I. State Information

State Information

Plan Year

Federal Fiscal Year 2022

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 9/1/2022

To 8/31/2023

IV. Date Submitted

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

Submission Date

Revision Date

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

Title

Organization

Signature: Date:

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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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 Nelson Smith

Title Commissioner

Organization PBHDS

Signature: Date: 14 Apr 2022

FY 2022 PATH FOA Catalog No.: 93.150 FOA No.: SM-21-F2 Approved: 02/23/2022

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

Nelson Smith

Title

Commissioner

Organization

VA DBHDS

Signature: Date:

FY 2022 PATH FOA Catalog No.: 93.150 FOA No.: SM-21-F2 Approved: 02/23/2022

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: Nelson Smith

Title: Commissioner

Organization: DBHDS

Signature: [signature] Date: 01 April 2022

FY 2022 PATH FOA Catalog No.: 93.150 FOA No.: SM-21-F2 Approved: 02/23/2022

Footnotes:

I. State Information

Funding Agreement

FISCAL YEAR 2022
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, 2023, 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 2022 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	
Title	
Organization	

Signature: Date:

FY 2022 PATH FOA Catalog No.: 93.150 FOA No.: SM-21-F2 Approved: 02/23/2022

Footnotes:

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Governor/Designee Name: Nelson Smith
Title: Commissioner
Organization: DBHDS

Signature: [signature]

Date: 4/14/2022

FY 2022 PATH FOA Catalog No.: 93.150 FOA No.: SM-21-F2 Approved: 02/23/2022

Footnotes:

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: Nelson Smith

Title: Commissioner

Organization: VA DBHDS

Signature: _____ Date Signed: _____

mm/dd/yyyy

FY 2022 PATH FOA Catalog No.: 93.150 FOA No.: SM-21-F2 Approved: 02/23/2022

Footnotes:

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: Nelson Smith

Title: Commissioner

Organization: DBHDS

Signature: _____ Date Signed: 04/14/2022
mm/dd/yyyy

FY 2022 PATH FOA Catalog No.: 93.150 FOA No.: SM-21-F2 Approved: 02/23/2022

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	

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 2022 PATH FOA Catalog No.: 93.150 FOA No.: SM-21-F2 Approved: 02/23/2022

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 $1,472,215 in Federal Fiscal Year (FFY) 2022-23 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 2022-2023 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 3,315 individuals and enroll 1,596 individuals a year the 2022-2023 PATH program year; approximately 91% 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	$37,555	75	65	90%
Arlington DBHS	Arlington County	$67,356	$44,427	610	302	98%
Blue Ridge CSB	Roanoke and Salem; Craig, Botetourt and Roanoke Counties	$75,332	$25,111	200	150	90%
Fairfax-Falls Church CSB	Fairfax and Falls Church; Fairfax County	$164,542	$203,492	240	160	100%
Hampton/Newport News CSB	Hampton and Newport News	$101,826	$33,603	200	100	80%
Loudoun County CSB	Loudoun County	$50,182	$252,027	60	42	75%
Norfolk CSB	Norfolk	$106,585	$56,039	250	125	100%
Portsmouth DBHS	Portsmouth	$53,715	$17,905	50	50	100%
Prince William Co. CSB	Manassas and Manassas Park; Prince William County.	$88,067	$54,457	70	41	97%
Rappahannock Area CSB	Fredericksburg; Spotsylvania, Stafford, Caroline and King George Counties.	$98,144	$32,715	200	145	85%
Region Ten CSB	City of Charlottesville; Albemarle, Green, Nelson, Fluvanna and Louisa Counties	$64,862	$21,620	125	75	75%
Richmond Behavioral Health Authority	Richmond (for veterans outreach, includes Henrico, Chesterfield and Hanover Counties and the City of Petersburg)	$172,710	$78,149	180	171	80%
Valley CSB	Staunton and Waynesboro; Augusta and Highland Counties	$41,147	$13,579	55	55	100%
Virginia Beach CSB	Virginia Beach	$126,949	$81,671	1000	115	100%
	Subtotal	**$1,317,600**	**$952,350**	**3,315**	**1,596**	**91%**
PATH and homeless service provider training and one-time PATH program support		$95,726				
DBHDS Administrative Set-Aside at 4% of total federal allocation		$58,889				
	Total Virginia PATH Program Budget	**$1,472,215**	**$952,350**	**$2,424,565**		

II. Executive Summary

2. State Budget

Planning Period From **9/1/2022** to **8/31/2023**

A budget and budget narrative that includes the state's use of PATH funds are required. The budget can be entered directly into WebBGAS, or you can upload the budget as an attachment. The Budget Narrative is a separate document that must be uploaded as an Attachment. It must provide a justification for the basis of each proposed cost in the budget and how that cost was calculated. The proposed costs must be reasonable, allowable, allocable, and necessary for the supported activity.

* Indicates a required field

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
a. Personnel	**39,216.00**	**0.00**	**39,216.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	65,392.00	30.00 %	0.30	19,618.00	0.00	19,618.00	Housing & Benefits Coordinator: Implements PATH provider monitoring protocols. Providers training and technical assistance to PATH providers.
Other (Describe in Comments)	82,666.00	25.00 %	0.24	19,598.00	0.00	19,598.00	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.

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**50.40 %**	**$ 19,763.00**	**$ 0.00**	**$ 19,763.00**	**Fringe Benefits for Behavioral Health Housing Manager & Housing and Benefits Coordinator.**

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

f1. Contractual (IUPs)	**$ 1,317,600.00**	**$ 952,350.00**	**$ 2,269,950.00**	
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)	**1.81 %**	**$ 26,666.00**	**$ 43,383.00**	**$ 70,049.00**	
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	**$ 95,636.00**	**$ 0.00**	**$ 95,636.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Staffing: Other (Describe in Comments)	$ 95,636.00	$ 0.00	$ 95,636.00	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)	**$ 1,472,215.00**	**$ 952,350.00**	**$ 2,424,565.00**

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)	$ 1,472,215.00	$ 952,350.00	$ 2,424,565.00	
Allocation of Federal PATH Funds	**$ 1,472,215**	**$ 490,738**	**$ 1,962,953**	

Source(s) of Match Dollars for State Funds:

Virginia PATH State Budget Narrative
PATH 2022-2023

A. Personnel:

1) Salary to support a portion of two staff positions at VA DBHDS in the total amount of $39,306 *($19,688 for Behavioral Health Housing Manager & $19,618 for Housing & Benefits Coordinator)*.

   a. 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.
   b. Housing & Benefits Coordinator: Implements PATH provider monitoring protocols. Providers training and technical assistance to PATH providers. Serves as State SOAR Lead.

2) Fringe to support positions listed above in the amount of $19,763.

B. Contractual (IUPs):

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.

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.

The table on the following page provides detail on the CSB PATH programs that will operate during the 2022-2023 PATH program year. 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.

Virginia PATH State Budget Narrative
PATH 2022-2023

PATH Provider Organization (All CMHCs)	Service Area (City/County)	Total Federal PATH Budget	Local Match
Alexandria CSB	Alexandria	$106,183	$37,555
Arlington DBHS	Arlington County	$67,356	$44,427
Blue Ridge CSB	Roanoke and Salem; Craig, Botetourt and Roanoke Counties	$75,332	$25,111
Fairfax-Falls Church CSB	Fairfax and Falls Church; Fairfax County	$164,542	$203,492
Hampton/Newport News CSB	Hampton and Newport News	$101,826	$33,603
Loudoun County CSB	Loudoun County	$50,182	$252,027
Norfolk CSB	Norfolk	$106,585	$56,039
Portsmouth DBHS	Portsmouth	$53,715	$17,905
Prince William Co. CSB	Manassas and Manassas Park; Prince William County.	$88,067	$54,457
Rappahannock Area CSB	Fredericksburg; Spotsylvania, Stafford, Caroline and King George Counties.	$98,144	$32,715
Region Ten CSB	City of Charlottesville; Albemarle, Green, Nelson, Fluvanna and Louisa Counties	$64,862	$21,620
Richmond Behavioral Health Authority	Richmond (for veterans outreach, includes Henrico, Chesterfield and Hanover Counties and the City of Petersburg)	$172,710	$78,149
Valley CSB	Staunton and Waynesboro; Augusta and Highland Counties	$41,147	$13,579
Virginia Beach CSB	Virginia Beach	$126,949	$81,671
	Subtotal	**$1,317,600**	**$952,350**

C. <u>Other:</u>

a. 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 in the amount of $95,636.

Footnotes:

II. Executive Summary

3. Intended Use Plans

Expenditure Period Start Date: **09/01/2022** Expenditure Period End Date: **08/31/2023**

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	$37,555.00	75	65	1	1
Arlington County DHS, Division of Behavioral Health Services	Community mental health center	Arlington	$67,356.00	$44,427.00	610	302	1	0
Blue Ridge Behavioral Healthcare	Community mental health center	Blue Ridge Behavioral Health	$75,332.00	$25,111.00	200	150	1	30
Fairfax-Falls Church Community Services Board	Community mental health center	Fairfax	$164,542.00	$203,492.00	240	160	3	23
Hampton-Newport News Community Services Board	Community mental health center	Hampton-Newport News	$101,826.00	$33,603.00	200	100	2	3
Loudoun Community Services Board	Community mental health center	Loudoun County	$50,182.00	$252,027.00	60	42	1	3
Norfolk Community Services Board	Community mental health center	Norfolk	$106,585.00	$56,039.00	250	125	1	5
Portsmouth Department of Behavioral Health Services	Community mental health center	Portsmouth	$53,715.00	$17,905.00	50	50	0	0
Prince William County Community Services	Community mental health center	Prince William	$88,067.00	$54,457.00	70	41	1	0
Rappahannock Area Community Services Board	Community mental health center	Rappahannock Area	$98,144.00	$32,715.00	200	145	1	35
Region Ten Community Services Board	Community mental health center	Region Ten	$64,862.00	$21,620.00	125	75	0	0
Richmond Behavioral Health Authority	Community mental health center	Richmond	$172,710.00	$78,149.00	180	171	1	5
Valley Community Services Board	Community mental health center	Valley	$41,147.00	$13,579.00	55	55	1	6
Virginia Beach Department of Human Services, Community Support Services Division	Community mental health center	Virginia Beach	$126,949.00	$81,671.00	1,000	115	2	9
		Grand Total	$1,317,600.00	$952,350.00	3,315	1,596	16	120

** IUP with sub-IUPs*

Footnotes:

Alexandria Department of Human and Community Services
720 N. St. Asaph Street
Alexandria, VA 22314
Contact: Krysta Pearce
Email Address: krysta.pearce@alexandriava.gov

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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**	**26,095.00**	**79,076.00**	

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	20,995.00	63,622.00	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	**$ 6,001.00**	**$ 0.00**	**$ 6,001.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 4,500.00	$ 0.00	$ 4,500.00	
Office: Supplies	$ 1,501.00	$ 0.00	$ 1,501.00	

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	**$ 11,749.00**	**$ 0.00**	**$ 11,749.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 2,797.00	$ 0.00	$ 2,797.00	bus fare
Client: Transportation	$ 2,500.00	$ 0.00	$ 2,500.00	Client Tranportation
Client: Other (Describe in Comments)	$ 2,500.00	$ 0.00	$ 2,500.00	Client Clothing
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
Client: Other (Describe in Comments)	$ 500.00	$ 0.00	$ 500.00	Client medical: co-pays, pill boxes, durable medical equipment
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	$ 37,555.00	$ 143,738.00	

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	$ 37,555.00	$ 143,738.00	

Source(s) of Match Dollars for State Funds:

Cash

Estimated Number of Persons to be Contacted: 75 Estimated Number of Persons to be Enrolled: 65

Estimated Number of Persons to be Contacted who are Literally Homeless: 68

Number staff trained in SOAR in grant year ending in 2021: 1 Number of PATH-funded consumers assisted through SOAR: 1

PATH Site Name: Alexandria					
Budget FFY (2022-2023 PATH Year)					Source
Staff Title	***Annualized*** Sa	FTE	Federal PATH Funds	Local Match	(Cash or
PATH Coordinator	$63,623	1.00	42,627	$20,996	Cash
Family Services Specialist Supervisor	$84,437	0.15	$8,486	$4,180	FTE
HMIS Mgmt. Analyst II	$55,756	0.05	$1,868	$920	FTE
Total Staff Salary	$203,816	1.2	$52,981	$26,095	FTE
PATH Coordinator	$26,722	1	$17,904	$8,818	Cash
Family Services Specialist Supervisor	$35,464	0.15	$3,564	$1,755	FTE
HMIS Mgmt. Analyst II	$23,418	0.05	$784	$386	FTE
Fringe	$85,603	1.2	$22,252	$10,960	Cash
		Total Personnel	**$75,233**	**$37,055**	

** Always list positions separately & separate salary from benefits ("fringe")*

Travel (Outreach travel, travel for training, state meetings, etc.)			
Use of Agency Vehicle	$0	$500	
Training Travel	$2,500	$0	
Training Conference Costs	$2,000	$0	
Total Travel Costs	**$4,500**	**$500**	

Equipment (Personal property/equipment having useful life of more than one year)			
Laptop (new)	$300	$0	
Cell Phone (replacement)	$0	$0	
Total Equipment Costs	**$300**	**$0**	

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies	$1,501	$0	
Outreach Supplies	$3,000	$0	
Supplies	$1,500	$0	
Total Supplies Costs	**$6,001**	**$0**	

Contractual			
Cell phone service fee	$2,200	$0	
Total Contractual Costs	**$2,200**	**$0**	

Other (List and Describe Each)			
Medication Assistance	$500	$0	
Identification related purchase costs (incl. Birth certificates)	$900	$0	
Client Lodging	$6,200	$0	
Bus Tokens	$2,797	$0	
Staff Training (non-travel registration and costs)	$1,000	$0	
Client Clothing	$2,500	$0	
Client Food	$1,552	$0	
Client Transportation	$2,500	$0	

Total Other Costs	**$17,949**	**$0**	
Total Proposed Budget	**$106,183**	**$37,555**	Is match > or = to

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Federal Fiscal Year 2022

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 received PATH funds:** $106,183.00
- **Contact Information: Krysta Pearce**. 703-746-5973 Krysta.pearce@alexandriava.gov

Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

- 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 our shelter services. The Homeless Services Assessment Center also has an active diversion and prevention component as well as Housing Locator 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 and families. 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. 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 to obtain the Housing Choice Vouchers.
- **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. The HOPC also works closely with ALIVE to obtain weekly / monthly food donations for PATH and other clients facing street homelessness.
- **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 case management team provided the CSB, substance misuse detoxification 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. HOPC makes the appropriate referral for clients who are in need of an inpatient or outpatient SA program and are referred out to other jurisdictions.

- **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 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; b. Any gaps that exist in the current service systems; c. A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and d. A brief

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

- 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.
- 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.
- 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.

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

- The homeless population is of great diversity throughout each of its programs. The HOPC, as a Licensed Social Worker and Qualified Mental Health Professional Therapist for Adults, 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. The HOPC is an advocate that each treatment provided is culturally appropriate and provided in an equitable fashion.
- Every staff member and clinician at DCHS, including the HOPC is required to attend an annual training in Cultural Competence.

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 within the previous FY:**
  - 608 people total "literally homeless"
  - 21 unsheltered homeless adults
- Single Adults
  - 317 of the homeless population in the City of Alexandria was male
  - 124 of the homeless population in the City of Alexandria was female
- Subpopulations (Adults Only)
  - 97 individuals were chronically homeless single adults
  - 33 individuals were veterans 8 chronic homeless
  - 75 individuals were chronic substance abusers
  - 170 individuals suffered from severe mental illness
  - 59 individuals had a physical disability
  - 20 individuals suffered from a chronic health condition
  - 8 individuals reported having a diagnosis of HIV/AIDS
- The PATH program projects contacting 75 consumers during the FY2022. Out of the 75 consumers contacted it is projected 65 individuals will be enrolled into the PATH Program. With 100% of those clients enrolled being served using PATH Funds.
- It is projected 90% of clients enrolled and utilizing PATH funds are 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.

- HOPC works closely with the shelters drop in center, meal programs, SA facilities detox and DCHS mental health centralized intake at identifying homeless 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.
- PATH also makes referrals to the liaison of the Veterans committee within OCS by identifying those Veterans who are accessing supportive services and or street outreach. HOPC also partners with local nonprofits to obtain appropriate sources and VASH housing vouchers.
- The HOPC also makes referrals to DCHS Workforce Developments Center Program Military Connection.

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 offered involvement and 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). The HOPC respects the clients' wishes in regard to family support and provides a safe space for support and reunification.

11. Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR): – Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

- The HOPC is the sole certified SOAR provider to PATH Clients.

12. 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 FY22-FY23 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 $63,623.00 = $42.627.00 in PATH funds and a $20,996.00 match. The HOPC spends 95% of their time dedicated to the PATH 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 in PATH funds and a $ 4,179.65 match. The FSSS 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 $55,756.00 = $1,868.00 in PATH funds and a $920.00 match. The HMIS MA 111 spends 5% of their time dedicated to the PATH program.

▪ **Fringe Benefits**

- For FY 22-FY23 there is an allotted $26,722.00 for the PATH Provider
- For FY 22-FY23 there is an allotted $35,464.00for the FSS Supervisor
- For FY 22-FY23 there is an allotted $23,418.00 for the HMIS Mgmt. Analyst II
- Total Fringe benefits $86,603.00

▪ **Travel**

- For FY 22-FY23 travel for PATH specific trainings is allotted $2,500.00
- For FY 22-FY23 training conference cost is allotted $2,000.00
- For FY 22-FY23 there is a $500.00 match that provides extra assistance in travel and training cost should extra monetary value be needed

▪ **Supplies**

- For FY 22-FY23 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 $300.00. Through current contracts $2,200.00 is supplied to contractors for the Cell Phone service fees and the wireless access card for laptop.

▪ **Other Additional Cost**

- Supplies (Office Supplies, Outreach Supplies, Additional Supplies) $6,001.00
- Medication Assistance - $500.00
- Identification related purchase costs (incl. Birth certificates) - $900.00
- Client Lodging - $6,200.00
- Bus Tokens - $2,797.00
- Staff Training (non-travel registration and costs) - $1,000.00
- Client Clothing - $2,500.00
- Client Food - $1,552.00
- Client Transportation - $2,500.00

13. 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, finances are allocated and routed to the fiscal staff for processing. The fiscal staff ensures all expenses are consistent with the required activity of 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
Email Address: acaro@arlingtonva.us

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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**	**18,631.00**	**85,987.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	85,987.00	100.00 %	0.78	67,356.00	18,631.00	85,987.00	Human Services Specialist

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0.00**	**$ 25,796.00**	**$ 25,796.00**	

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)	$ 67,356.00	$ 44,427.00	$ 111,783.00	

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	$ 44,427.00	$ 111,783.00	

Source(s) of Match Dollars for State Funds:

Cash

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 2021: 1

Number of PATH-funded consumers assisted through SOAR: 0

PATH Site Name: Arlington County					
Budget (2022-2023 PATH Year)			Federal PATH Funds	Local Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
Human Services Specialist	$85,987	1.00	$67,356	$18,631	Cash
Total Staff Salary	$85,987	1.00	$67,356	$18,631	Cash
Fringe	$25,796		$0	$25,796	Cash
		Total Personnel	**$67,356**	**$44,427**	
** Always list positions separately & separate salary from benefits ("fringe")*					
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle					
Training Travel					
Training Conference Costs					
		Total Travel Costs			
Equipment (Personal property/equipment having useful life of more than one year)					
Lapotop (new)					
Cell Phone (replacement)					
		Total Equipment Costs			
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies					
Outreach Supplies					
Supplies					
		Total Supplies Costs			
Contractual					
Cell phone service fee					
		Total Contractual Costs			

Other (List and Describe Each)			
Medication Assistance			
Identification related purchase costs (incl. Birth certificates)			
Rental Assistance			
Bus Tokens			
Staff Training (non-travel registration and costs)			
Total Other Costs			
Total Proposed Budget	**$67,356**	**$44,427**	Is match > or = to 1/3 of federal allocation?

Virginia Project for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Fiscal Year 2022-2023

1. Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

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

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 the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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 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 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 (PathForward [formally known as 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, our current PATH outreach worker, formally an ACPD officer, works directly 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 PathForward Shelter (formally known as Arlington Street People's Network or 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 PathForward (formally known as 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 student interns and recreational therapists who 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 ongoing long-term therapeutic care.

Community Mental Health Services:

In Arlington, the TOW/PATH team is a part of the Forensic Jail Diversion Team, within Residential and Specialized Clinical Services Bureau, located 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 one psychiatrist that 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/or 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 over 10 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, PathForward (formally A-SPAN), Opportunity Place, and 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 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 20% are Licensed Clinical Social Workers. 100% are between the ages of 30-55. 80% are female and 20% are male. 20% are African American, 40% are Latino, 20% are Native American, and 20% are Caucasian. 40% are bilingual in the English and Spanish language.

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

All staff members receive regular training in cultural and multicultural issues, racial equity, 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 Clinical Supervisor 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), Moral Reconation Therapy (MRT), and EMDR Therapy.

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. Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR): – Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

The TOW/PATH team currently has one SOAR-certified clinician on the team, and we work closely with several shelter providers/case managers who are SOAR-certified.

12. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds.
Amount of federal PATH funds requested: $67,356
Source and amount of minimum required 33% match fund: $33,678. 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.

13. 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: Brittany Huffer
Email Address: bhuffer@brbh.org

Provider Type: Community mental health center
PDX ID: VA-002
State Provider ID:
Contact Phone #: 540-353-2980

- **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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**36,608.00**	**5,200.00**	**41,808.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	36,608.00	100.00 %	1.00	36,608.00	0.00	36,608.00	PATH Case Manager
Other (Describe in Comments)	52,000.00	10.00 %	0.00	0.00	5,200.00	5,200.00	PATH Manager

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**21.89 %**	**$ 9,152.00**	**$ 0.00**	**$ 9,152.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 3,950.00**	**$ 0.00**	**$ 3,950.00**	

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)	$ 3,550.00	$ 0.00	$ 3,550.00	Use of Agency Vehicle

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

No Data Available

e. Supplies	**$ 9,350.00**	**$ 0.00**	**$ 9,350.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 9,000.00	$ 0.00	$ 9,000.00	
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	**$ 12,000.00**	**$ 13,341.00**	**$ 25,341.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 4,350.00	$ 5,000.00	$ 9,350.00	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)	$ 1,650.00	$ 1,341.00	$ 2,991.00	Essential Household Items
Other (Describe in Comments)	$ 1,000.00	$ 1,000.00	$ 2,000.00	Utility Deposits/Assistance

h. Construction (non-allowable)

i. Other	**$ 4,272.00**	**$ 5,800.00**	**$ 10,072.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 1,407.00	$ 1,700.00	$ 3,107.00	bus tokens
Client: Other (Describe in Comments)	$ 750.00	$ 1,250.00	$ 2,000.00	Healthcare co-payments
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	$ 1,665.00	$ 2,500.00	$ 4,165.00	

j. Total Direct Charges (Sum of a-i)	$ 75,332.00	$ 25,111.00	$ 100,443.00	

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	$ 25,111.00	$ 100,443.00	

Source(s) of Match Dollars for State Funds:

Cash

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 2021: 1

Number of PATH-funded consumers assisted through SOAR: 30

PATH Site Name: Blue Ridge Behavioral Healthcare					
Budget (2022-2023 PATH Year)			Federal PATH Funds	Local Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
PATH Case Manager	$36,608	1.00	$36,608		
PATH Manager	$5,200	0.10		$5,200	cash
Total Staff Salary	$41,808		$36,608		
Fringe	$10,452		$9,152		
		Total Personnel	**$45,760**	**$5,200**	
** Always list positions separately & separate salary from benefits ("fringe")*					
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle			$3,550		
Training Travel			$150		
Training Conference Costs			$250		
		Total Travel Costs	**$3,950**		
Equipment (Personal property/equipment having useful life of more than one year)					
Lapotop (new)			$0		
Cell Phone (replacement)			$0		
		Total Equipment Costs	$0		
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies			$350		
Outreach Supplies			$9,000		
Supplies					
		Total Supplies Costs	$9,350		
Contractual					
Cell phone service fee				$770	cash
		Total Contractual Costs		$770	

Other (List and Describe Each)			
Medication Assistance	$300	$200	
Identification related purchase costs (incl. Birth certificates)	$150	$150	cash
Rental Assistance	$2,000	$3,000	cash
Bus Tokens	$1,407	$1,700	cash
Staff Training (non-travel registration and costs)	$1,665	$2,500	cash
Cost Accosiated with Housing	$4,350	$5,000	cash
Healthcare co-payments	$750	$1,250	in kind
Essential Household Items	$1,650	$1,341	
Utility Assistance/Deposits	$1,000	$1,000	
Security Deposits	$3,000	$3,000	cash
Total Other Costs	$16,272	$19,141	
Total Proposed Budget	**$75,332**	**$25,111**	Is match > or = to 1/3 of federal allocation?

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Federal Fiscal Year 2022

1) **Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

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. Region Served: Roanoke City, Roanoke County, City of Salem, Craig County, and Botetourt County. The organization will receive $75,332 in federal PATH funds and $24,860 for the required 33% match funds. These funds are matched funds made available through the Virginia General Funds available to Blue Ridge Behavioral Healthcare. BRBH provides assurance through these funds the match required for this PATH project and detailed in the budget available on July 1, 2022, the start date for this project.

The primary point of contact for the PATH program is:
Hannah Evans – PATH worker
Phone: 540-541-0863
E-mail: hevans@brbh.org

Or

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

2) **Collaboration with HUD Continuum of Care (CoC) Program**: Describe the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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.

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.

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.
-Carillion 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 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 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; and

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. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

Blue Ridge Behavioral Healthcare has participated in HMIS (Blue Ridge Community Assistance Network-BRCAN) since its implementation in 2006. The current provider is Clarity. The PATH worker and manager are trained and fully utilizing HMIS for PATH data entry. In addition to HMIS, PATH worker enters data into Millennium, 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 qualifying 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. The PATH worker does participate in online trainings offered through the company's e-learning system, mandated on at least an annual basis. Other trainings include: A 4-hour training titled Racism as Trauma: What Every Professional Needs to Know, Perception is Everything: The Impact of Implicit Bias in Mental Health and Addictions, Adverse Childhood Experiences (ACES). As part of STEP-VA's Outpatient funding, certain staff are required to meet trauma-training standards. Trauma training is believed to help ensure a trauma informed approach is utilized and staff have the ability to target and address specific trauma related client needs that can improve outcomes.

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: 200

Projected number of adult consumers to be enrolled using PATH funds: 150

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.

a. The demographics of the target population.
American Indian or Alaska Native: 5%
Asian: 2%
Black or African American: 27%
Native Hawaiian or Other Pacific Islander: 0 %
White: 66%
Other: 0 %

*Based on the most recent demographics of enrolled PATH clients.

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 veteran's 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. See Appendix I – Guidelines for Consumer and Family Participation for more information.

The mission of Blue Ridge Behavioral Healthcare is to provide quality community-based services that prevent and address mental health disorders, developmental disabilities, and substance disorders. The following are the values we hold as important to BRBH:
The people we serve are our top priority, Our employees are our most valuable resource, Everyone has the right to be treated with respect and to participate fully in decisions that affect his or her life, We provide timely services in the least restrictive setting, that are accessible, affordable, efficient, and adaptable to individual needs, We collaborate with the individuals we serve, their families, and other providers in the community to achieve mutual goals and to maximize limited resources, We value fairness and diversity and are committed to cultural competence in our workplace and in our community, We adhere to ethical standards and professional codes of conduct, and We are responsible and honest, and respect confidentiality in dealing with individuals we serve and with each other.

Blue Ridge Behavioral Healthcare actively seeks input from family and clients. Currently BRBH has 8 Peer Recovery Specialist, 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, and the agency convenes the Local Human Rights Committee, the group that has oversight responsibility for the development and application of the Local Human Rights Plan.

BRBH utilizes a Client Satisfaction Survey that is administered twice per year. Unfortunately, COVID has disrupted the administrations dates, but BRBH hopes to be able to implement the survey again in the near future.

11) **Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR):** – Indicate the number of PATH staff that are

SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

The PATH worker is currently working toward her SOAR certification. She has completed her online curriculum and is scheduled to complete her in-person component in April 2022.

12) **Budget Narrative:** Provide a budget narrative that includes your local plan for the use of PATH funds. The narrative must be developed and described as outlined in Appendix II.

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.

13) **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.

Responsibility for grant compliance is with individual program directors. The Chief Financial Officer and Budget Administrator are involved however direct responsibility remains with the individual programs. The Budget Administrator is involved with recording revenue/receivables for other grants that are not on the reimbursement basis. Notification is received for the semi-monthly payments and the budget team provides a breakdown to be recorded by the accounting team as well. The Director of Business and Financial Services and the budget team work together during year-end close to determine the proper deferral of revenue and carryover of funds. After those amounts have been determined, then the entry is provided to the accounting staff to be recorded.

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 on Valley View has a deal with us) – 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 rule of thumb is to not pay 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 – not both
- 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 on Orange or Ramada Inn on Franklin
    - Use agency credit card
5. Valley Metro
    - Check cut 3x a year ($500 at a time) – request from 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
Email Address: Neva.Ortuno@fairfaxcounty.gov

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**108,462.00**	**134,128.00**	**242,590.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	96,809.00	100.00 %	0.45	43,284.00	53,526.00	96,810.00	Behavioral Specialist II
Other (Describe in Comments)	78,814.00	100.00 %	0.45	35,238.00	43,576.00	78,814.00	Behavioral Specialist II
Other (Describe in Comments)	66,967.00	100.00 %	0.45	29,940.00	37,026.00	66,966.00	Behavioral Specialist II

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**23.12 %**	**$ 56,080.00**	**$ 69,364.00**	**$ 125,444.00**	

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	$ 203,492.00	$ 368,034.00	

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	$ 203,492.00	$ 368,034.00	

Source(s) of Match Dollars for State Funds:

Estimated Number of Persons to be Contacted: 240 Estimated Number of Persons to be Enrolled: 160

Estimated Number of Persons to be Contacted who are Literally Homeless: 240

Number staff trained in SOAR in grant year ending in 2021: 3 Number of PATH-funded consumers assisted through SOAR: 23

PATH Site Name: Fairfax-Falls Church CSB			44.7%	55.3%	
Budget (2022-2023 PATH Year)			Federal PATH Funds	Local Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
Behavioral Specialist II	$66,967	1.00	29,941	37,026	In-kind
Behavioral Specialist II	$96,809	1.00	43,284	53,526	In-kind
Behavioral Specialist II	$78,814	1.00	35,238	43,576	In-kind
Total Staff Salary	$242,590		108,462	134,128	In-kind
Fringe	$125,443		56,080	69,364	In-kind
		Total Personnel	164,542	203,492	In-kind

** Always list positions separately & separate salary from benefits ("fringe")*

Travel (Outreach travel, travel for training, state meetings, etc.)			
Use of Agency Vehicle			
Training Travel			
Training Conference Costs			
Total Travel Costs			

Equipment (Personal property/equipment having useful life of more than one year)			
Lapotop (new)			
Cell Phone (replacement)			
Total Equipment Costs			

Supplies (Office Supplies, Outreach Supplies, Computer Software)			
Office Supplies			
Outreach Supplies			
Supplies			
Total Supplies Costs			

Contractual			
Cell phone service fee			
Total Contractual Costs			

Other (List and Describe Each)			
Medication Assistance			
Identification related purchase costs (incl. Birth certificates)			
Rental Assistance			
Bus Tokens			
Staff Training (non-travel registration and costs)			
Administrative Costs			
Total Other Costs			
Total Proposed Budget	**$164,542**	**$203,492**	**Is match > or = to 1/3 of federal allocation?**
	44.7%	55.3%	**Yes**

Question	Answer	Answer
Q2.a	164,542	
Q2.b	203,492	
Q2.c		PATH Funding: $164,542 or 44.7% for 3.0 FTE Behavioral Health Specialist II CSB In-Kind Match: $203,492 or 55.3% for 3.0 FTE Behavioral Health Specialist II

Virginia PATH Local Intended Use Plan, FFY 2022
PATH Program Year 2022-2023
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".

2. Collaboration with HUD Continuum of Care (CoC): Describe the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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 federally qualified 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 psychiatric rehabilitation 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, Virginia 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, Embry Rucker 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 presenting only with substance use disorder needs to Fairfax County services such as Detox, Medication Assisted Treatment (MAT), outpatient services, Substance Abuse Outreach Monitoring and Engagement (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, ACT and ICM programs. Specific residential treatment programs that focus on co-occurring treatment are Crossroads 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 CSB 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, there are several permanent supportive housing units funded by DBHDS in Fairfax County 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 works with all homeless mentally ill individuals regardless of their age, gender, disability, sex & gender identification, or race & ethnic background.

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. Additionally, the County makes available to all CSB employees a library of online trainings on numerous topics, including those aimed to raise cultural competency and health disparities awareness.

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: 160
c. Percentage of adult consumers projected to be "Literally Homeless": 100

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 and address language barriers through the use of interpreters or a language line for translation. 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 21 year-end report data:
Black or African American: 56
Asian: 3
Hispanic or Latino: 16
Caucasian: 56
Native American: 2
Data not collected: 4

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 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. 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 Office of Consumer and Family Affairs operates a peer recovery specialist training program with the goal of helping individuals obtain the training, certifications, and other related credentials needed to work in CSB programs as Certified Peer Support Specialists. 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. 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 CSB provides $203,492 of in-kind match funds, which cover the salary and fringe benefits for 3 of the program's full time outreach staff. The CSB's match of 55.3% 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, one 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
Email Address: alices@hnncsb.org

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**54,616.00**	**26,900.00**	**81,516.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Outreach worker	41,309.00	100.00 %	0.67	27,677.00	13,632.00	41,309.00	PATH Outreach Specialist
Outreach worker	25,750.00	100.00 %	0.67	17,252.00	8,498.00	25,750.00	Outreach assistant
PATH Administrator	55,820.00	5.00 %	0.03	1,684.00	830.00	2,514.00	Resource Development Specialist
Other (Describe in Comments)	63,338.00	10.00 %	0.07	4,245.00	2,090.00	6,335.00	Resource Development Specialist
Other (Describe in Comments)	112,188.00	5.00 %	0.03	3,758.00	1,850.00	5,608.00	Adult Clinical Director

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**32.74 %**	**$ 26,688.00**	**$ 6,703.00**	**$ 33,391.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 1,712.00**	**$ 0.00**	**$ 1,712.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 1,312.00	$ 0.00	$ 1,312.00	Use of agency vehicles
Other (Describe in Comments)	$ 400.00	$ 0.00	$ 400.00	Training Conference Costs

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

No Data Available

e. Supplies	**$ 3,010.00**	**$ 0.00**	**$ 3,010.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 2,500.00	$ 0.00	$ 2,500.00	
Office: Supplies	$ 510.00	$ 0.00	$ 510.00	

f. Contractual	**$ 3,154.00**	**$ 0.00**	**$ 3,154.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 1,852.00	$ 0.00	$ 1,852.00	Security
Other (Describe in Comments)	$ 1,302.00	$ 0.00	$ 1,302.00	cell phone service fee

g. Housing	**$ 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	Rental Assistance

h. Construction (non-allowable)

i. Other	**$ 11,646.00**	**$ 0.00**	**$ 11,646.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 1,500.00	$ 0.00	$ 1,500.00	Client Support Transportation
Client: Other (Describe in Comments)	$ 350.00	$ 0.00	$ 350.00	medication assistance
Client: Other (Describe in Comments)	$ 350.00	$ 0.00	$ 350.00	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.
Office: Other (Describe in Comments)	$ 9,046.00	$ 0.00	$ 9,046.00	Utilities, office space, janitorial, insurance
Staffing: Training/Education/Conference	$ 400.00	$ 0.00	$ 400.00	

j. Total Direct Charges (Sum of a-i)	$ 101,826.00	$ 33,603.00	$ 135,429.00	

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	$ 33,603.00	$ 135,429.00	

Source(s) of Match Dollars for State Funds:

In-Kind

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 2021: 2

Number of PATH-funded consumers assisted through SOAR: 3

PATH Site Name:HNNCSB						
Budget (2022-2023 PATH Year)			Federal PATH		Match Source	
Staff Title	***Annualized*** Salary	FTE	Funds	Local Match	(Cash or In-kind)	
Path Outreach Specialist	$41,309	1.00	$27,677	$13,632	In Kind	
Path Outreach Assistant	$25,750	1.00	$17,252	$8,498	In Kind	
Resource Development Specialist	$50,280	0.05	$1,684	$830	In Kind	
Director, Adult Care Coordination	$112,188	0.05	$3,758	$1,851	In Kind	
Manager, Homeless Services	$63,338	0.10	$4,245	$2,090	In Kind	
Total Staff Salary	$292,865		$54,616	$26,900	In Kind	
Fringe	$114,217		$26,688	$6,703	In Kind	
		Total Personnel	**$81,304**	**$33,603**		
** Always list positions separately & separate salary from benefits ("fringe")*						
Travel (Outreach travel, travel for training, state meetings, etc.)						
Use of Agency Vehicle			$1,312			
Training Travel			$400			
		Total Travel Costs	$1,712	$0		
Equipment (Personal property/equipment having useful life of more than one year)						
		Total Equipment Costs	$0	$0		
Supplies (Office Supplies, Outreach Supplies, Computer Software)						
Office Supplies			$510			
Outreach Supplies			$2,500			
Supplies						
		Total Supplies Costs	$3,010	$0		
Contractual						
Cell phone service fee			$1,302			
Security			$1,852			
		Total Contractual Costs	$3,154	$0		

Other (List and Describe Each)				
Medication Assistance	$350			
Client Support	$350			
Rental Assistance	$1,000			
Client Support Transportation	$1,500			
Staff Training (non-travel registration and costs)	$400			
Facility Expenses	$9,046			
Total Other Costs	$12,646	$0		
Total Proposed Budget	**$101,826**	**$33,603**	Is match > or = to 1/3 of federal allocation?	

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Fiscal Year 2022 -2023

1) **Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

   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 $33,603. The total budget for this project is $135,429.
   f. **Primary Contacts:**
      - **Bob Deisch - BobD@hnncsb.org 757-788-0032**
      - **A Dee Schwartz AliceS@hnncsb.org 757-240-5288**
      - **Jennifer Small – JSmall@hnncsb.org 757-788-0087**

2) **Collaboration with HUD Continuum of Care (CoC) Program**: Describe the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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 Manager of Homeless Services 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 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.

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 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) <u>Service Provision</u>: 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 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 Continuum of Care Coordinated Entry System. Staff also encourage all PATH clients to call and register with the regional Housing Crisis 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; and
   - 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.

- 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 Manager, 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) <u>Data</u>: 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.

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. The Resource Development Specialist sits on the Regional HMIS Steering Committee. 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 Analyst 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 qualifying 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. Eight

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 40 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 operates a SMI permanent supportive housing grant for chronically homeless individuals with serious mental illnesses, who also may have co-occurring substance abuse. PATH staff work closely with the SMI PSH 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) <u>Staff Information:</u>

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 Homeless Services Manager 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 Homeless Services Manager attend the annual national Health Care for the Homeless Conference where additional training is obtained including cultural competency information

8) <u>Client Information:</u> 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**. See Appendix I –**

Guidelines for Consumer and Family Participation for more information.

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 Homeless Services Manager 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 and evaluation of programs appropriate to meeting the needs of homeless individuals.

11) **Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR)**: – Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.
PATH has one staff member who is SOAR-certified.

12) **Budget Narrative:** Provide a budget narrative that includes your local plan for the use of PATH funds. **The narrative must be developed and described as outlined in Appendix II.**

The HNNCSB is requesting $101,826 in PATH funding with a match of $33,603. The total budget for this project is $135,429.

Staffing:

Position	Salary	Effort	Responsibilities

Path Outreach Specialist	**$41,309**	**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	**$25,750**	**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.**
Homeless Services Manager	**$6,335**	**10%**	**Directly oversees program and supervises outreach specialist and assistant. Presents individuals at SCAAN.**
Director, Adult Care Coordination	**$5,609**	**5%**	**Supervises Homeless Services Manager. Assures budget and grant requirements are met.**
Resource Development Specialist	**$2,514**	**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. $1,312 for the year.

Training Travel: Travel for training at the current IRS rate of 58.5 cents per mile.

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. $510 for the year

Outreach supplies: Bottled water, socks, food, and other items for the clients - total $2,500 for the year.

Contractual:

Cell phone service: Cell phones for that PATH Outreach Specialist and Assistant. Cost is based on historical usage. $1,302 for the year

Security: Security for the PATH facility (9am to 4pm) 1 day a week totals $1,852 a year.

Other:

Medical Assistance: $350 to purchase client prescriptions and over-the-counter medications that they cannot afford.

Rental Assistance: $1,000 to pay for one time rental assistance, security deposits, and other related expenses.

Bus tokens: $1,500 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: $400 per year to cover the cost of training that does not require any travel.

Client Support: $350 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 $9,046 for the year. This is based on historical figures.

Match:

Match is calculated at 33% of the Federal request. Our total match of $33,603 meets the required amount of match.

13) **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.

The Director of Adult Care Coordination and the Homeless Services Manager 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: Rachel Enghauser
Email Address: Rachel.Enghauser@Loudoun.gov

Provider Type: Community mental health center
PDX ID: VA-018
State Provider ID:
Contact Phone #: 703-777-0174

- **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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**43,182.00**	**166,824.00**	**210,006.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	98,643.00	100.00 %	0.44	43,182.00	55,460.00	98,642.00	PATH Clinician
Other (Describe in Comments)	89,465.00	100.00 %	0.00	0.00	89,465.00	89,465.00	PATH Clinician
Other (Describe in Comments)	87,596.00	25.00 %	0.00	0.00	21,899.00	21,899.00	PATH Supervisor

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0.00**	**$ 84,003.00**	**$ 84,003.00**	

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

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)	$ 50,182.00	$ 252,027.00	$ 302,209.00	

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	$ 252,027.00	$ 302,209.00	

Source(s) of Match Dollars for State Funds:

In-Kind

Estimated Number of Persons to be Contacted: 60

Estimated Number of Persons to be Enrolled: 42

Estimated Number of Persons to be Contacted who are Literally Homeless: 45

Number staff trained in SOAR in grant year ending in 2021: 1

Number of PATH-funded consumers assisted through SOAR: 3

PATH Site Name:					
Budget (2022-2023 PATH Year)			Federal PATH Funds	Local Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
PATH Clinician	$ 98,642.79	1.00	$43,182	$55,461	In-kind
PATH Clinician	$ 89,464.75	1.00		$89,465	In-kind
PATH Supervisor (25% of costs)	$ 21,898.74	0.25		$21,899	In-kind
Total Staff Salary	$ 210,006.28				
Fringe	$ 84,002.51			$84,003	In-kind
		Total Personnel	**$43,182**	**$250,827**	
** Always list positions separately & separate salary from benefits ("fringe")*					
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle					
Training Travel					
Training Conference Costs					
		Total Travel Costs			
Equipment (Personal property/equipment having useful life of more than one year)					
Lapotop (new)					
Cell Phone (replacement)					
		Total Equipment Costs			
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies					
Outreach Supplies					
Supplies					
		Total Supplies Costs			
Contractual					
Cell phone service fee				$ 1,200.00	In-kind
		Total Contractual Costs		$ 1,200.00	

Other (List and Describe Each)			
Medication Assistance			
Identification related purchase costs (incl. Birth certificates)			
Rental Assistance			
Bus Tokens			
Staff Training (non-travel registration and costs)			
Client Emergency Funds	$ 7,000.00		Federal PATH Funds
Total Other Costs	$7,000		
Total Proposed Budget	**$50,182**	**$252,027**	Local match is greater than required match of $17,342

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Federal Fiscal Year 2022

1) <u>Local Area Provider Description</u>: 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

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 assessments, 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 that MHSADS is requesting: $50,182. Point of contact: Loudoun County PATH Program Manager: Rachel.Enghauser@Loudoun.gov, 703.777. 0174

2) <u>Collaboration with HUD Continuum of Care (CoC) Program</u>: Describe the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

The Loudoun County Continuum of Care (CoC) meets regularly to discuss issues concerning individuals' experiencing homelessness among the various non-profit, faith based, government, and private groups advocating for the needs of Loudoun citizens. The CoC serves to network and provide consolidated support for housing related initiatives within Loudoun County. The CoC Coordinator is a position within the Department of Family Services (DFS). The CoC works closely with DFS who created a successful Information & Referral (I & R) program. The I & R program is one front door for individuals experiencing homelessness or at imminent risk of experiencing homelessness. Individuals contact I & R and are screened. I & R answers the Coordinated Entry Intake Line for Loudoun County. Through this line, they can access information about availability of permanent supportive housing, access to emergency funds, area food banks, referral process for Rapid Re-housing Program, referrals for emergency shelter, hypothermia shelter and drop-in center services. PATH works closely with the I & R team and provides ongoing education and training as indicated throughout the year.

3) <u>Collaboration with Local Community Organizations</u>: 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.

PATH has successful partnerships with many organizations within Loudoun County. The Loudoun Free Clinic provides free healthcare services to the uninsured and indigent while the PATH team offers support to apply for Medicaid. HealthWorks (FQHC) provides primary care to those with insurance. PATH successfully links individuals to both programs. PATH has collaborative relationships with local law enforcement, including the Leesburg Police Department and the Loudoun County Sheriff's Office. Both refer directly to PATH and when necessary, assist with trained CIT officers to outreach to individuals in the community. Shelters, including 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 provides housing support to those receiving services from 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) to link and engage PATH individuals into service. PATH expanded its outreach at County libraries to two facilities in different parts of the county and will outreach more frequently when referrals are identified.

4) **<u>Service Provision</u>**: 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 PATH team arranges for 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 to facilitate access to necessary support (MHSADS Same-Day Access for on-going behavioral healthcare, ICT for on-going wrap-around behavioral and physical healthcare, veteran services via local veteran supports, the Veteran administration, or collaborating with newly approved Service Member and Veteran and Family Peer specialist position in MHSADS. 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, sunscreen, 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 inpatient substance use rehabilitation and/ or detoxification services within the county which can be a barrier for individuals who are unwilling to leave the locality. Affordable housing is a major gap in Loudoun. The cost of housing is prohibited to most individuals experiencing homelessness, the Loudoun Permanent Supportive Housing Program has only 15 units. The Housing Choice Voucher program and the Affordable Dwelling unit both have exclusions and long waitlists. The Loudoun County Homeless Services Center (emergency shelter, cold weather shelter and drop-in center) will not allow entry to individuals with barrier crimes such as 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; and

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 or Emergency Services to determine if they are appropriate candidates for County contracted detoxification programs, residential or Medication Assisted Treatment.

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

PATH eligibility is determined by an individual or professional referral identifying an individual as homeless or becoming homeless and also has a diagnosis of a serious mental illness. PATH team members will engage individuals into services by providing PATH outreach services until they are able to 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 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 MHSADS electronic health record.

5) <u>Data</u>: 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.

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 qualifying residents.

PATH supports individuals with obtaining available housing. PATH provides case management supports with locating rental properties, application completion, application fees, negotiating property owner agreements, Housing Choice Voucher applications, and obtaining identification, credit reports and criminal background checks. PATH works with DFS 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.

The PATH team members are offered and complete many trainings on diversity, equity and inclusion. This includes age, race, ethnicity, disability and sexual orientation and identification. MHSADS has implemented a DEI committee which team members can participate and/or use for consultation and trainings. MHSADS vision statement includes Person-Centered language and practices and principles of recovery to all staff. PATH has bimonthly team meetings and regular individual supervision. MHSADS offers ethical trainings and consultations to address complex cases and situations.

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, MHSADS often uses the language line to assist non-English-speaking individuals to access our services. In person and written translation services may also be arranged when necessary.

8) <u>Client Information:</u> 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.

In FY23, Loudoun County MHSADS's PATH program is projecting to have contact with 60 individuals and to have 42 enrolled individuals. It is projected that 75% of those enrolled using will be literally homeless.

Of the individuals served by PATH from March 2021 to February 2022, approximately 73% are literally homeless.

Number of individuals contacted and enrolled by PATH March 2021-February 2022

Enrollment Status	# Individuals Served
Contacted	43
Enrolled	39
Total Served (unduplicated)	**51**

Demographics of Individuals Served by PATH from March 2021 to February 2022

Age	# Individuals	% Individuals
18 to 23	7	14%
24 to 30	7	14%
31 to 40	4	8%
41 to 50	7	14%
51 to 61	20	39%
62 and over	8	16%
Total Served (unduplicated)	**51**	**100%**

Race	# Individuals	% Individuals
Asian	4	8%
Black / African American	14	27%
Multi-Racial	2	4%
Native HI/Pacific Islander/American Indian/Alaska Native	1	2%
White / Caucasian	30	59%
Total Served (unduplicated)	**51**	**100%**

Hispanic Origin	# Individuals	% Individuals
Hispanic	4	8%
Non-Hispanic	45	92%
Total Served (unduplicated)*	**49**	**100%**

*Excluded 2 unknown

Gender	# Individuals	% Individuals
Female	19	37%
Male	32	63%
Total Served (unduplicated)	**51**	**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.

PATH staff screen every individual for possible veteran status. They assist those who do not have access to their DD214 document as this is essential to receiving benefits and support. 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 organizations and has successfully referred applicable individuals. PATH staff collaborate with the DFS Veterans Services Coordinator. The coordinator provides individualized support to assure veterans have access to service member resources.

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 PATH team consistently attempts to engage family members of the individual enrolled in the program. Staff are successful when the individual has family willing to participate and the individual is willing to have their involvement. PATH staff routinely encourage and facilitate contact between individuals served and members of their families, respecting their personal preferences. Our department's mission is person centered care, so the family's participation needs to be supported by the individual in service. Prior to the pandemic, the PATH staff facilitated consumers' participation in the CoC. Prior to the pandemic, one individual, who

formerly experienced homelessness, had been active in COC**.** Because the meetings became virtual, the individual was unable to continue to participate due to the lack of appropriate technical equipment. Staff have asked other current and former PATH individuals if they desired to participate in the CoC and all others have declined thus far. Barriers included lack of access to technology, limited technical skills, or discomfort with managing electronic systems such as Zoom. PATH staff will continue to attempt to be a bridge for PATH individuals so their voice may be heard in community organizations and groups. MHSADS values Peer Support services and has many internal and contracted peer staff. PATH staff maintain professional relationships with Peer Support staff from other programs who sometimes work with individuals transferred from PATH to those programs**.**

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

The budget document 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) <u>Programmatic and Financial Oversight</u>: Describe your agency's method of providing programmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

The PATH program has a bi-monthly team meeting. Clinical presentation of those served in PATH, barriers to treatment and services and resource requests are discussed. This is a robust discussion to meet the needs of those supported, maintaining compliance with governing bodies and updates on leveraging relationships with others, including community partners, to benefit those supported by PATH. PATH staff are provided regular scheduled supervision and consults are readily available 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 local match) to 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: John Guglielmino
Email Address: john.guglielmino@norfolk.gov

Provider Type: Community mental health center
PDX ID: VA-008
State Provider ID:
Contact Phone #: 757-837-8566

- **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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**75,182.00**	**30,061.00**	**105,243.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	64,456.00	100.00 %	0.66	42,541.00	21,915.00	64,456.00	
Case Manager	40,787.00	100.00 %	0.80	32,641.00	8,146.00	40,787.00	

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**29.84 %**	**$ 31,403.00**	**$ 16,178.00**	**$ 47,581.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 0.00**	**$ 7,800.00**	**$ 7,800.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 0.00	$ 5,500.00	$ 5,500.00	Use of Agency Vehicle
Other (Describe in Comments)	$ 0.00	$ 800.00	$ 800.00	Training Travel mileage
Other (Describe in Comments)	$ 0.00	$ 1,500.00	$ 1,500.00	Training Conference Costs

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

No Data Available

e. Supplies	**$ 0.00**	**$ 2,000.00**	**$ 2,000.00**	

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

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)	$ 106,585.00	$ 56,039.00	$ 162,624.00	

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)	$ 106,585.00	$ 56,039.00	$ 162,624.00	

Source(s) of Match Dollars for State Funds:

In-kind

Estimated Number of Persons to be Contacted:	250	Estimated Number of Persons to be Enrolled:	125
Estimated Number of Persons to be Contacted who are Literally Homeless:	100		
Number staff trained in SOAR in grant year ending in 2021:	1	Number of PATH-funded consumers assisted through SOAR:	5

PATH Site Name: Norfolk CSB							
Budget (2022-2023 PATH Year)			Federal PATH		Match Source		
Staff Title	***Annualized*** Salary	FTE	Funds	Local Match	(Cash or In-kind)		
PATH CM III	$64,456	1.00	$42,541	$21,915	In-Kind		
PATH CM II	$40,787	1.00	$32,641	$8,146	In-Kind		
Total Staff Salary			$75,182	$30,061	In-Kind		
Fringe			$31,403	$16,178	In-Kind		
		Total Personnel	**$106,585**	**$46,239**			
** Always list positions separately & separate salary from benefits ("fringe")*							
Travel (Outreach travel, travel for training, state meetings, etc.)							
Use of Agency Vehicle				$5,500			
Training Travel				$800			
Training Conference Costs				$1,500			
		Total Travel Costs		$7,800			
Equipment (Personal property/equipment having useful life of more than one year)							
Lapotop (new)							
Cell Phone (replacement)							
		Total Equipment Costs					
Supplies (Office Supplies, Outreach Supplies, Computer Software)							
Office Supplies							
Outreach Supplies				$1,000			
Supplies				$1,000			
		Total Supplies Costs		$2,000			
Contractual							
Cell phone service fee							
		Total Contractual Costs					

Other (List and Describe Each)					
Medication Assistance					
Identification related purchase costs (incl. Birth certificates)					
Rental Assistance					
Bus Tokens					
Staff Training (non-travel registration and costs)					
Total Other Costs					
Total Proposed Budget	**$106,585**	**$56,039**	Is match > or = to 1/3 of federal allocation?		

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Federal Fiscal Year 2022

1. **Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included

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 nearly 50 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, Assertive Community Treatment (ACT), 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. NCSB requested federal PATH funds in the amount of $106,585.

Primary point of contact:
John Guglielmino – Program Administrator
(757) 837-8566 john.guglielmino@norfolk.gov

2. **Collaboration with HUD Continuum of Care (CoC) Program:** Describe the organization's participation with local HUD (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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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 bi-weekly Service Coordination Committee meetings, where their outreach clients are referred for housing programs in the CoC. 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.
The CoC works collaboratively with the Southeastern Virginia Homeless Coalition to coordinate a continuum of care for homeless individuals, 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. 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 workers also provide outreach and support at the new shelter in Norfolk (The Center). This has allowed a more collaborative effort to engage hard to reach individuals. Housing and Homeless Services provides data entry into HMIS for all NEST participants. PATH provides weekly outreach at community meals to connect with residents experiencing homelessness. With the advent of COVID, PATH outreach became even more critical of a component to assist those eligible clients experiencing homelessness get connected to assistance and resources.

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 workers have served as team leads in the Point-in-Time Count and Project Homeless Connect events.

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 coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

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. Other internal departments PATH works directly with are: Intake, The Center Shelter, 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.

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 Men's Shelter – 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 Center Shelter/Healthy Hotel Shelter – The Center provides meals, day services, and shelter to homeless adults year-round, replacing the former winter shelter program called NEST. The Healthy Hotel came about as a response to the COVID pandemic to provide non-congregate shelter to the most vulnerable and medically compromised single adults experiencing homelessness. PATH staff are present at each the site weekly to provide support and to conduct assessments. They also provide information about resources available within the community.

St. Columba Day Center – Provides transitional housing for single adults, rental and utility assistance, food pantry, clothing closet, and day services. 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.

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: PATH assists their clients with obtaining SNAP, Medicaid, SSA application assistance and adult services. 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. PATH workers coordinate their schedules in conjunction with these programs to maximize their outreach potential and frequency of contact with clients.

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 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 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, 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, as well as various faith based and nonprofit community organizations that provide services and meal programs for persons experiencing homelessness in Norfolk.

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 also 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 CoC Coordinated Entry process and Service Coordination Committee meetings, the NCSB Housing and Homeless department, and 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. An ongoing partnership agreement between the CoC (SVHC) and NRHA provides up to 63 housing choice and public housing turnover units to the homeless population moving on from homeless housing programs. 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 clients with 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;

Shelter Availability

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. The advent of COVID greatly exacerbated this gap. This gap has been moderated recently to a degree with the opening of The Center, a low-barrier emergency shelter, in December 2021, but the need for emergency shelter and high barriers of other local shelters, still presents a gap, especially for PATH eligible clients.

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; and

Integrated Services: We have an internal integrated care services program 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, 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 ensures 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. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

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 qualifying residents.

The NCSB collaborates with the CoC (SVHC) and works in conjunction with the coordinated entry and assessment process 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.

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. PATH workers also receive trainings from the CoC Lead Agency and other providers to special populations to be as current as possible with cultural competence and related 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.

Looking at the HMIS PATH data from 7/1/2020 to 6/30/2021, the COVID pandemic had an acute direct impact in numbers of clients served compared to prior years' activities. PATH demographics for that period breaks down as follows:

PATH Street Outreach- 91 persons were outreached, and 45 were enrolled. Of those enrolled, 35 identified as Male and 9 as Female; 28 identified as Black/African American, 13 identified as White, 1 as Asian, 2 were of multiple races, and 1 refused to answer. Of those enrolled, only 2 identified as Hispanic/Latino; 39 were between the ages of 25-61, and 6 were 62 and older.

PATH Services – 65 persons were outreached, and 31 were enrolled. Of those enrolled, 18 identified as Male, and 13 as Female; 22 identified as Black/African American, 6 as white, 2 as Asian, and 1 as multi-racial; 2 identified as Hispanic/Latino; 26 were between the age ranges of 25-61, 1 age 18-24, and 4 age 62 and above.

For the FY 2022-23 grant year, PATH staff projects they will outreach roughly 250 persons, enrolling around 125 of them. 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 the COC partners to address Veteran Homelessness, including the Virginia Veteran and Family Support program, the VA outreach workers, and two Support Services for Veterans and Families (SSVF) programs. 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. **See Appendix I – Guidelines for Consumer and Family Participation for more information.**

The NCSB employs 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. Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR). Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure clients applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

The NCSB PATH outreach program employs two outreach workers. The Lead outreach worker is SOAR-Certified, and the second is in process of completing SOAR certification. The PATH program's close collaboration with SSA points of contact allow them to more effectively connect clients when needed and intervene with additional advocacy for client's to obtain SSI/SSDI benefits they are eligible for.

12. Budget Narrative: Provide a budget narrative that includes your local plan for the use of PATH funds. **The narrative must be developed and described as outlined in Appendix II.**

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 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 $64,456.01/year. $42,540.96 of this salary is charged to the grant, while the remaining is used for local cash match. The second position's salary is over $40,787.41/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 $31,403. The remaining portion of the benefits ($16,178) are used for local cash match.

c) Travel: Travel costs requested under the grant total $7800. The majority of the cost ($5500) is for vehicle use by two PATH staff, for fee, gas, and maintenance over the grant year. Approximately $230 per month, per staff person ($230x2x12mo = $5520-rounded down to $5500). The remaining $2300 is requested for anticipated travel costs by plane or rental car as well as conference fees, for 2 staff to attend state and national conferences.

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

***Contractual costs are for use of 2 cell phones by staff at approximately $50/mo ($50x2x12mo=$1200).

13.<u>Programmatic and Financial Oversight</u>: Describe your agency's method of providing programmatic and fiscal oversight to ensure PATH funds are used on eligible expenses that benefit eligible consumers.

PATH program staff are supervised by the outreach Program Administrator and Department Head with Housing and Homeless Services. The Program Administrator 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. The Program Administrator 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. Program Administrator and Department Head 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 from the grant.

Portsmouth Department of Behavioral Health Services
505 Washington Street, Suite 200
Portsmouth, VA 23704
Contact: Dwight Williams
Email Address: dwight.williams@portsmouthva.gov

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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:

In-kind

Estimated Number of Persons to be Contacted: 50

Estimated Number of Persons to be Enrolled: 50

Estimated Number of Persons to be Contacted who are Literally Homeless: 100

Number staff trained in SOAR in grant year ending in 2021: 0

Number of PATH-funded consumers assisted through SOAR: 0

PATH Site Name: Portsmouth Department of Behavioral Health Services					
Budget FFY 2022/SFY 2023 (2022-2023 PATH Year)			Federal PATH Funds	Local Match	Match Source (Cash or In-kind)
Staff Title Case Manager	***Annualized*** Salary	FTE			
Salary for 1 PATH Case Manager at $3729.50 monthly	$40,000	1.00	$40,000		
Fringe Benefits for 1 PATH Case Manager at $1330.67 monthly	$10,400		$10,400		
		Total Personnel	**$50,400**		
Travel (Outreach travel, travel for training, state meetings, etc.)					
Fuel for agency vehicle for 1 PATH Case Manager @ $83.33 monthly				$1,000	
Training Travel					
Training Conference Costs					
		Total Travel Costs		**$1,000**	
Equipment (Personal property/equipment having useful life of more than one year)					
		Total Equipment Costs	**$2,000**		
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Outreach Supplies for consumers, including, winter clothing (coats, hats, gloves, socks, shoes), blankets, feminine hygiene items, underwear, and personal hygiene items.				$4,405	
		Total Supplies Costs		**$4,405**	
Contractual					
Cell phone service fee for 1 PATH Case Manager @ $41.67 monthly				$500	
1 HMIS License for the PATH Case Manager			$1,315		
		Total Contractual Costs	**$1,315**	**$500**	
Other (List and Describe Each)					
Medication Assistance					
Identification related purchase costs for 40 consumers (Birth certificates, DMV photo IDs) at $25/consumer				$1,000	
Rental Assistance, including payment of deposits, household items, and temporary housing for 20 consumers				$5,000	
248 Daily Bus Tokens for consumers @$4 each				$1,000	
Staff Training (non-travel registration and costs)					
Administrative Costs, including billing, reimbursement, data management, utilization review, and staff supervision				$5,000	
		Total Other Costs	$0	**$12,000**	

Total Proposed Budget	**$53,715**	**$17,905**	

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Fiscal Year 2022 -2023

1. **Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included

   Portsmouth Department of Behavioral Healthcare Services (PDBHS) is a Behavioral Health Authority that provides a full range of mental health and substance use services to the residents of Portsmouth, VA, which is a part of Region 5. The amount of PATH funds noted on the proposed budget is $53,715. The primary point of contact for our PATH program is Dwight Williams (PATH Case Manager). He can be reached at (757) 335-3443 or by e-mail at dwight.williams@portsmouthva.gov. His immediate supervisor is Dean Burgess. He can be reached at (757) 393-8928 ext. 5733 or dburgess@portsmouthva.gov

2. **Collaboration with HUD Continuum of Care (CoC) Program:** Describe the organization's participation with local HUD (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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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 coordination of activities and policies with those organizations. Provide specific information about how coordination with other outreach teams will be achieved.

   PDBHS is an active member of the local HUD CoC (PHAC/PCAN). PDBHS coordinates with The Planning Council to accurately document homeless records in HMIS. The PATH CM presents outreached homeless cases to the PCAN team at the bi-monthly PCAN meeting to be considered for housing.

   The PATH CM meets with local businesses, churches, shelters, schools, and private mental health organizations to educate them about the PATH program and the services offered through PATH. Community partners provide a variety of goods and services (hygiene items, clothing, furniture, financial assistance, housing, and employment opportunities). Additionally, with the PATH program being a part of PDBHS, individuals outreached are linked to SDA (Same Day Access) where they can be assessed and referred to a variety of services, to include primary screenings, therapy, and medication management. PATH staff maintains contact with other outreach agencies through the PCAN (Portsmouth Community Assessment Network) coordinated entry meetings.

Policies and procedures are reviewed, discussed, and updated if needed during the PHAC coordinated entry committee meetings.

4. <u>Service Provision:</u>

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;

Services provided align with PATH goals by physically going into the streets and shelters where homeless individuals congregate to provide outreach and education on the services offered through PATH and PDBHS. PATH CM participates in the P.I.T count (Point In Time) to identify homeless individuals that are literally sleeping in the streets and places not meant for human habitation. PATH CM meets with shelter directors to discuss program guidelines and review cases of homeless individuals receiving shelter services. Current Path CM utilizes shared experience as a veteran to build rapport, instill hope, and maximize efforts. PATH CM maintains ongoing contact with Shelter Plus Care program case manager, also apart of PDBHS, to inquire about any vacancies as to refer applicable individuals in efforts to link to long-term housing.

B. **Any gaps that exist in the current service systems;**

Any gaps identified are addressed by the Case Manager, Program Administrator, and Clinical Manager.

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

PATH services include outreach, case management, education, intake, assessment, community resource (MH/SA services, employment referrals) linkage, as well as access to tangible items such as clothing, hygiene products, bus passes, and food.

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

PATH eligibility is determined by establishing individuals' homeless status based on HUD's guidelines and definitions for determining homelessness. PATH enrollment is ongoing and is documented by assigning an individual to PATH in the PDBHS Electronic Health Record, Credible, as well as in HMIS, an additional electronic database.

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

   The PATH CM uploads client information, as well as housing assessment information, into HMIS and creates a coordinated entry. The PATH CM adheres to all HMIS policies and procedures as well as ensures completion of any mandatory trainings facilitated by The Planning Council to include learning labs on coordinated entry refreshers. The PATH CM submits monthly data quality reports. The PATH CM's direct supervisor, as well as the Clinical Manager all have HMIS licenses to support the PATH CM as needed. Any additional training needs are identified and addressed by the appropriate persons.

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.

   The PATH CM collaborates with property managers and landlords to have them register their property with the City of Portsmouth to ensure suitable accommodations and to negotiate lower rental rates for PATH clients. Current companies and agencies that participate with PDBHS PATH program are Eberwine Properties, Billez Housing Program, James Bentley Services, and PDBHS Shelter Plus Care Program. PATH CM also collaborates with Portsmouth Redevelopment & Housing Authority (PRHA) to learn about the various housing vouchers and lottery programs that they periodically offer to the public.

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 CM utilizes a person-centered approach to interacting with clients, which allows them to focus on the individual, their needs, and circumstance and not their demographic identifiers, to best meet them where they are. PATH CM also has ongoing opportunity to discuss and process any internal conflict or bias regarding a person's demographic, sexuality, age, gender, etc.

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

      The PATH CM receives training throughout the year from various organizations and speakers on people experiencing homelessness and how to work with varying issues. The PATH CM is also required to take agency annual training on cultural diversity, person-centered approach, as well as human rights.

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.

   Most of the client population are African American men who are literally homeless and suffer from mental health and/or substance use issues. The age range is wide (25-75). The PATH program plans to contact and enroll 50 participants with 100% of those individuals being literally homeless. PATH also coordinates with Portsmouth Public Schools Homeless Liaison to offer services to school age children and their families.

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 current PATH CM is a disabled veteran who maintains contact with the Veterans Administration to remain knowledgeable about the various programs and resources offered to the veteran population. The PATH CM immediately notifies the CoC upon meeting a homeless veteran to make an "off week" referral, as opposed to waiting for the next coordinated entry meeting to present the veteran for 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.

    PDBHS employs certified peers with lived experience so there is the potential for hire of those directly or indirectly involved with PATH. Additionally, when board seats are open for an individual and/or family member or an individual receiving services at PDBHS, the Director makes this known to the entire agency, to include the PATH CM. The PATH CM also informs individuals currently enrolled in PATH of the various community events hosted by PDBHS throughout the year and inquires about their interest in volunteering at these events.

11. **Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR).** Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure clients applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

    The PATH Case Manager, as well as the supervisor are both enrolled in the online self-paced SOAR training and should be finished soon. Conversely, PATH enrolled individuals are linked to PDBHS which gives them access to a SOAR trained CM that can assist them with applying for SSA benefits, until the PATH CM is certified.

12. **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

13. **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.

    Programmatic structure of the PATH program includes a PATH CM that is directly supervised by a Program Administrator. The PATH Program receives additional oversight by one of PDBHS Clinical Managers, who directly supervises the Program Administrator. Both the PATH CM and Program Administrator receive monthly formal supervision to discuss the program, job performance, etc.; however, any pertinent matters can be addressed at any time. The PDBHS Finance Department provides financial oversight of PATH funds to ensure funds are being utilized appropriately. A requisition form that itemizes expenses must be submitted and approved by the finance Admin or Asst. Admin before any funds are dispersed. Further, expenses are coded via a designated account code. All receipts are kept by the finance department as well.

Prince William County Community Services
15941 Donald Curtis Drive
Woodbridge, VA 22191
Contact: Lynn Fritts
Email Address: lfritts@pwcgov.org

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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**	**16,198.00**	**102,402.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Outreach worker	17,000.00	50.00 %	0.05	802.00	16,198.00	17,000.00	PT
Other (Describe in Comments)	85,402.00	80.00 %	1.00	85,402.00	0.00	85,402.00	PATH Therapist

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**0.00 %**	**$ 0.00**	**$ 37,917.00**	**$ 37,917.00**	

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	**$ 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	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
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	$ 54,457.00	$ 142,524.00	

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	$ 54,457.00	$ 142,524.00	

Source(s) of Match Dollars for State Funds:

In-kind

Estimated Number of Persons to be Contacted: 70

Estimated Number of Persons to be Enrolled: 41

Estimated Number of Persons to be Contacted who are Literally Homeless: 68

Number staff trained in SOAR in grant year ending in 2021: 1

Number of PATH-funded consumers assisted through SOAR: 0

PATH Site Name: PWC					
Budget (2022-2023 PATH Year)			Federal PATH Funds	Local Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
PATH Therapist	$ 85,402	0.80	$85,402		
PATH Therapist PT	$ 17,000	0.50	$802	$16,198	
Total Staff Salary	$102,402	1.30			
Fringe	$37,917			$37,917	
		Total Personnel	**$86,204**	**$54,115**	
** Always list positions separately & separate salary from benefits ("fringe")*					
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle					
Training Travel					
Training Conference Costs					
		Total Travel Costs			
Equipment (Personal property/equipment having useful life of more than one year)					
Lapotop (new)					
Cell Phone (replacement)					
		Total Equipment Costs			
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies				$100	
Outreach Supplies			$450	$60	
		Total Supplies Costs	$450	$160	
Contractual					
Cell phone service fee			$125		
		Total Contractual Costs	$125		

Other (List and Describe Each)						
Medication Assistance	$188	$140				
Identification related purchase costs (incl. Birth certificates)	$200					
Rental Assistance	$300	$42				
Bus Tokens	$200					
Cab Vouchers	$200					
Housing Move-In Associated Costs (e.g., lines/dishes)	$200					
Total Other Costs	$1,288	$182				
Total Proposed Budget	**$88,067**	**$54,457**	Is match > or = to 1/3 of federal allocation?			

Virginia PATH Local Intended Use Plan
PATH Program Year 2022 - 2023

1. Local Area Provider Description
a. Name: Prince William Community Services
b. Organization Type: Community Mental Health Center
c. Region Served: The Prince William County Community Services serves Prince William County, the Cities of Manassas and Manassas Park.
d. Amount of federal PATH funds requested: $88,067
e. Primary Point of Contact: Lynn M. Fritts Phone: office 703-792-7947; cell 571-437-1021 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. If the organization is not currently working with the CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.*

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 (DSS), 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), Service Continuum, 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 staffed by PWC DSS, Homeless Services Division. PATH has established a positive working relationship with CE, contacting CE on clients' behalf and following up with CE in complicated circumstances. PATH maintains a collaborative relationship with PWC DSS Homeless Services as CS and DSS have expanded with outreach programs designed to specifically target the unsheltered homeless population.

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 an 8-bed Supportive 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 32 degrees or below and provide showers on Fridays. PATH receives referrals from staff operating the hypothermia and shower program.
- 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.
- Serving Our Neighbors (SON) Mobile Drop-In Center provides outreach and engagement to the unsheltered homeless at Manassas Presbyterian Church on Tuesdays and Thursdays. An average of 18 unsheltered homeless attend daily with 2-4 new attendees coming in each week.
- Clinical Homeless Services Program (CHSP), within PWC CS, was developed because of a gap in outreach, engagement and case management services to the homeless population not meeting the criteria for PATH enrollment. Staff with CHSP include a full-time clinician housed within the Ferlazzo Shelter and another clinician focused on the unsheltered population, primarily in Western PWC, but able to outreach the entire county. CHSP clinicians outreach, engage and provide case management to adults with symptoms of mental illness (but not necessarily to the severity of SMI), and/or Substance Use Disorder, and/or Intellectually / Developmentally Disabled, homeless population. PWC DSS employs one full time outreach staff, partnering with the outreach CHSP clinician on scheduled outreach days. The PATH lead clinician supervises PATH and CHSP.
- 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 are contacted by members of the community about a family member or someone they may have encountered in their neighborhood and are concerned about. 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.
- 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 Medicaid or Medicare.

- 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 or calling when the office opens at 8 AM to ensure being seen that day). Clients are given the option for phone, video, or face-to-face appointments to complete the clinical assessment portion of the intake process. 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 treatment 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. A part-time 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, Richmond Behavioral Health, National Capital Treatment and Recovery in Arlington, and the Mohr Center in Charlottesville. Fairfax, Alexandria, and the Mohr Center provide detox opportunities. 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. 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. 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 UVA 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 five emergency shelter facilities (Ferlazzo Shelter, Supportive Shelter, SERVE, Hilda Barg Homeless Prevention Center and Beverly Warren Emergency Homeless Shelter) for the homeless, providing a total of 198 beds. ACTS operates an emergency domestic violence shelter. The PATH therapists work 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 units 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 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 housing for 15 SMI consumers in a congregate living setting. 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 10 SMI, formerly 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, in congregate housing, for the chronically homeless including six PSH beds for medically fragile clients. Pathways Homes, Inc. offers 15 one-bedroom apartments, using COC PSH funding, for chronic homeless individuals determined to have a Serious Mental Illness and/or Substance Use Disorder. PATH clients who have transitioned into mainstream services will continue to be referred. PATH therapists work collaboratively with the PSH programs to maximize continuity of care.
- PWC Office of Housing and Community Development: The Housing Choice Voucher Program (HCV) 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 HCV wait list is not expected to open again during the proposed grant year. As of March 2022, there are 575 families on the Wait List. On average about 100 people are called from the wait list each year. The County also administers other federal rental assistance programs to include Non-Elderly Disabled (NEDS), Family Unification Program (FUP), Mainstream Vouchers, Veteran Affairs Supportive Housing (VASH). PWC OHCD received funding in 2021 for 53 Emergency Housing Choice Vouchers (EHCV) for homeless individuals and families. Manassas City and Manassas Park received 10 EHCV for the homeless. Referrals for EHCV projects went through the Prince William County Coordinated Entry System. In addition, PWC OHCD received 18 CARES Act Vouchers. OHCD currently serves on average 1,976 families per year with the average cost per unit for the Housing Choice Voucher Program of $1,162 per month. OHCD anticipates opening this fiscal year for special populations the wait list for NEDS Voucher and Mainstream Voucher applicants who meet the eligibility requirements of the

program(s) as well as meeting preference one, live or work in Prince William County. These waiting lists will be lottery based with 100 NEDS and 100 Mainstream.

The Bill Mehr Homeless Drop-In Center, operating under the Cooperative Council of Ministries (CCOM), in partnership with Prince William County Department of Social Services, provided a year-round Drop-In Center in Woodbridge, working with many of the chronically homeless individuals. The public health crisis related to COVID-19 effectively shuttered the doors to the Bill Mehr Center. The facility lacked the space to adequately allow participants and staff to socially distance from one another. The Drop-In Center is now co-located with the Ferlazzo Shelter. 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, sandwich and coffee shop establishments, and 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 public benefits, 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. Barriers to housing are formidable for those with extensive criminal histories, on the sex offender registry, or have poor credit history.

Permanent Drop-In Center(s): The lack of permanent, brick and mortar Drop-In Center (DIC) sites to accommodate the unsheltered homeless in western and eastern PWC has become even more apparent in the last two years. The Bill Mehr Drop-In Center, located in Eastern PWC, served as DIC for many years but closed in early 2020 because of COVID-19. While the DIC has temporarily moved to a location that includes an adult-only shelter, offices of Community Services and Department of Social Services, participation is only a fraction of pre-COVID days. Services that were popular among the unsheltered homeless (washers and dryers, mail, computer assistance with job applications, meal planning designed for the unsheltered, etc.) are no longer available. The SON Mobile DIC came about in Western PWC because that area had no DIC-type resources. Overall plans to operate a permanent, brick and mortar location in Western PWC has hit major roadblocks (lack of available properties, strong community opposition to one proposed location).

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 (now WellSky). 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*.

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 Committee. The PWA PSH Committee coordinates referrals made to the various PSH providers throughout the area. The PSH Committee 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 Piedmont Global Language Services, 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 from FY 2022 Annual Report:

Race / Ethnicity of PATH Enrolled	**% PATH Enrolled**		**Age Parameters**	**% PATH Enrolled**
American Indian or Alaskan Native	0		18-23	3
Asian	3		24-30	9
Black or African American	37		31-40	35
Native Hawaiian or Pacific Islander	0		41-50	26
White	60		51-61	26
Hispanic / Latino	14		62+	0
Gender of PATH Enrolled			**Veteran Status**	
Female	29		Veteran	8
Male	65		Non-Veteran	92
Transgender	6			
			Co-Occurring SUD	
Chronically Homeless			Co-Occurring SUD	41
Yes	44		No Co-Occurring SUD	59
No	56			

b. *Projected number of adult consumers to be contacted with PATH funds:* The PWC PATH program projects to outreach at least 70 individuals during FY 2023.

c. *Projected number of adult consumers to be enrolled using PATH funds*: The PWC PATH program projects to enroll at least 41 individuals during FY 2023.

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 Ferlazzo Shelter Drop-In Center, SON Mobile Drop-In Center, 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, substance use, health issues, lack of income and housing. PATH therapists link clients directly with mainstream services for issues identified in the needs assessment. Services available to veterans include mental health, substance abuse, primary health, case management, employment, education, and housing as identified in Sections Three and Four of this application. PATH therapists directly link clients with services available to veterans and/or families of veterans, such as the US Department of Veterans Affairs (VA) and Supportive Services for Veteran Families (SSVF). The PATH therapist actively participates in the COC Service Continuum subcommittee where homeless veterans have been placed on a By-Names list for housing purposes. Friendship Place, Operation Renewed Hope Foundation and Volunteers of America work 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. PATH therapists link veterans to Easter Seals for employment training and resources.

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. Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR):
Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

The PWC CS SOAR trainer completed an intense SOAR Train the Trainers program in 2007. The SOAR trainer is also the PATH supervisor identified in various places throughout this document. SOAR based trainings have been provided to CS clinicians as well as community partners, such as emergency shelter case managers, non-profit housing providers and crisis stabilization clinicians on an annual basis for the last eight years. To date, more than 300 individuals have been trained. PATH clinicians have assisted six consumers with SSI/SSDI applications using the SOAR model through three quarters of FY 2022. PWC PATH developed a method to document / track the SSI/SSDI application process with respect to completion of benefit applications, eligibility determination, overall status of the application at any given time and outcomes of the applications submitted on behalf of PATH Enrolled consumers. PWC PATH will assess the capacity to do the same on a larger scale on behalf of all CS consumers applying for SSI / SSDI benefits.

12. **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 for prescriptions not covered by insurance or out or pocket costs
- Identification related costs (birth certificates, etc.)
- Rental assistance costs
- Bus tokens
- Cab vouchers
- Housing Move-In costs (linens, dishes, etc.)

13. 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 2023 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, and 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
Email Address: jmcintosh@rappahannockareacsb.org

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**41,669.00**	**18,823.00**	**60,492.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	60,492.00	100.00 %	0.69	41,669.00	18,823.00	60,492.00	

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**24.34 %**	**$ 14,721.00**	**$ 3,000.00**	**$ 17,721.00**	

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	**$ 41,754.00**	**$ 10,892.00**	**$ 52,646.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 41,754.00	$ 10,892.00	$ 52,646.00	Contract with Micah Ecumenical Ministries for PATH outreach and SOAR services

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)	$ 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:

In-Kind

Estimated Number of Persons to be Contacted: 200

Estimated Number of Persons to be Enrolled: 145

Estimated Number of Persons to be Contacted who are Literally Homeless: 170

Number staff trained in SOAR in grant year ending in 2021: 1

Number of PATH-funded consumers assisted through SOAR: 35

PATH Site Name: Rappahannock Area CSB					
Budget FFY 2022/SFY 2021 (2022-2023 PATH Year)			Federal PATH Funds	Local Match	Match Source (Cash or In-kind)
Staff Title	***Annualized*** Salary	FTE			
PATH Case Manager	$60,492	1.00	$41,669	$18,823	
Total Staff Salary	$60,492	1			
Fringe	$17,721		$14,721	$3,000	
		Total Personnel	**$56,390**	**$21,823**	
** Always list positions separately & separate salary from benefits ("fringe")*					
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle					
Training Travel					
Training Conference Costs					
Staff Mileage					
		Total Travel Costs	**$0**		
Equipment (Personal property/equipment having useful life of more than one year)					
Lapotop (new)					
Cell Phone (replacement)					
		Total Equipment Costs			
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies					
Outreach Supplies					
Supplies					
		Total Supplies Costs			
Contractual					
Cell phone service fee					
Micah Contract			$41,754	$10,892	
		Total Contractual Costs	$41,754	$10,892	
Other (List and Describe Each)					
Medication Assistance					
Identification related purchase costs (incl. Birth certificates)					
Rental Assistance					
Bus Tokens					
Staff Training (non-travel registration and costs)					
		Total Other Costs			
		Total Proposed Budget	**$98,144**	**$32,715**	Is match > or = to 1/3 of federal allocation?

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Fiscal Year 2022 -2023

1) **Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

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) 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.

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 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 access services. PATH also participates in weekly discharge planning 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 of individuals to homelessness when 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 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 do not fit into another organization.

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.

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 housing that is more permanent. 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 that 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 a 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 which works with its Program for Assertive Community Treatment, 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 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;

a. 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;

b. PATH attempts to bridge the Gaps in service by providing one-time assistance with rent or security deposits, prescription and transportation assistance through direct assistance and local bus tickets.

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

c. 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.

d. 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. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

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.

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.

Once and individual is identified as PATH-eligible, he/she is assisted in obtaining an intake appointment with an RACSB therapist, 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 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.

a. 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 translation

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

b. 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: 200
- Projected number of adult consumers to be enrolled using PATH funds: 145
- 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.

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***. See Appendix I – Guidelines for Consumer and Family Participation for more information.***

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) **Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR)**: – Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with community stakeholder who is SOAR-certified.

Our PATH program has 1 certified SOAR worker, who is also the Local Lead for our area. The Local Lead has led efforts alongside our CoC and State Lead to increase the number of certified SOAR workers within our service area. At least 3 staff at Micah Ministries - not including the PATH SOAR worker - are certified and at least 1 case manager in RACSB's PSH program is trained and certified as well. 3 more SOAR workers exist in our area as well, one within Child Support Enforcement, another at Louis Ann's Hope House, and a third at Empowerhouse. In addition to the PATH SOAR worker, PATH partners with the Child Support worker to process additional cases the PATH worker cannot immediately serve.

12) **Budget Narrative:** Provide a budget narrative that includes your local plan for the use of PATH funds. **The narrative must be developed and described as outlined in Appendix II.**

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.

13) **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.

The projected PATH Budget is developed annually to outline how the grant funds and matching funds will be utilized. The PATH Outreach Worker meets and communicates regularly with his supervisor, to discuss plans to cover medications, rental assistance and security deposits. Any invoices for medications are reviewed to determine if Medicaid can be retro-billed, prior to submission for payment. 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
Email Address: DEIDRE.CREASY-QUIRINDOONGO@regionten.org

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**$ 1,062.00**	**$ 1,000.00**	**$ 2,062.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 0.00	$ 500.00	$ 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	**$ 3,000.00**	**$ 0.00**	**$ 3,000.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 3,000.00	$ 0.00	$ 3,000.00	Initial Housing Costs

h. Construction (non-allowable)				
i. Other	**$ 2,910.00**	**$ 0.00**	**$ 2,910.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Transportation	$ 500.00	$ 0.00	$ 500.00	
Client: Other (Describe in Comments)	$ 1,910.00	$ 0.00	$ 1,910.00	medication assistance
Client: Other (Describe in Comments)	$ 500.00	$ 0.00	$ 500.00	IDs

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:

Cash and In-Kind

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: 94

Number staff trained in SOAR in grant year ending in 2021: 0

Number of PATH-funded consumers assisted through SOAR: 0

PATH Site Name: Region Ten Community Services Board with On Our Own of Charlottesillve as contractor					
Budget (2022-2023 PATH Year)					
Staff Title	***Annualized*** Salary	FTE	PATH Funded	Match	Match Source (Cash or In-kind)
Agency PATH case manager outreac	$31,279	0.75	$31,279		
Total Staff Salary	$31,279				
Fringe	$ 6,000			$6,731	Cash
		Total Personnel	**$31,279**	**$6,731**	
** Always list positions separately & separate salary from benefits ("fringe")*					
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle				$2,000	In Kind
Training Travel					
Training Conference Costs					
		Total Travel Costs	**$0**	$2,000	
Equipment (Personal property/equipment having useful life of more than one year)					
Cell phone			1,000		
Laptop (New)					
		Total Equipment Costs	1,000	$0	
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies				$500	Cash
Outreach Supplies				$500	Cash
Supplies			1062-		
		Total Supplies Costs	1,062	$1,000	
Contractual					
Cell phone service fee				$1,000	Cash
On Our Own PATH Woker .80 FTE			25,611	10889	

Total Contractual Costs	25,611	$11,889			
Other (List and Describe Each)					
initial housing costs	3,000				
Medication Assistance	1,910				
Identification Related Costs (incl. Birth Certificate)	500				
Bus Tokens	500				
Administrative Costs					
Total Other Costs	5,910	$0			
Total Proposed Budget	**$ 64,862**	**$ 21,620**	Is match > or = to 1/3 of federal allocation?		

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Fiscal Year 2022-2023

1) **Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

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, including Albemarle, Louisa, Fluvanna, Greene and Nelson 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. Region Ten receives $64,862 in PATH funds that we supplement with a 33% match of $54,551.

Primary Point of Contact = Deidre Creasy-Quirindoongo (434) 972-1885 deidre.creasy-quirindoongo@regionten.org

2) **Collaboration with HUD Continuum of Care (CoC) Program**: Describe the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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. 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.**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 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 PATH Director attends all CIT meetings and meets periodically with other community partners.

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 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. In April of 2021, the COC, Piedmont Housing Alliance and TJACH all collaborated to purchase Premier Circle, a 120 unit building where Charlottesville's most vulnerable experiencing homelessness are housed. 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; and

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. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

PATH staff have met with HMIS officials and were trained by the local COC. Staff attend HMIS user quarterly meetings at the Haven and participate in HMIS webinars. Due to COVID, most meetings have been held virtually and less frequently.

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.

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, PACEM seasonal shelter, First St. Church Day Haven and the Salvation Army.

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.

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

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.

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. Cultural competence training is also required for Region Ten Community Services Board 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.

Due to COVID-19 only 73 PATH consumers were enrolled from 07/2020-06/2021 and 116 were contacted. Our projected numbers for this year are to contact 125 individuals and enroll 75. Of the 75 enrolled, it is anticipated that 75% will be literally homeless. Of the 73 PATH consumers enrolled this past year, 43% were female, 57% were male. 49% were African American, 51% were Caucasian, and less than 1% were of Hispanic Origin. A little over 15% had a military history.

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 collaborates with the SSVF (**Supportive Services for Veteran Families**) Program to ensure that Veteran's experiencing homelessness are served. Likewise, Region Ten has a Veteran Engagement peer that assists veteran's in building safety and connection and navigating the systems. Path has also built a relationship with Central Virginia healthcare alliance system for veteran supports.

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. ***See Appendix I – Guidelines for Consumer and Family Participation for more information.***

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 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) **Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR):** – Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

a. Currently our PATH Outreach worker is SOAR certified and assisted PATH participants in getting connected with SSI/SSDI.

12) **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.*

13) **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.

Programmatic and Fiscal oversight to ensure PATH funds are used on eligible expenses are closely monitored by the PATH's Director and Region Ten's Finance departmen

Richmond Behavioral Health Authority
107 S. 5th Street
Richmond, VA 23219
Contact: Katie Chlan
Email Address: katie.chlan@rbha.org

Provider Type: Community mental health center
PDX ID: VA-015
State Provider ID:
Contact Phone #: 804-819-4255

- **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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**121,481.00**	**18,249.00**	**139,730.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Case Manager	52,173.00	100.00 %	1.00	52,173.00	0.00	52,173.00	
Case Manager	49,912.00	100.00 %	1.00	49,912.00	0.00	49,912.00	
Case Manager	38,792.00	50.00 %	0.50	19,396.00	0.00	19,396.00	
PATH Administrator	91,244.00	20.00 %	0.00	0.00	18,249.00	18,249.00	Program Manager

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**33.04 %**	**$ 46,163.00**	**$ 0.00**	**$ 46,163.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 800.00**	**$ 20,000.00**	**$ 20,800.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Conference Registration Fee	$ 500.00	$ 0.00	$ 500.00	
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**	**$ 3,400.00**	**$ 3,400.00**	

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	$ 400.00	$ 400.00	cell phone purchase

e. Supplies	**$ 0.00**	**$ 8,500.00**	**$ 8,500.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Outreach Supplies/Hygene kits/Misc.	$ 0.00	$ 6,500.00	$ 6,500.00	
Office: Supplies	$ 0.00	$ 2,000.00	$ 2,000.00	

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

No Data Available

g. Housing	**$ 3,966.00**	**$ 25,000.00**	**$ 28,966.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	$ 3,000.00	$ 25,000.00	$ 28,000.00	rental assistance
Other (Describe in Comments)	$ 966.00	$ 0.00	$ 966.00	furniture bank fees

h. Construction (non-allowable)

i. Other	**$ 300.00**	**$ 3,000.00**	**$ 3,300.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Client: Other (Describe in Comments)	$ 250.00	$ 1,500.00	$ 1,750.00	identification fees
Office: Other (Describe in Comments)	$ 50.00	$ 1,000.00	$ 1,050.00	medication assistance
Staffing: Training/Education/Conference	$ 0.00	$ 500.00	$ 500.00	

j. Total Direct Charges (Sum of a-i)	$ 172,710.00	$ 78,149.00	$ 250,859.00	

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)	$ 172,710.00	$ 78,149.00	$ 250,859.00	

Source(s) of Match Dollars for State Funds:

In-Kind and Private Donors

Estimated Number of Persons to be Contacted: 180

Estimated Number of Persons to be Enrolled: 171

Estimated Number of Persons to be Contacted who are Literally Homeless: 144

Number staff trained in SOAR in grant year ending in 2021: 1

Number of PATH-funded consumers assisted through SOAR: 5

PATH Site Name: RBHA					
Budget (2022-2023 PATH Year)			Federal PATH		Match Source
Staff Title	***Annualized*** Salary	FTE	Funds	Local Match	(Cash or In-kind)
PATH Case Manager	$52,173	1.00	$52,173		
PATH/SOAR Case Manager	$49,912	1.00	$49,912		
PATH CPRS	$38,792	1.00	$19,396		
Program Manager	$91,244	0.20		$18,249	in kind
Total Staff Salary					
Fringe			$46,163		
		Total Personnel	**$167,644**	**$18,249**	
** Always list positions separately & separate salary from benefits ("fringe")*					
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle				$20,000	in kind
Training Travel			$300		
Training Conference Costs			$500		
		Total Travel Costs	**$800**	$20,000	
Equipment (Personal property/equipment having useful life of more than one year)					
Lapotop (new)				$3,000	in kind
Cell Phone (replacement)				$400	in kind
		Total Equipment Costs		$3,400	
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies				$2,000	in kind
Outreach Supplies				$5,000	private grant
Supplies				$1,500	private grant
		Total Supplies Costs		$8,500	
Contractual					
Cell phone service fee				$2,500	in kind
Annual CARITAS Furniture Bank Membership Fee				$100	in kind
		Total Contractual Costs		$2,600	

Other (List and Describe Each)			
Medication Assistance	$50	$1,000	private donors
Identification related purchase costs (incl. Birth certificates)	$250	$1,500	private grants
Rental Assistance	$3,000	$25,000	private grants
Staff Training (non-travel registration and costs)	$0	$500	private grants
furniture	$966	$0	
Total Other Costs	$4,266	$28,000	
Total Proposed Budget	**$172,710**	**$78,149**	Is match > or = to 1/3 of federal allocation?

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Fiscal Year 2022-2023

1) **Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

Richmond Behavioral Health (RBHA) fearlessly champions the health, wellness, and recovery of the people and communities we serve. 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, state, and federal grants and the City of Richmond.

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 almost three decades, services have been provided to this population via multiple channels, including: PATH, Community Development Block Grant (CDBG) funding, funding from the United States Department of Housing and Urban Development and funding through the Department of Behavioral Health and Developmental Services (DBHDS). Individuals receiving all levels of mental health services, but especially those receiving intensive case management and ACT-level services, are also at-risk and frequently experience homelessness.

RBHA is requesting **$172,710** in PATH funds for Federal Fiscal Year 2022-2023. Katie Chlan, LCSW, Program Manager II for Homeless and Residential Services and Special Projects (804-819-4255, katie.chlan@rbha.org) will serve as the primary point of contact for the PATH program.

2) **Collaboration with HUD Continuum of Care (CoC) Program**: Describe the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

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, and the CoC Quality Improvement Leadership Committee. 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 Chief Operating Officer 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 public health crisis of Covid 19 has provided additional opportunities for collaboration with other providers within 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 responses, as well as implementing them once appropriate.

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.

RBHA's three PATH workers diligently to 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 or desiring services at the agency 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.

RBHA's PATH outreach team is a part of the community's coordinated outreach team, and the teams are in constant contact to ensure coverage of the service area, but also to eliminate duplication of services. Case conferencing and information sharing via HMIS are two examples of this coordination that occurs on a regular basis.

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, outreach referral to PSH
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 veteran's homeless or disabled veterans	PATH- will provide linkages to DVOPs for homeless veterans when appropriate.
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.
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 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;
b. Any gaps that exist in the current service systems;
c. A brief description of the current services available to clients who have both a serious mental illness and a substance use disorder; and
d. A brief description of how PATH eligibility is determined, when enrollment occurs, and how eligibility is documented for PATH enrolled clients.

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 ACT. 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, Inclement Weather Shelter (currently 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 individuals experiencing homeless on the streets. Participation with Coordinated Outreach has facilitated numerous placements for individuals who are experiencing chronic 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.

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.

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.

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. RHBA PATH workers are active in this process and advocate for the individuals they are serving to receive these housing resources. New this year, PATH outreach workers have assisted with securing and utilizing Emergency Housing Vouchers (EHVs). This Covid-related resource has provided an additional permanent housing options for those who qualify, and PATH staff have worked closely with the CoC to ensure that program participants have access to this resource.

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.

While historically, there have been very few gaps identified, the ongoing public health crisis has exposed gaps within the current services system. These include a lack of affordable rental housing, lack of support within the community to assist with obtaining documents necessary for housing, and lack of services for individuals once they are placed in mainstream housing through the EHV program. The PATH team provides support to those they are able, but the demand far outweighs what this team is able to provide.

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.

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 as a Licensed Clinical Social Worker, 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.

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.

RBHA's PATH program began entering client level data into HMIS in 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 qualifying 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 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
- Assist individuals with applying for EHVs and assisting with the housing search and location process, and collaborating with CoC lead agency as well as RRHA during this process

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.

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

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.

PATH staff are required to complete an annual cultural competance training. In addition, all staff hold registrations through the Department of Health Professions (QMHP-A or CPRS) and are required to complete ongoing Continuing Education trainings 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.

The January 2022 point in time count of people experiencing homelessness reported by Homeward for Metro Richmond include (preliminary Data):

739 total homeless individuals were counted. This represents an 11% decrease from the January 2021 count, but 35% increase in the number of people experiencing homelessness in January 2020 (pre-pandemic).

RBHA's PATH program served a total of 152 individuals from 07/01/20 – 06/30/21 and has served 123 individuals during the current reporting year (as of 03/27/22). The total number of individuals served have been lower during the pandemic, for a variety of reasons, but the number of contacts each individual has had has increased dramatically. The limited housing options has also caused this shift in demographics.

Based on the numbers above, it is projected that the RBHA PATH program will provide services to 180 individuals total for FY 23. It is estimated that 95% of these will be enrolled, and that 80% will be literally homeless when they begin receiving services.

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 (SSVF), Coordinated 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.

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 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 (CPRS) working on the PATH team. He adds his perspective as a former consumer of services on a regular basis.

11) **Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR):** – Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure

client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

RBHA's PATH team has one member who is SOAR certified. In addition, this employee serves as the regional lead for SOAR and works closely with the CoC as well as DBHDS to assist with training and providing support to additional SOAR workers within the CoC.

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

The attached 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 78,149, will be made available during FY 2023.

Staffing - RBHA proposes to continue allocating the majority of PATH funds for direct staff salaries and fringe benefits (2.5 FTE). This includes two FT employees and a PT employee who is shared with another program. The work and duties of this position are described above. All supervision for this program is provided in-kind.

The salaries for these positions are comparable to those within the organization. Two positions are 100% for this program, and one is 50%.

Fringe Benefits – fringe benefits are calculated using the agency standard of 38%.

Travel – The majority of travel expenses are provided in-kind. However, there is a small amount that will be allocated to the grant and used to support staff travel.

Other - Of the remaining funds, $50 will be used for medications, $250 will be used to assist individuals with getting Identification, 3,000 will be used for short term rental assistance, and $966 will be used to purchase furniture.

The RBHA PATH program has begun doing expensive fundraising to offset gaps in this program's budget. As costs and salaries increase, 97% of the grant is used for salaries, leaving only a small amount for all the necessary items to successfully conduct outreach. A total of $28,000 has been committed or secured to date to provide additional funds for these housing related expenses detailed above.

RBHA will provide in-kind match funding totaling $78,149 for the balance of personnel costs, the use of agency vehicle(s), additional costs for conferences/other, program training, costs for agency-related trainings, cell phone replacement and service fees, office supplies, CARITAS furniture bank partnership fee, monthly employee parking, MIS support/data entry/EMR transition, and general overhead, client related expenses, and administrative support and supervision.

13) **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.

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.

In October of 2021, RBHA transitioned to a paperless, web-based process, PaperSave, to submit and process check requests. This new system still allows the individual PATH worker to request funds but adds additional levels of accountability and monitoring during the check request process. The Program Manager still signs off and verifies eligibility on all requests (electronically) prior to submission to the finance department. 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
Email Address: lcampbell@vcsb.org

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**30,479.00**	**13,579.00**	**44,058.00**	

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 %	0.70	30,479.00	13,579.00	44,058.00	

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**24.21 %**	**$ 10,668.00**	**$ 0.00**	**$ 10,668.00**	

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)	$ 41,147.00	$ 13,579.00	$ 54,726.00	

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	$ 13,579.00	$ 54,726.00	

Source(s) of Match Dollars for State Funds:

Cash

Estimated Number of Persons to be Contacted: 55

Estimated Number of Persons to be Enrolled: 55

Estimated Number of Persons to be Contacted who are Literally Homeless: 55

Number staff trained in SOAR in grant year ending in 2021: 1

Number of PATH-funded consumers assisted through SOAR: 6

PATH Site Name: Valley Community Services Board					
Budget (2022-2023 PATH Year)			Federal PATH		Match Source
Staff Title	***Annualized*** Salary	FTE	Funds	Local Match	(Cash or In-kind)
PATH Outreach Worker	$43,260	0.70	$30,479	$13,579	cash
Program Manager	$8,160	0.10	$0		
Total Staff Salary	$51,420		$30,479	$13,579	
Fringe	$17,997		$10,668		
		Total Personnel	**$41,147**	**$13,579**	
** Always list positions separately & separate salary from benefits ("fringe")*					
Travel (Outreach travel, travel for training, state meetings, etc.)					
Use of Agency Vehicle					
Training Travel					
Training Conference Costs					
		Total Travel Costs	**$0**	$0	
Equipment (Personal property/equipment having useful life of more than one year)					
Lapotop (new)					
Cell Phone (replacement)					
		Total Equipment Costs	$0	$0	
Supplies (Office Supplies, Outreach Supplies, Computer Software)					
Office Supplies					
Outreach Supplies					
Supplies					
		Total Supplies Costs	$0	$0	
Contractual					
Cell phone service fee					
		Total Contractual Costs	$0	$0	

Other (List and Describe Each)			
Medication Assistance			
Identification related purchase costs (incl. Birth certificates)			
Rental Assistance			
Bus Tokens			
Staff Training (non-travel registration and costs)			
Total Other Costs	$0	$0	
Total Proposed Budget	**$41,147**	**$13,579**	Is match > or = to 1/3 of federal allocation?

Valley Community Services Board
PATH Intended Use Plan
2022-2023

1) **Local Area 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 (same as previous year budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.

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, Assertive Community Treatment, juvenile detention program, jail services including forensic discharge planning, ICF/ID and ID group homes, infant/toddler services, state psychiatric facility discharge planning, and representative payee services, to give a small sampling. 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. VCSB's catchment area includes the cities of Staunton and Waynesboro, and the counties of Augusta and Highland. The primary point of contact for the PATH program is Lydia Campbell, Community-Based Services Supervisor, 540-213-7542, lcampbell@vcsb.org.

2) **Collaboration with HUD Continuum of Care (CoC) Program**: Describe the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.

VCSB is part of the Valley Homeless Connection, a local planning group (LPG) that is part of the Balance of State Continuum of Care coordinated by the Virginia Department of Housing and Community Development. 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.

3) **Collaboration with Local Community Organizations: 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.

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 daytime 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 street outreach worker at this time and can often be found at known homeless encampments, as well as single person campsites, engaging with the community and establishing rapport with new community members.

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 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 four 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 emergency shelter and entry into HMIS. Clients are automatically added to the By Name List and prioritized based on their membership in the subpopulations of chronic homelessness, veteran status, or unaccompanied youth ages 18-24. This prioritization and case conferencing system ensure that our community's limited resources are targeted to the most vulnerable individuals experiencing homelessness. 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;

Valley LPG longs for a day where there is no need for an emergency shelter waitlist and households receive emergency shelter as soon as they present a need for it. Unfortunately, the need for emergency shelter continues to present as an urgent need and capacity, while increasing, is not at the same level as that of need in the community. The flow of available shelter beds is becoming stagnant as the flow of available units becomes stagnant. We have long said that we do not need additional emergency shelter but additional permanent housing options in our community. It is remarkably frustrating to have the most funding, due to COVID-19 funds, that we have ever had in this community before and still not be able to spend it quickly enough because of the lack of available units.

Due to the influx of funding and due to administering the Rent and Mortgage Relief Program in 2020, Valley LPG has developed relationships with more than 30 landlords, but new units are not coming online – the inventory is stagnant. Many of the calls CE receives are from households who've lived in their homes for 5 years or more, but the landlord is now selling the property and they are looking for a new place to rent. In these cases, we can focus on diversion, however it does not change the fact that the flow of housing inventory was built on the evictions of others, leading to an ever-perpetuating cycle of trauma for households. We are never going to be able to truly end homelessness until we can increase the available housing stock in our community.

The methodology for determining these gaps is purely anecdotal at this point. The LPG has spent the last two years breaking down silos and fences between partners, shifting to a commonly held belief that everyone experiencing homelessness in our community belongs to us. We work to bring partners into the work and are constantly educating to avoid duplication of efforts.

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

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 inquiries 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 participates in PATH service, the client is then enrolled in PATH. Clients are quickly connected to evaluations by LMHP-types through Open Access at VCSB. 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. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

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 qualifying residents.

Identification as an individual experiencing homeless during outreach activities results in placement on the community's By Name List regardless of whether 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.

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

a. 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 of staff. PATH staff works diligently to establish trust and rapport with individuals

experiencing homelessness inclusive of these differences. PATH staff operate within Housing First principles and provide care with a trauma

b. 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 are included and participating in the homeless response system's conversation surrounding racial disparities among those who are presenting for homeless services in our community.

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 demographics of individuals experiencing homelessness in our community as of 03/01/22 are as follows:

Race - 79.67% white, 14.29% black, 6.04% multiple races, 0.55% Native Hawaiian or Pacific Islander

Ethnicity –79.12% non-Hispanic/ Latinx, 21.43% Hispanic/ Latinx

Gender – 52.20% male, 46.15% female, 1.65% transgender, 0.55% no single gender

Age – 66.48% ages 25-61, 24.18% ages 18-24, 5.49% ages 62+, 3.85% ages under 18.

40.11% report having one or more disabling condition. 61.6% of those reporting they have one or more disabling condition report having a mental health disorder.

It is projected that at least 55 adult clients will be contacted and enrolled. 100% of clients to 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.

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 subpopulations 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, has added a formerly homeless individual to our governance structure. The PATH supervisor is also a VCSB client family member.

11) **Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR):** – Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made in a timely manner in conjunction with a community stakeholder who is SOAR-certified.

The PATH Outreach Worker is 1 of 4 SOAR certified staff at VCSB. Additionally, the PATH Outreach Worker will be attending SOAR Local Lead training April 19-22, 2022.

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

VCSB is requesting funding for the salary for .7 of an FTE to staff the PATH program with a PATH Outreach Worker, who spends 70% of her time outreaching and linking PATH eligible clients with mainstream resources, including SNAP, SSI/SSDI via SOAR, health resources, and housing opportunities. Additionally, the PATH Outreach Worker maintains necessary and accurate data in HMIS. Funding will VCSB also requests funding for the salary of .10 of an FTE for the program manager to supervise the PATH program. This position provides individual supervision to the PATH Outreach Worker, monitors data quality, maintains relationships with partner agencies, and prepares necessary reports regarding the PATH program. Valley Mission provides a 33% match to contribute to staffing costs incurred with this program.

13) **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.

The PATH program is overseen by Lydia Campbell, Community Based Services Supervisor who actively participates in assisting the PATH Outreach Worker to achieve the goals of this program. Lydia reports to Assistant Director of Behavioral Health -Community Based Services 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's accounting department is comprised of a CFO, Payroll Administrator, Accountant, Accounts

Payable, 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. 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
Email Address: kybjohns@vbgov.com

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.

I certify that the responses to this Narrative Question in the FY 2020 PATH Application are still accurate. Yes ○ No ○

Planning Period From **9/1/2022** to **8/31/2023**

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	**90,955.00**	**60,637.00**	**151,592.00**	

Position *	Annual Salary *	% of time spent on PATH *	PATH-Funded FTE	PATH-Funded Salary *	Matched Dollars *	Total Dollars	Comments
Other (Describe in Comments)	70,136.00	100.00 %	0.60	42,082.00	28,054.00	70,136.00	Clinician III
Other (Describe in Comments)	45,909.00	75.00 %	0.60	27,545.00	18,364.00	45,909.00	Clinican I
Other (Describe in Comments)	35,547.00	100.00 %	0.60	21,328.00	14,219.00	35,547.00	BHDS Assistant

Category	Percentage	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
b. Fringe Benefits	**20.47 %**	**$ 31,036.00**	**$ 20,690.00**	**$ 51,726.00**	

Category	Federal Dollars	Matched Dollars	Total Dollars	Comments
c. Travel	**$ 2,558.00**	**$ 344.00**	**$ 2,902.00**	

Line Item Detail *	Federal Dollars *	Matched Dollars *	Total Dollars	Comments
Mileage Reimbursement	$ 330.00	$ 220.00	$ 550.00	travel training
Other (Describe in Comments)	$ 2,228.00	$ 124.00	$ 2,352.00	Use of agency vehicle

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

No Data Available

e. Supplies	**$ 0.00**	**$ 0.00**	**$ 0.00**	

No Data Available

f. Contractual	**$ 2,400.00**	**$ 0.00**	**$ 2,400.00**	

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
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)	$ 126,949.00	$ 81,671.00	$ 208,620.00	

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	$ 81,671.00	$ 208,620.00	

Source(s) of Match Dollars for State Funds:

Cash and In-Kind

Estimated Number of Persons to be Contacted: 1,000

Estimated Number of Persons to be Enrolled: 115

Estimated Number of Persons to be Contacted who are Literally Homeless: 1,000

Number staff trained in SOAR in grant year ending in 2021: 2

Number of PATH-funded consumers assisted through SOAR: 9

PATH Site Name: Virginia Beach						
Budget (2022-2023 PATH Year)			Federal PATH Funds	Local Match	Match Source (Cash or In-kind)	
Staff Title	***Annualized*** Salary	FTE				
Clinician III	**$70,136**	1.00	42,082	28,054		
BHDS Assistant	**$35,547**	1.00	21,328	14,219		
Clinician I	**$45,909**	0.75	27,545	18,364		
Total Staff Salary	$151,592					
Fringe	$51,726		31,036	20,690		
		Total Personnel	**$121,991**	**$81,327**	**$0**	
** Always list positions separately & separate salary from benefits ("fringe")*						
Travel (Outreach travel, travel for training, state meetings, etc.)						
Use of Agency Vehicle			$2,228	$124		
Training Travel			$330	$220		
Training Conference Costs						
		Total Travel Costs	$2,558	$344	$0	
Equipment (Personal property/equipment having useful life of more than one year)						
Lapotop (new)						
Cell Phone (replacement)						
Computer Software						
		Total Equipment Costs			$0	
Supplies (Office Supplies, Outreach Supplies, Computer Software)						
Office Supplies						
Outreach Supplies						
Storage						
Supplies						
Financial Management						
		Total Supplies Costs			$0	
Contractual						
Cell phone service fee						
Lease/Rent of Equipment - Copier fees						
HMIS Licensing Fees			$2,400	$0		
		Total Contractual Costs	$2,400	$0	$0	

Other (List and Describe Each)				
Medication Assistance/Co-pays/Dental				
Identification related purchase costs (incl. Birth certificates)				
Rental Assistance				
Bus Tokens				
Total Other Costs	$0	$0		
Total Proposed Budget	**$126,949**	**$81,671**	Is match > or = to 1/3 of federal allocation?	

Virginia Projects for Assistance in Transition from Homelessness (PATH)
Local Intended Use Plan
Fiscal Year 2022-2023

1) **Local Area Provider Description:** Provide a brief description of the provider organization receiving PATH funds, including name, type of organization, region served, and the number of PATH funds the organization will receive (same as previous year's budget amount). The primary point of contact for the PATH program and corresponding phone number and email address also needs to be included.
    a. Type of organization: City of Virginia Beach, Department of Human Services (DHS) Behavioral Health Division.
    b. Name: Virginia Beach DHS, Behavioral Health Division, PATH
    c. Region served: Virginia Beach
    d. Funds: 208,620.00
    e. Primary Point of Contact: Kathleen Brooks-Johnson
        i. Office: 757-385-0672
        ii. Cell: 757-636-3160
        iii. Email: KYBJohns@vbgov.com
    f. Program Description:

City of Virginia Beach Department of Human Services (DHS) is a comprehensive public human services agency. The Behavioral Health (BH) Division provides a full range of services including medication management, case management, emergency services, Marcus Alert, crisis stabilization and detoxification, prevention, day treatment, psychosocial rehabilitation, mental health support services with supportive residential services properties, and child and youth treatment programs. Virginia Beach DHS BH PATH program focus is providing individuals with a serious mental illness (SMI) experiencing homelessness or imminent danger of being 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 support services, case management services, etc. PATH supports 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 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 connects Consumers to our State Opioid Response (SOR) program which supports outpatient substance abuse treatment specializing in methadone treatment with the Virginia Beach Methadone Clinic or PATH will link individuals with our Restore Office Based Opioid Treatment (OBOT) program for individuals living with opiate addiction.

2) **Collaboration with HUD Continuum of Care (CoC) Program**: Describe the organization's participation with local HUD 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 CoC(s), briefly explain the approaches to be taken by the organization to collaborate with the CoC(s) in the areas where PATH operates.
The PATH Team Leader (TL) represents the VBDHS BH Division as an active member of the Continuum of Care Program, Performance Monitoring Committee. The PATH TL attends numerous meetings that supports developing and initiating strategies to eradicate homelessness. The Bringing an End to All City Homelessness (BEACH) committee meeting, BEACH Community Partnership meeting which is an advocacy organization consisting of faith-based, governmental, and nonprofit organizations. Department of Housing and Neighborhood Preservation (DNHP) is the Lead agency for CoC, and PATH TL elected as Chair/Co-chair of the Performance Monitoring Committee and member of the BEACH Governing Board. PATH TL represents the Virginia Beach DHS BH Division on the Coordinated Entry and Assessment Committee, Service Prioritization Assistance Meeting (SPAM). 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 Rapid Re-housing and Permanent Supportive Housing (PSH) vacancies according to their vulnerability status. Candidates are referred for housing based upon DHNP 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 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.
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 a 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 Outreach Coalition meeting facilitated by People in Need (PIN) ministries to address stakeholder concerns, trends, barriers and develops 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 must access services that will promote the 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, Judeo Christian Outreach Center, Scott Memorial Church, Faith in Action, and Star of the Sea. PATH staff frequents local businesses, such as, Walmart, Wegmans, Target, Food lion, 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 Southeastern Virginia Health Systems 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 a direct referral to Pathways Center in Virginia Beach, VA or the Regional Crisis Stabilization Center in Hampton, VA 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 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.

Analysis of public data by VBDHS personnel have led to the following projections for SMI and veteran potential clients:

- VBDHS BH PATH program projects outreaching 1000 adult consumers annually.
- VBDHS BH PATH program projects enrollment of 115 adult consumers annually.

Based on these projections for SMI and Veteran populations, the following supportive services and steps are planned:

Outreach workers contact homeless individuals where they sleep by going into `various campsites, boardwalk areas and engaging individuals who may be panhandling. PATH services are provided routinely, and we check in with local churches. PATH staff attends homeless support groups to help and educate. 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 emphasizes 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 in the areas where the homeless tend to frequent. These areas include, but are not limited to, 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), Scott Memorial, 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 the Virginia Beach Police Department and any inter-agencies of Virginia Beach. PATH staff performs occasional outreach efforts in partnership with local police to ensure campsite 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 and working with local Stakeholders. Shelter housing durations at HRC range from 6 months to 1+ years. The longer stays have resulted in less availability in a local shelter and left other homeless individuals on the waitlist for RRH and PSH. PATH has identified a gap in the ability for homeless individuals to access affordable housing and have certification of disability. Numerous individuals were given an opportunity for RRH and PSH during the SPAM meeting only to lose the opportunity due to no certification of disability. PATH TL has observed and shared concerns when an individual is not referred to Behavioral Health Division and their coordinated entry assessment indicates the individual has a mental health history. A lack of continuity of care when hospitalized consumers must be discharged back to the streets. The lack of affordable housing development addresses the lack of affordable options.

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

The following service areas are available to support individuals' needs and PATH staff provides linkage as needed:

- *Marcus Alert* provides direct mental health care to individuals experiencing a behavioral health crisis that may jeopardize their current community living situations. The Regional Call Center will provide an immediate response 24/7 and they will assess and triage the crisis call to determine which of the four levels of care on the crisis continuum are appropriate to include 1. crisis phone counseling, 2. Mobile Crisis Response (MCR) services and/or Community Stabilization 3. Mobile Co-responder Team (MCRT) services and 4. Emergency Services.

- *HRC* provides shelter or a permanent home for 100+ homeless individuals and family members at a time. Other essential services provided are day services, coordinated entry, health clinic services, and Department of Human Services treatment options, etc.

- *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 improving their quality of life.

- *Project LINK* is a program that provides intensive case management services to pregnant, postpartum, 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* is located at Pembroke Six and Magic Hollow and their services focus on individuals with serious mental illness issues and significant substance use disorders. Services include psychiatric evaluations, medication management, group therapy, and limited individual and family counseling.

- *Residential Crisis Stabilization Units (CSU)* – There are two CSU programs located in Virginia Beach – Pathways Center and Regional Crisis Stabilization Center 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. Both programs accept indigent and Medicaid participants.

- *Assertive Community Treatment (ACT)* – Services are correlated to the individuals' assessed clinical needs, functional ability, and level of motivation. These services are designed for those who demonstrate a clinical need for 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* provide 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 and provide recovery and harm reduction resources and support.

- *Restore* is our OBOT program that provides Medicated Assisted Treatment (MAT) options that are evidence-based, trauma-informed and are effective for adults with substance use and mental health disorders. Medications in combination with counseling and behavioral therapies are used to provide a whole-patient approach to treatment.

- *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 24/7 emergency crisis response to all individuals in the City of Virginia Beach experiencing 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.

- *Other Community Supports* – In addition to the aforementioned DHS resources and support, PATH will also link individuals to the following community resources, to include, but not limited to, *Clean Slate* which is *Bon Secours* outpatient treatment program that focuses on opiate addiction and provides an alternative to methadone; *Sentara Behavioral Health* inpatient and outpatient support services and *Virginia Beach Psychiatric Center* inpatient services that all help sustain individuals for long-term success in the community, etc.

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 – Adult (QMHP-A) 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 an 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 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. For any providers not fully participating in HMIS, please describe plans to complete HMIS implementation.

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. PATH TL is responsible for submitting a cumulative twelve-month COC APR report monthly and maintaining a less than 5 percent error rating to avoid an audit. The program is audited for data content and collection quality by the HMIS Administrator annually. Data is collected utilizing worksheet templates provided by HUD and they are completed at each intake for consumers, with the new Cerner Electronic Health Record PATH paper intakes will eventually be obsolete. To ensure accurate reporting, the VB PATH staff reviews individual electronic HMIS records before 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 incorporated the new HMIS data requirements in the intake packet, plus, the staff is 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 qualifying residents.

Virginia Beach DHNP offers 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. 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:
An 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 training to ensure staff provides 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 with their rights and information pertained to service recommendations. Staff is 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 receives 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 is also responsible for completing annual Ethics, Human Rights, Blood Borne Pathogen and Pandemic Flu 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 homeless.

VBDHS projects outreaching 1000 adult consumers annually.
VBDHS projects enrollment of 115 adult consumers annually with 100% being homeless.

RACE/ETHNICITY (120)	Percentage
American Indian	.0%
Asian	.008%
Black/African American	39%
Hispanic/Latino	.06 %
White/Caucasian	64 %
Multi-Racial	.04%

AGE (201)	Percentage
0 – 17	0%
18 – 24	0.06%
25 – 34	0.2%
35 – 44	28%
45 – 54	28%
55 – Up	15.8%

GENDER (161)	Percentage
Male	49%
Female	47.8%
Transgender	1.6%

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 assesses 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 deposits and first-month rent.

10) **Consumer Involvement:** Describe how individuals who experience homelessness and have a 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***. See Appendix I – Guidelines for Consumer and Family Participation for more information.***

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 rights, and they voluntarily sign consent forms for services and fees (based on income). Once individuals are admitted into ongoing treatment, they sign other documents notifying them of their rights and choices as 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 to understand and help for friends and families affected by substance use and *Help Me Understand* trainings that provides education regarding mental health disabilities to include depression, anxiety, schizophrenia, etc. 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 for their recovery and relapse prevention.

Currently, PATH staff do not self-identify as having a 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) **Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, Recovery (SOAR**): – Indicate the number of PATH staff that are SOAR-certified. If your program does not have a SOAR-certified staff, describe how efforts to ensure client applications for mainstream benefits are completed, reviewed, and a determination made promptly in conjunction with a community stakeholder who is SOAR-certified.

PATH has two SOAR-certified Staff members.

12) **Budget Narrative:** Provide a budget narrative that includes your local plan for the use of PATH funds. **The narrative must be developed and described as outlined in Appendix II.** See below under Appendix II.

13) **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.

The program uses an eligibility checklist to determine that individuals meet the criteria for PATH services. We work within budgeted categories to provide support to eligible individuals and link those who require additional support beyond the grant's ability. This may be accomplished through other CSB service areas or via linkage to external partners. The program ensures individuals' support is provided by grant requirements and reconciles monthly with a 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 PATH TL and CSA reviews the PATH program for clinical and financial compliance during monthly supervision meetings. 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.

Appendix II Budget Development and Narrative Instructions

VA PATH providers must comply with the terms and conditions of the award, per 45 CFR §75.101. All grant recipients must have established written procurement policies and procedures that are consistently applied.

All applications must have a detailed budget justification and narrative that explains the federal and the non-federal expenditures broken out by category and line item, and:

• The budget narrative must match the costs identified.

• The budget narrative and justification must be consistent with and support the program narrative.

• The budget narrative and justification must be concrete and specific. It must provide a justification based on each proposed cost in the budget and how that cost was calculated. The same level of detail must be provided for matching funds. The basis of your estimates can be ongoing activities, market rates, quotations received from vendors, historical records, etc. but the proposed costs must be reasonable, allowable, allocable, and necessary to the supported activity.

Address the following information for the budget narrative and justification:

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, an FT Clinician III, a Behavioral Health Assistant, and a PT Clinician I.

- The Clinician III serves as the Program Team Leader (PTL) and coordinates staff activities, staff oversight, data tracking reports to include two electronic health records- Homeless Management Information System and Cerner, generate weekly Staff services reports, reports clinical and financial performance monthly during Supervision and ensures program target objectives and State Performance measures are met monthly. The PTL serves as the primary point for the coordination of services and continued outreach efforts. The PTL serves as a liaison between the DHS partners at the Housing Resource Center and inter-agency, community homeless service providers – Judeo Christian Outreach Center, People in Need (PIN), Potter's House just to name a few, city stakeholders- Ocean Front Library, Central Library, Virginia Beach Police department, Department of Housing and Neighborhood Preservation, Department of Social Services, Integrated Services Team, and churches. The PTL serves as the representative for the VBDHS BH Division PATH program at numerous meetings and a Board member, Performance Monitoring Committee meeting and recently elected Chair/Co-Chair with Samaritan House Staff member, elected Governing Board member, Bringing an End to All City homelessness (BEACH), HMIS Coordinated Entry and assessment committee, HMIS Learning Lab, the Virginia Beach Homeless Advocacy and Resource Partnership, Bringing an End to All City Homelessness, Performance Measures Committee, Service Prioritization Assistance Meeting weekly (SPAM), and DNHP meeting and links weekly with their Outreach Team. Participation and collaboration are necessary to know all issues and concerns that our population faces and the need to adjust to the trends that have been observed to prevent any barriers or additional areas of vulnerability that are faced by are Consumers. The integrated services model at

the HRC involves participation in groups focused on Continuum of Care target areas.

- The BH Assistant will provide 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 homeless individuals on the streets, and they will connect with homeless people in other areas where homeless persons are known to frequent. They are responsible for conducting face-to-face Motivational interviews and for collecting information on individuals who are suspected to have an SMI or co-occurring illness.

- The Clinician I provide outreach services to individuals with SMI, or co-occurring disorders. 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 meet 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 $151,592 of which $51,726 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.

This program cannot support the full cost amount for travel; however, travel is a critical requirement of the PATH program. The program will contribute $2,228 towards travel and the city will absorb the remaining travel costs.

D. Supplies: Supplies are items costing less than $5,000 per unit (federal definition), often having one-time use.

Provide the following information for the narrative and justification:

• Items – list supplies by type, e.g., office supplies, postage, laptop computers. The justification must include an explanation of the type of supplies to be purchased and how it relates to meeting the project objectives.

This program cannot support the cost of supplies; however, supplies are a critical need for the PATH program. This cost will be absorbed by the city.

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:	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. 1. Age: The individual is 18 years of age or older. 2. DIAGNOSIS: The individual has a diagnosed major mental disorder. At least one of the following diagnoses must be present. Adjustment disorder or V Code diagnoses do not meet this criterion. -Schizophrenia, all types -Major Affective Disorder -Paranoid Disorder -Organic Disorder -Other Psychotic Disorder -Personality Disorder -Other mental health disorder that may lead to chronic disability 3. Level Of Disability: There must be evidence of severe and recurrent disability resulting from mental illness. The disability must result in functional limitations in major life activities. The individual must meet at least two of these criteria on a continuing or intermittent basis. The individual: -Is unemployed; employed in a sheltered setting or a supportive work situation; has markedly limited or reduced employment skills; or has a poor employment history. -Requires public financial assistance to remain in the community and may be unable to procure such assistance without help. -Has difficulty establishing or maintaining a personal social support system. -Requires assistance in basic living skills such as personal hygiene, food preparation, or money management. -Exhibits inappropriate behavior that often results in intervention by the mental health or judicial system. 4. Duration Of Illness: The individual's treatment history must meet at least one of these criteria. The individual: -Is expected to require services of an extended duration. -Has undergone psychiatric treatment more intensive than outpatient care more than once in his or her lifetime (e.g., crisis response services, alternative home care, partial hospitalization, and inpatient hospitalization). -Has experienced an episode of continuous, supportive residential care, other than hospitalization, for a period long enough to have significantly disrupted the normal living situation.

	If Yes is checked for criterion 1, and for at least one response in criterion 2, and for at least two responses in criterion 3, and for at least one response in criterion 4, then check Yes here to indicate that the individual has serious mental illness. NOTE: Any diagnosis checked in 2 above must be documented in the individual's clinical record and in the Community Services Board's information system, and the individual's clinical record also must contain documentation that he or she meets any criteria checked in 3 and 4 above. SMI criteria are further defined as follows:
Co-occurring Disorders:	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.

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 Virginia Housing (state housing finance agency), 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 $34 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. However, in Virginia's 2011 Homeless Point-In-Time (PIT) Count, there were 1,080 adults with serious mental illness reported and the number increased in the 2021 PIT Count to 1,180. Similarly, this sub-population consistently remains 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 (CoC) 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.

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Footnotes:

Virginia PATH Services for Veterans

Population

According to the most recent data from the National Center for Veterans Analysis and Statistics (2019) an estimated 730,215 veterans of all eras of service are living in the Commonwealth of Virginia. This comprises approximately 10% of Virginia's total adult population. Twenty-nine (29) percent, or 214,030, 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 14.5%; Newport News 15.2%; Norfolk 14.9%; Hampton 18.3%, and Virginia Beach 17.7% (US Census Bureau, 2020). 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, 2020). Approximately 8% of the population of the Northern Virginia jurisdictions are veterans. Nestled between Northern Virginia and Central Virginia is the city of Fredericksburg with a veteran population of 11%.

Central Virginia Area: PATH service areas in the central Virginia area include the City of Richmond, which has a small veteran population at 5.2%, and Region Ten CSB, whose catchment area includes cities and counties with a total veteran percentage of 4.5%.

Western Area: Blue Ridge Behavioral Health covers city/county areas with veteran populations around 9%, 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 and will continue to work to implement effective strategies to prevent and end homelessness for veterans in Virginia. From 2021 to 2020 the counts of homeless Virginia veterans showed that there was an 18% decrease in the total number of homeless veterans (from 395 to 325); however, the United States Department of Housing and Urban Development (HUD) did not require homeless Continua of Care to conduct an unsheltered Point in Time Count due to the COVID-19 pandemic. Therefore, it the prevalence of unsheltered veterans in 2021 is unknown. From 2019 to 2020, there was 22% decrease in unsheltered homeless veterans (from 92 to72).

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

VVFS Region	PATH Communities	PATH Providers
	Fairfax County	Fairfax-Falls Church CSB
	Loudoun County	Loudoun County CSB
	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 2022.

PATH Site	Description of Services Provided to Veterans
Alexandria CSB	HOPC works closely with the shelters drop in center, meal programs, SA facilities detox and DCHS mental health centralized intake at identifying homeless Veterans. DCHS Center for Economic Support's

PATH Site	Description of Services Provided to Veterans
	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. PATH also makes referrals to the liaison of the Veterans committee within OCS by identifying those Veterans who are accessing supportive services and or street outreach. HOPC also partners with local nonprofits to obtain appropriate sources and VASH housing vouchers. The HOPC also makes referrals to DCHS Workforce Developments Center Program Military Connection.
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 staff screen every individual for possible veteran status. They assist those who do not have access to their DD214 document as this is essential to receiving benefits and support. 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 organizations and has successfully referred applicable individuals. PATH staff collaborate with the DFS Veterans Services Coordinator. The coordinator provides individualized support to assure veterans have access to service member resources.
Norfolk	PATH staff works in collaboration the COC partners to address Veteran Homelessness, including the Virginia Veteran and Family Support program, the VA outreach workers, and two Support Services for Veterans and Families (SSVF) programs. 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.
Portsmouth	The current PATH CM is a disabled veteran who maintains contact with the Veterans Administration to remain knowledgeable about the various programs and resources offered to the veteran population. The PATH CM immediately notifies the CoC upon meeting a homeless veteran to make an "off week" referral, as opposed to waiting for the next coordinated entry meeting to present the veteran for housing.
Prince William	PATH therapists provide direct active outreach services to veterans in the local Ferlazzo Shelter Drop-In Center, SON Mobile Drop-In Center, 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, substance use, health issues, lack of income and housing. PATH therapists link clients directly with mainstream services for issues identified in the needs assessment. Services available to veterans include mental health, substance abuse, primary health, case management,

PATH Site	Description of Services Provided to Veterans
	employment, education, and housing as identified in Sections Three and Four of this application. PATH therapists directly link clients with services available to veterans and/or families of veterans, such as the US Department of Veterans Affairs (VA) and Supportive Services for Veteran Families (SSVF). The PATH therapist actively participates in the COC Service Continuum subcommittee where homeless veterans have been placed on a By-Names list for housing purposes. Friendship Place, Operation Renewed Hope Foundation and Volunteers of America work 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. PATH therapists link veterans to Easter Seals for employment training and resources.
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 staff collaborates with the SSVF (Supportive Services for Veteran Families) Program to ensure that Veteran's experiencing homelessness are served. Likewise, Region Ten has a Veteran Engagement peer that assists veteran's in building safety and connection and navigating the systems. Path has also built a relationship with Central Virginia healthcare alliance system for veteran supports.
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, have completed Veteran/Military specific competency training.
Valley CSB	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 subpopulations focused on in case conferencing.
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

PATH Site	Description of Services Provided to Veterans
	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.

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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 1,596 individuals to be enrolled by Virginia PATH during FY 2022-23, approximately 91% 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. Based on the most recent SAMSHA-approved PATH Annual Report for Virginia (2020), PATH programs reported providing case management services to 75% 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.

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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.

As of July 1, 2021, DBHDS has been allocated a total of $34 million in State General Funds, with which we anticipate securing an estimated 1,721 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 months 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.

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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 SAMHSA 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.

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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 assists 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 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).

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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.

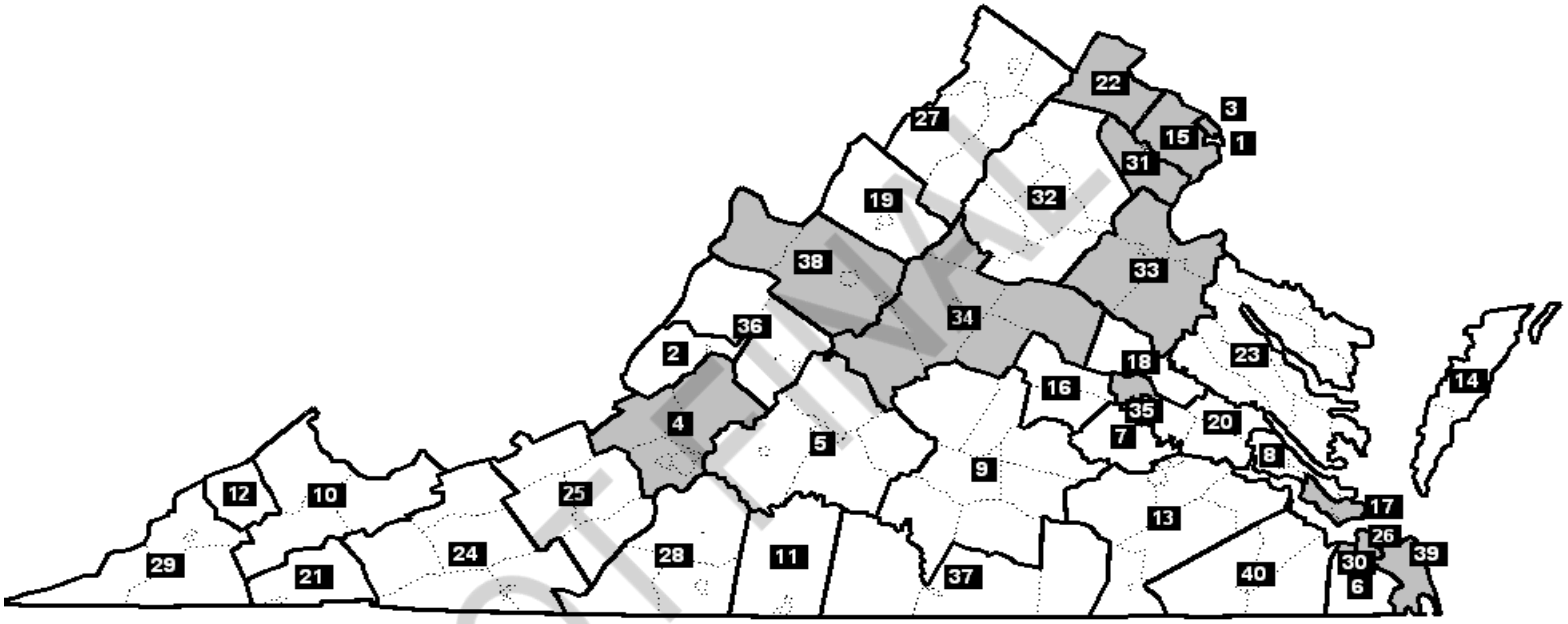
Currently, all Virginia PATH programs are sited in community mental health centers that receive their base funding through electronic warrants from DBHDS twice monthly from September through August. Current PATH sites include all major metropolitan areas, covering at least 56% of the estimated eligible 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 2022 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.

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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 24,236 (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, fourteen (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 2019-2020 National Survey on Drug Use and Health's estimate of 5.6%. 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 484,714 adults in Virginia had a serious mental illness in 2021. 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

CSB Name	2021 Adult Population Estimate	SMI Adult Population Estimate (5.6%)	Homeless/At-risk estimate (5% of SMI)	2021 PIT SMI Adults
Alexandria CSB	158,675	8,886	444	27
Alleghany Highlands CSB	20,880	1,169	58	
Arlington County CSB	237,107	13,278	664	41
Blue Ridge Behavioral Healthcare	260,016	14,561	728	22
Chesapeake Integrated Behavioral Healthcare	250,256	14,014	701	
Chesterfield CSB	369,943	20,717	1036	
Colonial Behavioral Health	177,415	9,935	497	
Crossroads CSB	100,735	5,641	282	
Cumberland Mountain Community Serv.	85,384	4,782	239	
Danville-Pittsylvania Community Services	102,739	5,753	288	
Dickenson County Behavioral Health Serv.	13,902	779	39	
District 19 CSB	178,843	10,015	501	
Eastern Shore CSB	45,544	2,550	128	
Fairfax- Falls Church CSB	1,184,054	66,307	3315	284
Goochland-Powhatan Community Services	55,584	3,113	156	
Hampton-Newport News CSB	321,663	18,013	901	44
Hanover County CSB	110,903	6,211	311	
Harrisonburg-Rockingham CSB	138,931	7,780	389	
Henrico Area Mental Health and Developmental Services	366,486	20,523	1026	
Highlands Community Services	71,310	3,993	200	
Horizon Behavioral Health	263,298	14,745	737	
Loudoun County Dept. of MH, SA and Developmental Serv.	425,204	23,811	1191	6
Middle Peninsula-Northern Neck CSB	143,149	8,016	401	
Mount Rogers CSB	114,554	6,415	321	
New River Valley Community Services	184,523	10,333	517	
Norfolk CSB	238,102	13,334	667	90
Northwestern Community Services	244,972	13,718	686	
Piedmont Community Services	135,178	7,570	378	
Planning District One Behavioral Health Services	83,165	4,657	233	
Portsmouth Department of Behavioral Healthcare	97,883	5,481	274	21
Prince William County CSB	542,646	30,388	1519	53
Rappahannock Area CSB	387,068	21,676	1084	72
Rappahannock-Rapidan CSB	184,006	10,304	515	
Region Ten CSB	267,273	14,967	748	74
Richmond Behavioral Health Authority	226,623	12,691	635	203
Rockbridge Area Community Services	40,897	2,290	115	
Southside CSB	79,604	4,458	223	
Valley CSB	128,047	7,171	359	37
Virginia Beach CSB	458,028	25,650	1282	83
Western Tidewater CSB	161,018	9,017	451	
Population Sub-totals	**8,655,608**	**484,714**	**24,236**	**1057**

* PIT (Point in Time) Count = total for larger CoC area, which may include jurisdictions not in the CSB catchment area.

1) Based on 2021 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.

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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 that are allocated PATH funds have identified the source of their local match contribution, and provided assurance that required match funds will be available as of the start of the PATH program year on September 1, 2022. As is evident in the 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 2022 is 65% 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.

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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, 2021, DBHDS has been allocated a total of $34 million in State General Funds, with which we anticipate securing an estimated 1,721 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, DBDS 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.

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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 and local providers participate in the PATH HMIS Learning Collaboratives and the SPC also relays information from these meetings to providers.

DBHDS PATH utilized the additional technical assistance funding that SAMSHA awarded to contract with Advocate for Human Potential, Inc. (AHP, Inc.). Over the course of the last year, the SPC and AHP, Inc. have collaborated on the following as a part of the technical assistance work:

- Analysis of Virginia reports in SAMHSA's PATH Data Exchange (PDX) and provider-level Homeless Management Information Systems (HMIS) reports and data;
- Learning collaborative around the strategic use of data in program design and implementation;
- One-on-one mentoring/coaching for the SPC around aggregate data analysis and performance metric development, program analysis including refining the program manual, strategic thinking; and,
- VA PATH provider assessment and TA around HMIS/PDX data and other topical needs.

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.

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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 2021, there were forty-one active SOAR communities in Virginia, with 683 SOAR-trained workers across the Commonwealth, and 204 of those individuals are actively processing cases (at least two per year as required). Also through July 2021, six of the fourteen PATH providers had eight SOAR-trained staff; and, the other providers without currently trained staff are receiving training in June 2022. COVID created a number of barriers for PATH stuff, specifically. They saw an increase in responsibilities, including assisting with emergency hotel/shelter programs for individuals who were literally homeless. There was a significant amount of staffing turnover related to COVID, contributing to staffing shortages and a reduced number of individuals receiving training and maintaining SOAR certification during the last two years.

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 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. As the partnership moved into its third year, Virginia SOAR saw its highest approval rating yet, averaging an 88% approval rate on all initial SOAR applications in FY 2020. Where Virginia used to struggle with SOAR-assisted claims getting lost at the local SSA office and 1696's not being associated with claims, 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 claims are being assigned to seasoned SOAR Analysts at DDS and SSA.

The DDS PRO's 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 Analysts 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. This collaborative project also includes regular contact and standing meetings 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 PRO's and the Area Director's Office allow us to continue to build the partnership to better serve SOAR claimants.

As COVID began to impact the homeless community in Virginia, we saw significant changes in staffing, both within our homeless programs and our state Social Security and Disability Determination offices. Our local SSA Offices saw a 40% reduction in staffing and our local DDS Offices saw a 60% reduction in staffing. This has caused delays in case processing at both offices, as well as inappropriate denials for claims due to inexperienced examiners. We saw initial approval rates drop from 88% in FY20 to 70% in FY21 due to these changes. Thankfully, our established partnership with SSA has assisted us with these changes. SSA and DDS implemented a follow-up policy for denials and delayed processing, resulting in positive changes as we moved into FY22. Overall approval ratings have jumped back up to 78% and processing times are only 9 days longer than they were pre-COVID.

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 2020, eight 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, 683 individuals received the initial training for SOAR. As a result, the initial approval rate for SOAR in Virginia went from 76% in FY19 to 88% in FY20.

Georgi was selected to participate in the SAMHSA SOAR Expert Panel in FY20, as part of a selection of contracted subject matter experts from across the country under the SOAR National Technical Assistance Grant held by PRAI from SAMHSA. She has been invited back as a member of the panel in FY21 and FY22. Georgi was requested to present at the SOAR State Lead Conference in Atlanta in May 2022, providing an overview of building effective SOAR programs at the state level.

In FY19, the SOAR project began expanding its scope to outreach to state psychiatric facilities and local/regional jails, in an attempt to catch individuals exiting institution who would be returning to homelessness. In FY19, the Virginia SOAR project, in collaboration with the SOAR TA Center, DBHDS and our regional SSA and DDS Directors, implemented pre-release agreements between local state psychiatric hospitals and SSA offices. Through this project, Virginia Social Security facilities are able to flag claims as pre-release, expediting claims processing and utilizing a central tracking system to ensure individual claims are completed prior to exiting institutions. Georgi provided initial training for hospital-based benefits workers and continues to provide ongoing training for new workers. She also continues to lead bi-weekly meetings with facilities workers and SSA to troubleshoot pre-release claims. This process addresses barriers to discharge for individuals with serious mental illness and chronic homelessness, while also reducing hospital census and the use of Discharge Assistance Planning (DAP) funding and increasing successfully linkage to PSH programs.

The psychiatric pre-release process crossed over to the implementation of a pre-release process for Forensic Discharge liaisons working in local and regional jails across Virginia. This program began as a pilot project in FY19 with two jails. The success of the pilot project resulted in this program expanding to 11 localities and more than 15 regional jails. The liaisons focus on pre-release linkage to benefits and housing for individuals with serious mental illness. The Virginia SOAR Program has trained all Forensic Discharge staff within the 15 regional jails to utilize the SOAR pre-release process. This process utilizes the same streamlined, expedited processing through Regional Representatives and Professional Relations Officers (PROs). The Forensic Discharge pre-release project has a current initial approval rate of 83%, with an average processing time of 112 days.

These initiatives, along with continued outreach and technical assistance, have prompted Virginia as being identified as a SOAR Top 10 State in FY18, FY19, FY20 and FY21 and as 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 78% initial approval rate for initial SOAR applications in 2021, well above the national average of 65%.

SOAR WORKS VIRGINIA

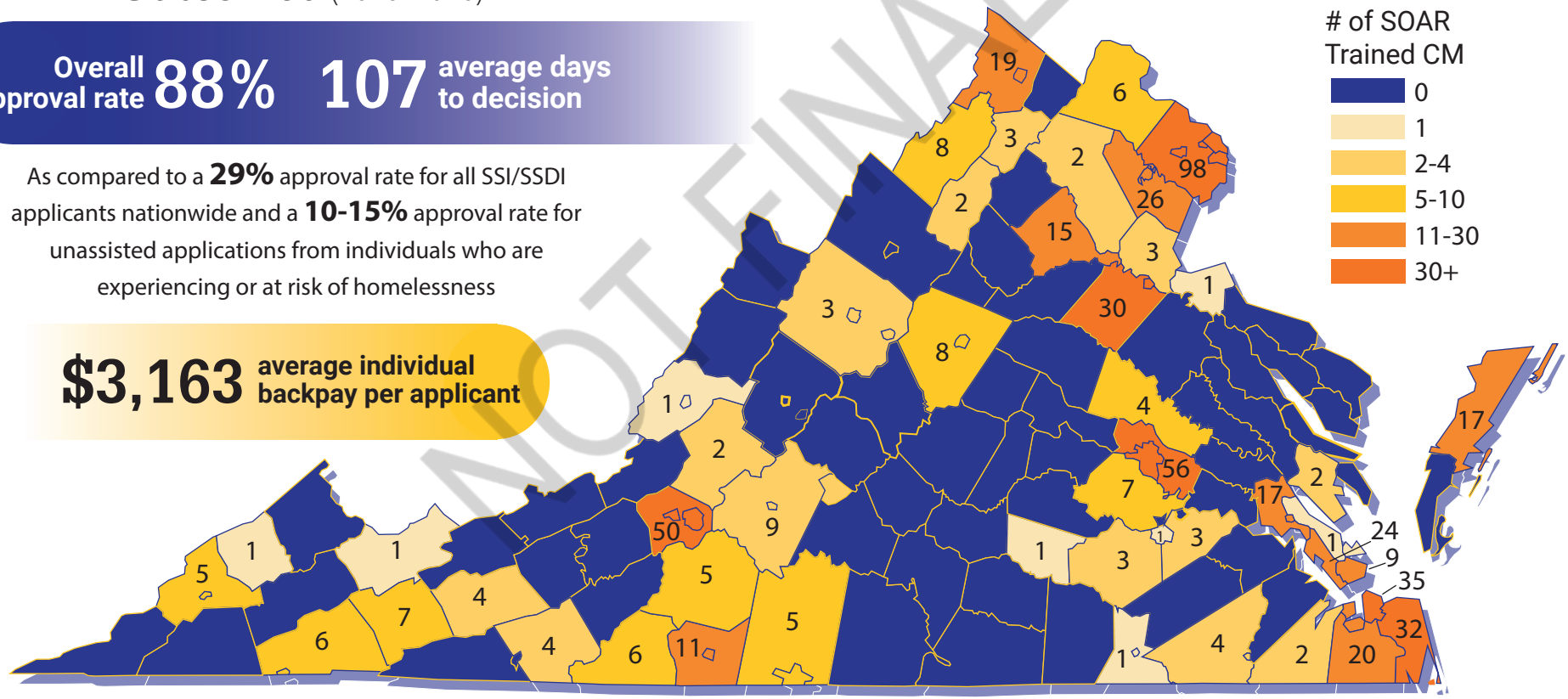
SSI/SSDI Outreach, Access, and Recovery (SOAR) is a national initiative designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness, 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 (2019-2020):

Overall approval rate 88% **107 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

$3,163 average individual backpay per applicant



How to Become Involved

How to Become Involved If you're interested becoming involved with the Virginia SOAR initiative please review Virginia SOAR Website (https://virginiasoar.wixsite.com/virginiasoar) and reach out to the Virginia SOAR State Team Lead Georgi Fisher (georgi.fisher@dbhds.virginia.gov) or the Virginia SAMHSASOAR 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.

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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 several years, 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, have been locally implemented in conjunction with the assistance of the SPC.

PATH Reported Activities

Charitable Choice for PATH

Does your state use PATH funds to fund religiously-affiliated providers to provide substance use treatment services? Yes ○ No ◉
If "Yes" is selected please list providers in text box below and complete the rest of the table

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.

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Footnotes:

COMMONWEALTH of VIRGINIA

Office of the Governor

Glenn Youngkin
Governor

April 4, 2022

Yan Rong
Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane
Rockville, Maryland 20857

Dear Ms. Rong:

I am delegating responsibility for the Projects in Assistance in Transition from Homelessness (PATH) Grant to the Commissioner of the Virginia Department of Behavioral Health and Developmental Services (VA DBHDS), effective this date. 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) 786-5682

As such, I am also authorizing Nelson Smith, Commissioner of VA DBHDS, to sign all required documents with the submission of the annual PATH grant application for this and subsequent years of my administration.

Sincerely,

Glenn Youngkin

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