion: Highest cumulative approval rates on initial application for states with at least 300 cumulative decisions, at least 24 decisions in 2019 (2 per month), and a 2019 approval rate above the national average. Combined, these states had 15,757 decisions.

SOAR WORKS VIRGINIA

SSI/SSDI Outreach, Access, and Recovery (SOAR) is a national initiative designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness, medical impairment, and/or a co-occurring substance use disorder. SOAR seeks to end homelessness and promote recovery through increased access to income supports, housing, and an eventual return to work.

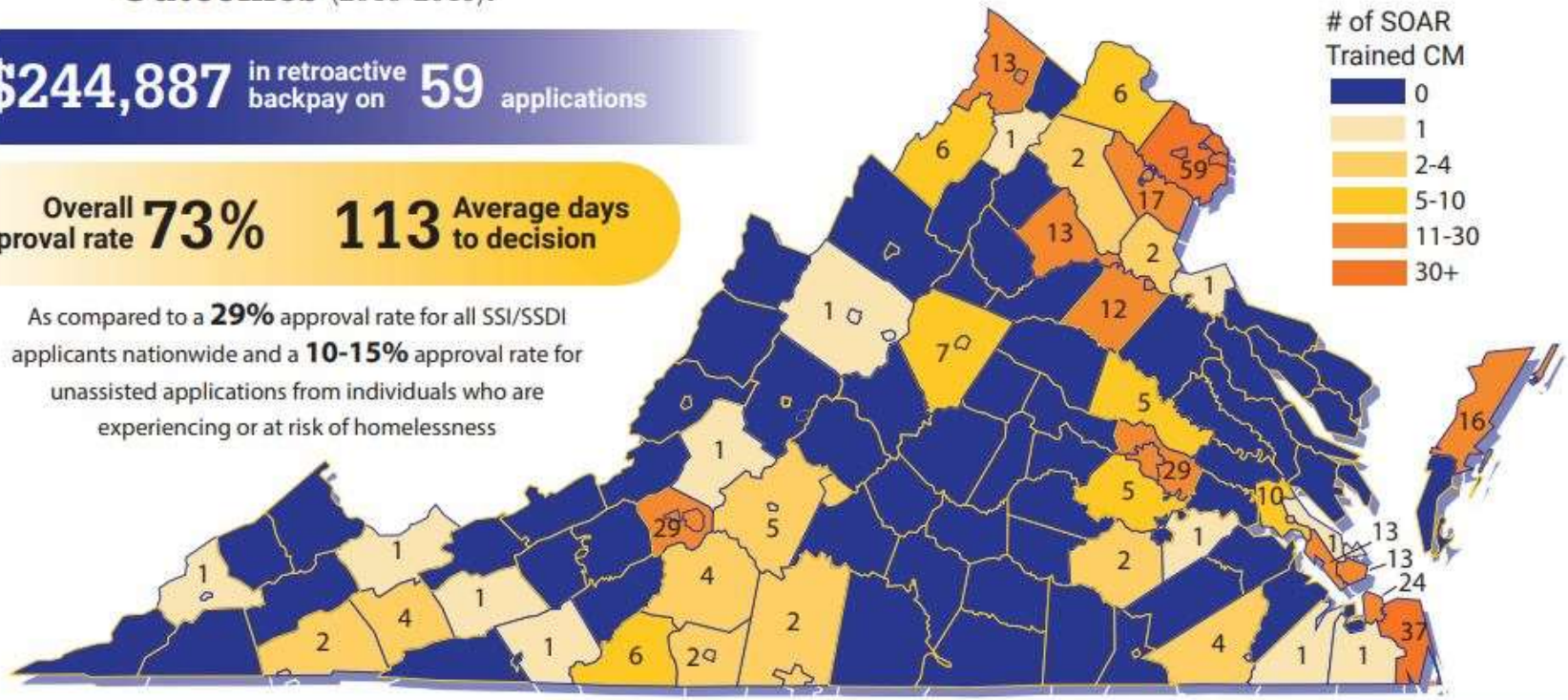
Outcomes (2018-2019):

$244,887 in retroactive backpay on **59** applications

Overall approval rate **73%**

113 Average days to decision

As compared to a **29%** approval rate for all SSI/SSDI applicants nationwide and a **10-15%** approval rate for unassisted applications from individuals who are experiencing or at risk of homelessness



How to Become Involved

If you're interested becoming involved with the Virginia SOAR initiative please review *Getting Involved with SOAR* (https://soarworks.prainc.com/sites/soarworks.prainc.com/files/Getting_Involved_with_SOAR-Adult-and_Child.docx) and reach out to the Virginia SOAR State Team Lead Georgi Fisher (georgi.fisher@dbhds.virginia.gov) or the Virginia SAMHSA SOAR TA Center Liaison Abigail Kirkman (akirkman@prainc.com).

III. State Level Information

N. PATH Eligibility and Enrollment

Narrative Question:

Describe how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented.

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes:

M. PATH Eligibility and Enrollment

Historically, DBHDS has worked diligently to ensure that PATH providers understand program eligibility, adopt policies to support engagement and enrollment of eligible individuals, and document eligibility as PATH workers build rapport with individuals receiving services. PATH staff have a range of qualifications including peers with lived experience with homelessness, Qualified Mental Health Professionals (QMHPs) and Licensed Mental Health Professionals (LMHPs). Regardless the qualification of the PATH workers, all PATH providers are embedded in local Community Services Boards (CSBs), the single point of access for Virginia's public mental health system. This structure allows PATH to assist individuals with accessing a range of assessment, evaluation, and treatment from behavioral health professionals, including LMHPs who can verify the presence of a serious mental illness (SMI) according to the DBHDS definition.

PATH programs are deeply embedded in the homeless services continuums in their community and all conduct street outreach and shelter in-reach. As a result they are able to verify homelessness through direct observation of the individual's living situation and through access to HMIS to verify histories of homelessness. As homeless points of entry are consistently requiring documentation of homelessness or at risk status to access shelter and housing resources, PATH workers are adept at understanding the PATH and HUD definitions of homelessness and verifying this status in HMIS and in the PATH record.

PATH programs also understand that PATH resources are designated for individuals who meet the DBHDS definition of having a serious mental illness and/or co-occurring substance use disorder. PATH providers describe a process of engaging individuals, building rapport, and using their training and expertise to determine that an individual appears to have an SMI. If the individual is interested in PATH services, providers explore sources available to them to determine if an SMI determination has already been made by a licensed clinician. These records include their own CSB electronic health records, private provider records including free clinics or federally qualified health centers, and hospital records. A recent evaluation that verifies all of the components of the SMI definition would support PATH enrollment and be noted in the PATH record. If such documentation is not available, a PATH worker who is an LMHP may conduct the clinical evaluation, or the PATH worker will assist the individual with accessing a clinical evaluation through the CSB intake process. Virginia has recently mandated that CSBs provide Same Day Access for mental health services, and PATH-engaged individuals have benefitted from the streamlined access to clinical services that this approach provides. If PATH providers are unable to obtain verification of SMI, they understand that the individual is not PATH-eligible.

Over the last year, the SPC has worked with PATH providers and HMIS administrators using the framework presented in the State PATH Contact HMIS Data Collection Decision Tool to ensure that the applicable data elements are defined consistently throughout the state to improve the quality and accuracy of aggregate data and PATH program implementation. As a part of this work, other areas of data collection coordination, including HMIS street outreach policy and record-building processes, are actively being locally addressed and/or implemented in conjunction with the assistance of the SPC.

PATH Reported Activities

Charitable Choice for PATH

Expenditure Period Start Date: Expenditure Period End Date:

Notice to Program Beneficiaries - Check all that apply:

- ☐ Used model notice provided in final regulation.
- ☐ Used notice developed by State (please attach a copy to the Report).
- ☐ State has disseminated notice to religious organizations that are providers.
- ☐ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☐ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA's Treatment Facility Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.
- ☐ _____ Enter total number of referrals necessitated by religious objection to other substance abuse providers ("alternative providers"), as defined above, made in previous fiscal year. Provide total only no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

Not Applicable - please see attachment area for signed form

FY 2020 PATH FOA Catalog No.: 93.150 FOA No.: SM-20-F2 Approved: 03/09/2020

Footnotes: