

Title: 1.9 Housing First Team (HFT)

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Reviewed By: Governing Council

Approved By: Governing Council

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Overview

The Housing First Team (HFT) is a multi-disciplinary team available to provide short-term, intensive services connecting persons currently or previously experiencing homelessness who have a mental illness with needed resources. The HFT operates in conjunction with the Coordinated Entry System (CES) By-Name List to provide an extra layer of intensive services and assistance with connecting clients to housing programs.

The primary functions of the HFT are to:

- Connect persons on the By-Name List who are already housed at, or have an active referral to a CoC or ESG housing program;
- Coordinate with housing providers and program staff through the housing referral process and ensure that the client is supported and engaged until the client is determined to no longer require intensive services.

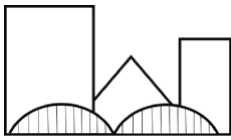
The HFT will utilize community-based referrals and their own intensive case management skills to assess clients for needs, find appropriate referrals to community resources, and work with the client during the initial referral process to ensure that clients are a part of the goal planning process.

Persons Served

The HFT will provide coordinated community referrals to promote housing retention and stability for up to 60 individuals who have a mental illness currently or formerly experiencing homelessness in Shelby County. Persons assisted by the HFT must have an active referral to, or be already housed in a CoC- or ESG-funded housing program.

Referral Process

Clients are connected to the HFT by an email referral completed by the client's current case manager or alternative service provider. The email should include: client's name, contact



information, and name of CoC or ESG program. The subject of the email referral should read 'HFT Referral' and be sent to coordinatedentry@cafth.org. CAFTH will facilitate email referrals to the HFT through HMIS.

The HFT will actively engage referred clients within a week of receiving referrals. All services are voluntary; if a client agrees to HFT services an appointment is made as soon as possible with the client and HFT staff.

Intake

The HFT will utilize the Arizona Self-Sufficiency Matrix (ASSM) at the initial intake meeting between the client and HFT to create the client's individual plan of care. The HFT and the client will work together to identify their needs and desires as it relates to their personal success. An initial plan of care is completed following the intake meeting.

Following the intake meeting, the HFT will determine what resources will be referred or offered with a plan of action, including timelines for referrals to be completed. Individual plans of care should be made in collaboration with the HFT and client.

Upon exiting the intake meeting, the client should be made aware of all referrals being made on their behalf, be aware of additional resources available to them and understand their plan of care as it relates to their housing stability.

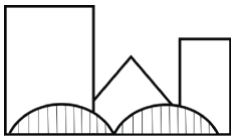
Timeframe for Services Provided by HFT

The intended timeframe for services provided by the HFT is short-term, with flexibilities allowed for clients who may need more assistance. The team is designed to provide specialized referrals for services based on the client's need and stability goals.

Upon completion of a client's plan of care, referrals and resources on the plan should be completed within two weeks of the dated plan of care.

The HFT is not meant to replace case managers or alternative service providers through other agencies, but instead work alongside those agencies to help provide additional support and resources to connect clients with the referrals and services they need to meet stability goals.

The HFT will assist with plan implementation and transition of services to promote self-sustainability utilizing mainstream services.



Process for Evaluating Client Progress and Needs

The HFT will meet monthly to review progress and continued needs for all clients. This time will be used for success sharing, open case conferencing, resource sharing and determining continued individual needs for HFT clients.

The Arizona Self-Sufficiency Matrix (ASSM) will be completed for every client in 30-day increments leading up to the 60-day time frame for terminating additional HFT services with the client if enough progress has been made.

The HFT will continually monitor success for referrals and progress made towards goals, and will re-evaluate at the 60 day mark to terminate services or to assess if more referrals or intensive interventions are needed.

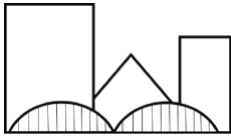
If additional specialized referrals are needed from the HFT, documentation must be used to show that case managers have used all available resources to try to meet client needs and stability goals. After the HFT has terminated services, the case manager will be encouraged to complete the assessment in 90-day increments for as long as the client is enrolled in the housing program.

Documentation Guidelines

HMIS must be utilized for all clients and for all services provided through the HFT. Documentation must include the initial intake assessment, case notes on all referrals and interventions provided, subsequent assessments, and a final assessment/ termination form that outlines client progress and/or completion of goals.

Monthly Meetings

The HFT will meet monthly in conjunction with the Single Adults Committee to case conference and resource share. The purpose of the monthly meeting will be to allow single adult homeless providers to case conference with the HFT, utilizing their clinical and resource knowledge to best serve the community. Additionally, HFT clients can be discussed, allowing open case conferencing and for additional supportive service providers to lend their expertise.



Services Provided:

The core services the HFT will provide will be:

- Coordination Services
 - Example: Coordination with housing providers and case managers to facilitate housing referrals and placements
- Support Services Referral
 - Examples: connection to benefits, transportation, medical care, employment services and housing
- Mental Health Referral
 - Examples: Referrals to mental health providers, substance abuse treatment providers, Individual and/or group therapy
- Mediation Services
 - Examples: Mediation with support networks (family, friends, etc.)
- Crisis Intervention
 - Examples: Connection to mental health crisis agencies/services
- Assessment Services
 - Example: Completing the ASSM