211 San Bernardino County CES

By: Marisela Manzo

"I'm too small to make the call"

To Report Child Abuse in San Bernardino County

Dial 211
or 800-827-8724

Para Reportar el Abuso de Niños en el Condado de San Bernardino
Marque el 211 o 800-827-8724

FIRST 5 SAN BERNARDINO — United Ways serving San Bernardino County / United Way — Children's Network — San Bernardino County Children and Family Services — 211 Get Connected. Get Answers.

IE♥HP
A Public Entity
Inland Empire Health Plan

♥211 Community Connect

FREE 24 Hour Breastfeeding Helpline
Baby's Optimal Nutrition with Ultimate Support (BONUS)
Speak with an International Board Certified Lactation Consultant (IBCLC) for help with feeding your child!
DIAL 2-1-1
FIRST 5

Stronger Hearts™ Helpline

County of San Bernardino **Reentry COLLABORATIVE**

United Way

COUNTY OF SAN BERNARDINO PRESCHOOL SERVICES DEPARTMENT

California **211** Get Connected. Get Answers.

Medi-Cal

cal fresh — BETTER FOOD FOR BETTER LIVING

211 RIDE

CONNECT IE

PATHWAYS HOME™
Housing Coordination Program

2-1-1 VetLink

SAN BERNARDINO COUNTYWIDE Vision 2 Read IT'S UP TO US!

Partners in Hope
SAN BERNARDINO COUNTY CHILDREN AND FAMILY SERVICES

COUNTY OF SAN BERNARDINO DEPARTMENT OF PUBLIC HEALTH

2-1-1 CAREERS Navigate Your Future

Community Action Partnership SBC	Knowledge and Education for Your Success
Catholic Charities	Life Community Development
Central City Lutheran	Lighthouse Social Service Centers
Central City Lutheran Mission	Mercy House
Citi Link	New Hope Village, Inc.
Homeless Management Information System	Rialto PD
Housing Authority County of San Bernardino	Redlands PD
Family Services of Redlands	Salvation Army
Foothill AIDS Project (FAP)	Sheriff's HOPE Team (Street Outreach Entity)
Foothill Family Shelter	Step Up on Second
Frazee Community Center	Time for Change Foundation
Global One Development Center	United Way 211 (Coordinating Entity)
High Desert Homeless Services	U.S. Vets
Inland Housing Inland Valley Hope Partners	Upland Community Restoration Team

The coordinated system

PATHWAYS HOME™
Housing Coordination Program

The Coordinated Entry System (CES) is a powerful tool designed to ensure that homeless persons are matched, as quickly as possible, with the intervention that will most efficiently and effectively end their homelessness when there is availability.

PATHWAYS HOME™
Housing Coordination Program

United Way

Pathways Home is San Bernardino County's groundbreaking collaboration between more than 30 agencies within the Homeless Partnership with the express purpose of creating sustainable, cost-effective, client centered pathways out of homelessness and diverting them into community resources or self-resolve.

Prioritization?

San Bernardino County Focus

❑ Veterans

❑ Chronically Homeless People

❑ Unaccompanied Women

❑ Unsheltered Children

Implementation Of the System
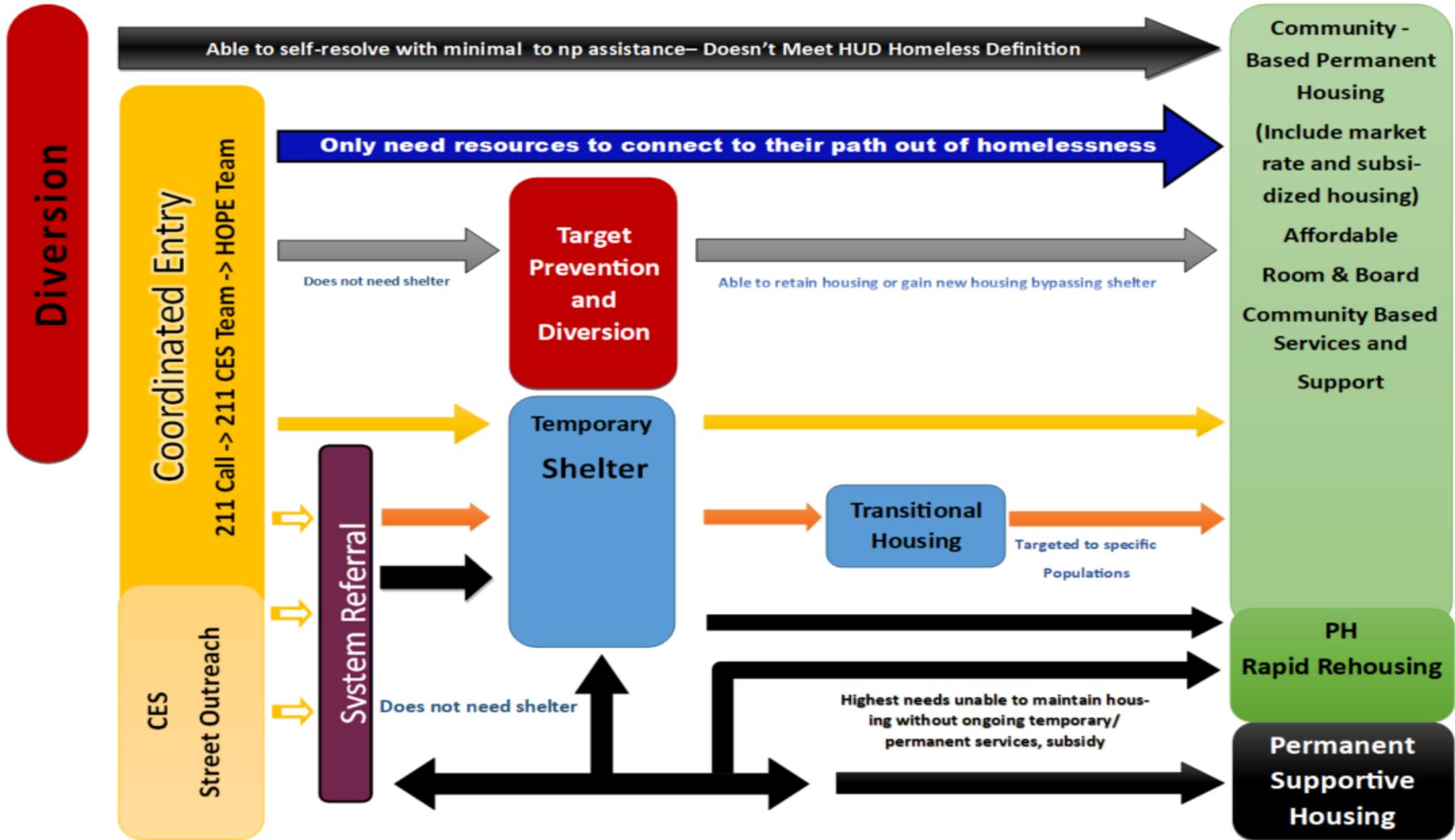
CES Focus

Our focus is to assist in coordinating those who are **literally homeless continuously** into housing resources as available

211 Housing Coordinator's

* Assess Client for intake or diversion

* Identify, match and refer client to available housing resource

* Identify mainstream resources for additional service referrals

* Outreach- Engage the community
    * Providing guidance : Clothing, snacks, shower etc…, on the field

* Identify Gaps with data

* Align Resources

* Report to ICH / HUD

* Provide 3-digit access for public and direct connection for partners
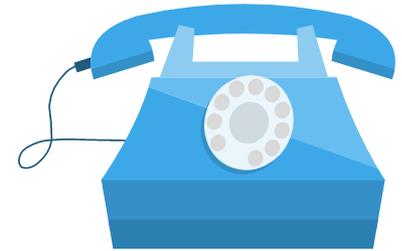
Working with Vulnerable Population

We strive to work with the most vulnerable population in the San Bernardino County. As outreach workers we treat individuals with dignity and provide information to help them survive the best they can in their situation. It is vital to recognize the strength and resilience of each person to survive 100% of their hardship thus far.

Outreach:

- We make a list of people we are verifying and reach out the day before.

- We call them when we are on our way when we have a teammate

- Our goal is to verify their living situation to continue the process and sign consents (4 documents) to share their information with the programs we work with.

- **Based on availability we can provide:** Hygiene Kits, Food Kits, ID Vouchers, Bus Passes, Gas Cards, Pet Food and 211 resources

The reality is:

1. We get about 310 referrals a month for follow-up and call back's for CES we only have the capacity to do 100 assessments a month and the availability to do 5-10 referrals a month.

2. Meaning for the remaining 90 household or so we have to divert from the system.

3. Most programs may be able to help if they find a landlord that will take them with Deposit and First month rent only

4. What is their goal to increase their income: Employment referrals – Some programs will only help with 1st month rent and deposit or the max of 3 month's.

Outreach
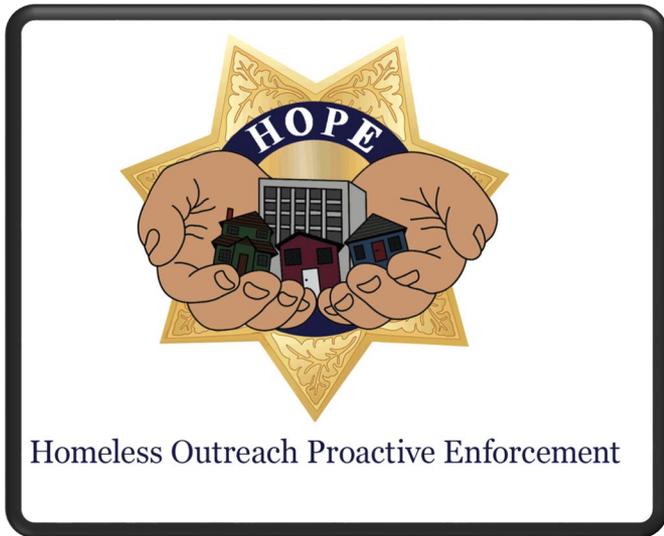
Identify and assess people facing homeless in the field

Connected with outreach across the county identify resources and connections

Able transport clients to housing programs is available

SBC CES Housing Search & Stabilization

Housing Identification and Placement (HIP) Squad

- **Identify and recruit landlord partners**

- **Develop a pipeline of available units for people facing homelessness with a priority of service-engaged veterans & chronically homeless**

- **Help resolve landlord-tenant issues as they arise with organizations**

All PSH and RRH Service Partners

- **Assist clients with removing barriers and connect with available rental units**

- **Secure tenant-based rental and move-in financial assistance**

- **Assist clients with housing stabilization case management**

VI-SPDAT & VI-F-SPDAT
Vulnerability Index Service Prioritization Decision Tool for Individuals and Families

B. Risks

8. In the past six months, how many times have you or anyone in your family...

a) Received health care at an emergency department/room? _____ ☐ Refused

b) Taken an ambulance to the hospital? _____ ☐ Refused

c) Been hospitalized as an inpatient? _____ ☐ Refused

d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? _____ ☐ Refused

e) Talked to police because they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they must move along? _____ ☐ Refused

f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? _____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR EMERGENCY SERVICE USE. — SCORE:

9. Have you or anyone in your family been attacked or beaten up since they've become homeless? ☐ Y ☐ N ☐ Refused

10. Have you or anyone in your family threatened to or tried to harm themself or anyone else in the last year? ☐ Y ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF HARM. — SCORE:

11. Do you or anyone in your family have any legal stuff going on right now that may result in them being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ Y ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR LEGAL ISSUES. — SCORE:

✓ History of Housing and Homelessness?
✓ Risks?
✓ Socialization & Daily Function?
✓ Wellness?
✓ Medical Conditions
✓ Drug or Alcohol Conditions
✓ Mental Health Conditions

CES Assessment

Check for a housing assessment

Review if needed

Matching Process

How a person scores on the VI-SPDAT will guide the housing coordinator recommendations to make the appropriate match and referral. If an assessment:

Tier 1, an Affordable Housing (AH) referrals will be provided. "We are NOT required to offer housing intervention at this time". IF a family or a Veteran scores in this tier, they may be eligible for RRH programs it may be shorter programs.

Tier 2 a Rapid Re-Housing (RRH) referrals will be provided. Additionally, a referral to AH. IF they meet Chronically Homeless criteria (see below), they may be eligible for PSH.

Tier 3 a Permanent Supportive Housing (PSH) referral will be provided. Additionally, a referral to AH program and any population-specific housing resource that apply to them. (Must have a diagnosable Chronic Disability)

Chronically Homeless:
Requires an individual or head of household to have a disability and to have been living in a place not meant for human habitation, in an emergency shelter, or in a safe haven for at least 12 months either continuously or cumulatively over a period of at least 4 occasions in the last 3 years.

A. *First Priority–Homeless Individuals or Families with a Disabling Condition with Long Periods of Episodic Homelessness and Severe Service Needs Level 1, 2, 3*
B. *Second Priority—Homeless Individuals and Families with a Disability with Severe Service Needs: Not meeting the LOH Level 4*
C. *Third Priority—Homeless Individuals or families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs Level 5*

Coordinated Entry
211 Call -> 211 CES Team -> HOPE Team Community Outreach

Referral

Priority Level 1

Those with the longest length of homelessness and scoring/utilizing the severe service needs

Scoring: High
LOH: 3 +

Priority Level 2

Those with the minimum requirement of length of homelessness and meeting the minimum PSH requirements
Scoring: High to Moderate
LOH: 1 Year

Priority Level 3

Those meeting CH eligibility requirements and scoring below PSH

Scoring: low to moderate
LOH: 1 Year

Priority Level 4

Homeless Individuals and Families with a Disability with Severe Service Needs: Not meeting the LOH

Scoring: Moderate to high
LOH: Literally Homeless

Priority Level 5

Homeless Individuals & Families with a Disability Coming from Places Not Meant for Human Habitation, Without Severe Service Needs:
Score : low to moderate
LOH: Literally Homeless

PSH

RRH

Community Based Resources

Accepted is a transition used for PSH programs because they are not enrolled until Housed. Some RRH do not enroll until Housed.

Enrolled process is used for RRH programs once Households are determined eligible for their program. Or Housed PSH

DOs and DON'Ts of VI-SPDAT

When explaining the VI-SPDAT and Sacramento Coordinated Entry System to a Client:

- **DO** explain SB County **Coordinated Entry System** as a collaboration of service providers working to streamline services to help connect homeless individuals to available resources and appropriate housing.

- **DO** ask a client to sign the VI-SPDAT consent form prior to conducting the survey.

- **DO** explain the VI-SPDAT as an assessment that enables our network of service providers to understand their needs, program eligibility, and assist in matching them to the best resources available.

- **DO** read all questions as is to the client. The order of the VI-SPDAT cannot change. As a self-reported tool, the sequence is vitally important. An individual must provide informed consent prior to the VI-SPDAT being completed.

- **DO** provide clarification of any questions the client expresses or appears to not understand,

- **DON'T** complete the VI-SPDAT solely through observation or using known information within your organization.

- **DON'T** change client answers because you believe they are being dishonest.

- **DON'T** mention that people will receive a score after participating in a VI-SPDAT, and **DON'T** give them the score.

- **DO** explain Rapid Rehousing (RRH) or Permanent Supportive Housing (PSH) and how each type of housing program caters to a client's needs.

- **DO** empower and encourage those who score <5 to utilize community resources to exit homelessness on their own.

- **DON'T** guarantee housing to a client or give them a timeframe in which they will be housed.

- **DON'T** tell a client that the most vulnerable are being prioritized for housing. Please remember that we are using the VI-SPDAT to **match people to appropriate housing**.

- **DON'T ever go back into and Assessment to change answers, the system logs all changes. If you change answers, your HMIS account will be deactivated!**

Select the Case Management" menu group.

The selected agency can respond to the referral by searching for the client and selecting Referral. They can accept it by clicking on "Incoming Referral".

The agency would than complete the Outcome Information section of the referral form.

HMIS Referral Email

HMIS # 40608 Incoming referral

Lesley Velasco <clienttrack-1-5@clienttrack.com>

Fri 3/15, 1:33 PM

intake@keysnonprofit.org; Lesley Velasco; Marisela Manzo

Inbox

Good Afternoon,

This email is to advise you that Client ID 40608 Chappell G. has been referred to your organization.

Client can be reached at phone number 909-677-1318 or 702-684-9065.
This client would need assistance with Bridge housing, they are currently in a motel paid by Mercy house and we are reaching out to CAPS for motel assistance for 7 days. Once that is over this family will become unsheltered.

This case is a little unique please reach out to me if you have any questions.
I am working with Office of Homeless Services to correct head of household in HMIS.

Thank you.

Reply all | v

We upload
-HMIS Consent, Homeless Verification, and consent to collaborate and discuss cases

Protocol's for Referral's

Policies & Procedures

- Receiving Program makes contact with client within 72 business hours

- Determination of eligibility are determined day of intake.

- If client misses 2 appt. they will be redirected to CES staff.

- PSH has 30 days of identification

Non-Enrollment Form

- there is no actual vacancy available; or no actual funding is available

- the individual or family missed two intake appointments;

- the household presents with more people than referred by the HC and the Receiving Housing Program of Emergency Shelter/ TH and project base PSH cannot accommodate the increase;

- Client is determined to be not literally homeless;

- Client is over the income limits for San Bernardino County AMI (Area Medium Income); only ESG, SSVF or TAD providers

- If client needs are determined to be at a higher level of care from what the program is able to accommodate;

We Will Need Point of Contact (POC)

- ✓ **We will need all staff email addresses and phone numbers you would like us to email referrals to.**

- ✓ **If you have several projects we will need contact information for each project if they are different**

- ✓ **We will provide you our POC – but this joint email is the easiest way to contact us:**

<u>211CES@ieuw.org</u>

So how is it done……….

Collaboration with Communication is the Key;

Meeting on a regular basis;

All clients are everyone's client;

Thinking outside the Box with creative resources;

Group Accountability.

Case Conferencing

We bring resources to the table outside of the box

Work together to identify all possible resources any person around the table may know

We go through process of elimination knowing the case and the resources

- We are able to eliminate resources that they are not eligible for

We coordinate by delegate roles and responsibilities

We are able to share information to identify impediments to know how to best approach the case

We work together!!
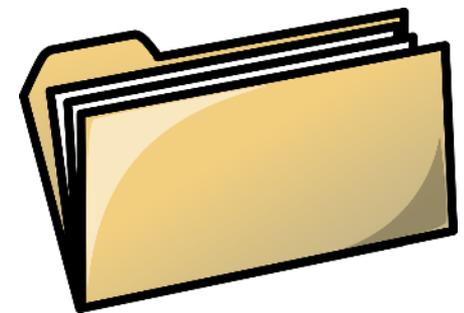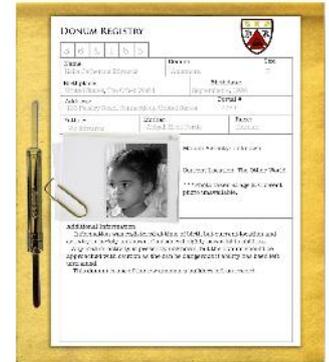
The Challenges

If a client walks into a provider's office requesting services, the following must take place:
Literally Homeless Client

- Outreach has to confirm client is literally homeless.

- Consent forms must be signed along with a homeless certificate.

- If agency is trained to do VI-SPDAT's, a VI-SPDAT must be completed before referral request.

- Signed documents must be sent to 211ces@ieuw.org along with a reciprocal referral request.

- Documents can also be uploaded to HMIS.

Questions

"Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it is the only thing that ever has." ~ Helen Keller