Projects for Assistance in Transition from Homelessness (PATH) Grant

Requirement: Contract
42 U.S.C. 290cc-21 et. seq.
42 C.F.R., Part 54

Frequency: Annual Monitoring
Annual Report
Quarterly Report

Due Date: Ongoing

The Managing Entity shall contract with Network Service Providers who qualify under Section 522(a) (42 U.S. Code § 290cc–22) and have the capacity to provide, directly or through arrangements, the services specified in subsection 522(b), including coordinating the provision of services to meet the needs of eligible individuals.

To be eligible for PATH, individuals must:

- Be 18 years or older,
- Have serious mental illnesses or serious mental illnesses and co-occurring substance use issue, and
- Be homeless or at imminent risk of becoming homeless.

COVERED COSTS: Allowable administrative and general program costs that are incurred under the Projects for Assistance in Transition from Homelessness (PATH) Grant.

RECIPIENTS: Individuals with serious mental illness or serious mental illness and substance use disorders, and are homeless or at imminent risk of becoming homeless.

Eligible Services. PATH-funded services may include screening, clinical assessment, community-based mental health services, substance use treatment, and housing assistance. Eligible services can be found in subsection 522(b), (42 U.S. Code § 290cc–22). (Services are not the same as referrals, so if the PATH program does not actually deliver a PATH-funded service to the individual it should be considered a referral). Additional terms related to the PATH Program workflow, referrals, and services may be found in the PATH Annual Report Manual.

Allowable PATH- funded services:

a. Outreach services;
b. Screening and diagnostic treatment services;
c. Habilitation and rehabilitation services;
d. Community mental health services;
e. Alcohol or drug treatment services;
f. Staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where individuals who are experiencing homelessness and serious mental illness seek services;
g. Case management services, including:

1. Preparing a plan for the provision of community mental health and other supportive services to the eligible homeless individual involved, and reviewing such plan not less than once every 3 months;
2. 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 services;
3. Providing assistance to the eligible homeless individual in obtaining income support services, including housing assistance, food stamps, and supplemental security income benefits;
4. Referring the eligible homeless individual for other services as needed; and
5. 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;

h. Supportive and supervisory services in residential settings;
i. Referrals for primary health services, job training, educational services, and relevant housing services;
j. Housing services, upon approval of the Managing Entity including:
    1. Minor renovation, expansion, and repair of housing;
    2. Planning of housing;
    3. Technical assistance in applying for housing assistance;
    4. Improving the coordination of housing services;
    5. Security deposits;
    6. The costs associated with matching eligible homeless individuals with appropriate housing situations; and
k. One-time rental payments to prevent eviction.

FUNDING: Costs associated with this BE/OCA combination are directly charged to the PATH Grant and requires one-third of the total fiscal year allocation, in-kind or cash match.

CHARTING:

Admissions and Discharge

All PATH admissions are voluntary and require consent and participation.

The Network Service Provider shall maintain the following clinical documentation for individuals served in the program:

Intake Documentation Requirements

The file contains basic demographic information, which includes; (1) Client's name, (2) address, (3) telephone number, (4) marital status, (5) sex, (6) legal status, (7) race, (8) date of birth, (9) guardian contact information for minors, (10) referral source and (11) staff name of who has responsibility of the client.

The file contains, if applicable, a time-specific statement authorizing release of confidential information, signed and dated by the client or guardian, which designates the agency to receive the information,

purpose of the disclosure, how much and what kind of information to be disclosed, statement that the consent if subject to revocation at any time and date which consent will expire if not revoked before.

Assessments/Examination Documentation Requirements

The PATH assessment is completed within 30 days after intake and includes the following with client input: (1) presenting problem, (2) current and potential strengths and problems, (3) relationship with family members and significant others, (4) service agencies with whom the client has been involved and involvement or need for involvement in social support systems.

Service/Treatment Planning

The PATH service/treatment plan is completed 30 days after intake with the following goals and objectives with client input: (1) Achievable observable measurable, (2) reasonable timeframe, (3) actions needed to attain the goals and staff responsible, (4) incorporate needs and strengths from the assessment and (5) goals for each identified issue.

Progress Notes Requirements

PATH Progress notes shall be prepared at least monthly for clients having a service/treatment plan unless documented otherwise.

Progress notes contain the (1) client's name, (2) client identification number, (3) staff name, (4) service date, (5) service duration, (6) a description of the service provided, (7) progress, or lack thereof, relative to the service/treatment plan or modified service/treatment plan from changes in client's needs, resources or findings.

PATH Progress note content address PATH case management and housing activities.

Discharge/Termination Requirements

If no contact over 90 days, file must be closed, unless service/treatment plan indicates less frequent contact. The reason for the discharge/termination must be included.

Discharge/Termination report must be in the client record within 4 weeks after the termination of services.

Discharge/Termination report shall include the following: Evaluation of impact of agency's services on client's goals/objectives, date and signature of individual preparing report, if there is a referral and a reason for the referral must be noted.

Funding and Allocations:

In order to appropriately serve persons in accordance with the provisions contained herein, **Case Management must be billed at minimum 30%** of the total service delivery billing per fiscal year, not including incidentals.

PATH Network Service Providers must:

1) Annually submit an application packet which includes a budget and an Intended Use Plan (IUP) for Managing Entity and Department review and approval.
    a. The Department will provide a budget, an IUP template and due date.
        i. The IUP must cover needs and services for the upcoming State fiscal year (7/1 – 6/30). Providers shall detail how PATH programs collaborate with the local Continuum of Care (CoC)and the Coordinated Entry process, and include signed letters of support from the CoC Lead Agency.
            1. Ensure budget costs charged to the grant are allowable as authorized under 45 CFR § 75.403, and that housing expenses do not exceed the maximum 20 percent allowable per section 522(h) (42 U.S. Code § 290cc–22).
            2. PATH programs must work in collaboration with their Managing Entities on developing their Local Area Provider-Intended Use Plan (IUPs) and budgets. The detailed description of IUP requirements can be found in the PATH Funding Opportunity Announcement (FOA) for the Grant year. PATH providers must annually review the most current FOA for new or amended IUP and budget requirements.
            3. Implement an approved and signed Local Intended Use Plan that demonstrates compliance with Title V, Part C, Section 522 of the Public Health Services Act.
            4. Allocate and expend no more than 25% of the PATH award for administrative and supervisory expenses; a minimum of 75% of PATH funding must be used for front-line staff and direct services to eligible consumers. These allocations shall be outlined in the annual budget.
            5. Get approval of the Intended Use Plan (IUP) from the local Continuum of Care (CoC) Governing Body in their area, prior to submission to the Managing Entity (include how the PATH services fit with the priorities of the local CoC plan). Work with the local Continuum of Care entities (funded by the U.S. Department of Housing and Urban Development) to assist providers in using HMIS and to coordinate homeless services locally.
        ii. The IUP must specify a plan to reach the areas in which the greatest number of individuals who are experiencing homelessness with a need for mental health, substance use disorder, and housing services are located.
        iii. PATH programs must join the local Continuum of Care membership and be a member in good standing with their local Lead Agency Coalition or CoC.
        iv. PATH programs must establish a license to use the local HMIS systems within their region.
        v. If no significant changes to PATH programs are anticipated for the upcoming fiscal year, the PATH Director must submit a letter certifying that the response to the IUP has not changed.

2) Ensure that PATH funded case managers are trained in Housing Navigation to:

    a. Provide individualized support by helping each PATH-enrolled individual develop a personalized service plan to address any barriers to obtaining and maintaining permanent housing.

    b. Provide employment linkage, benefits establishment, linkage to community providers for substance use treatment, primary and mental health care, and all other services needed to assist individuals in reaching their recovery goals.

    c. Perform community outreach to business owners, realtors, landlords, housing developers and other service providers to build strong relationships and identify new and existing opportunities to better assist individuals in accessing resources, employment, supportive services, and housing opportunities.

3) Review service plans every three months and the plan must include:

    a. Community mental health services;

    b. Coordination and referrals for needed services such as shelter, daily living activities, personal and benefits planning, transportation, habilitation and rehabilitation services, prevocational and employment services, and permanent housing; and

    c. Assistance to obtain income and income support services, , Supplemental Nutrition Assistance Program (SNAP) benefits, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI);

4) Maintain individual medical records for each PATH participant containing an intake form, a determination of eligibility for PATH-funded services, a service plan, and progress notes. If the PATH program is part of a larger milieu of services the consumer is participating in at a community provider the PATH material must be integrated into that record.

5) Submit an annual report no later than November 17th via the PDX at https://pathpdx.samhsa.gov/account/login.

6) Train designated staff on SSI/SSDI Outreach, Access, and Recovery (SOAR) using the SOAR Online Course, available at: https://soarworks.samhsa.gov/content/soar-online-course-catalog

    a. PATH programs must have specifically identified case manager(s) trained in the SSI/SSDI Outreach, Access and Recovery (SOAR) model. PATH programs must identify staff to assist all eligible individuals with SSI/SSDI applications using the SOAR model. In the event PATH programs do not directly provide assistance using the SOAR model are required to have formal agreements with organizations who do and outline prioritization, coordination, and tracking of referrals; PATH staff must link potentially eligible individuals to non-profit or advocacy organizations assisting with applications for Social Security benefits.

7) For those PATH programs who are using the SOAR model, programs must enter SSI/SSDI application data into SOAR Online Application Tracking (OAT) database at soartrack.prainc.com/, in accordance with DCF's Guidance 9.

8) Provide at least one dollar of local matching funds for every three dollars of PATH funds received and expend local matching funds to provide eligible services to PATH eligible persons to PATH participants. Match-funded expenditures must align with the services identified in the local IUP budget.

a. SAMHSA requires that all participating PATH providers must match PATH funds directly or indirectly through donations from public or private entities in order to provide non-federal contributions in an amount that is not less than one dollar for every three dollars of federal PATH funds received. This match requirement is embedded in the providers' contract documents and verified through financial monitoring of PATH providers by the Managing Entities. funds must be available throughout the life of the grant period. Matching in-kind funds may be used only to support PATH-eligible services. providers may utilize a variety of match sources including state general revenue, private donations, county funding, non-federal grants, city funding, and fees to meet the match requirement. Each provider's source of match must be specified in the IUPs, alongside a detailed description of how matching funds will be used.

b. Calculating Match
Example: $300,000 federal award
Must provide $1 for every $3 in federal dollars
Calculation: $300,000/3 = $100,000 match to be provided
TOTAL PATH EXPENDITURES = $400,000

9) Employ policies and procedures that ensure priority use of other available funding sources for services and supports (i.e., Medicaid, local Continuum of Care Housing Funding).

10) Include consideration of continuity of care needs specifically for people experiencing homelessness in disaster response plans. PATH providers shall assess, at least annually, and amend as appropriate, their disaster response plan to ensure it continues to meet the service needs of the target population.

11) Establish plans for new hire training and continued training on each system in the PATH coverage area.

a. PATH providers must have a training plan for all PATH employed and contract staff. PATH staff must receive periodic training in cultural competence, health disparities, and appropriate best practices such as Trauma Informed Care, Motivational Interviewing, Recovery- oriented care, and Housing First.

12) Adhere to the standards established in the Florida PATH Program Manual.

13) The State PATH Contact (SPC) reserves the right to exclude a provider seeking to apply for PATH Grant funding.

14) Program priorities for use of PATH funds by providers, at a minimum, must include targeting adults in the priority population who are experiencing homelessness or are at risk of homelessness and maximize serving the most vulnerable adults who are literally and chronically homeless; Conducting street outreach and/or case management is the priority service delivery. PATH programs may conduct street outreach to locate eligible individuals followed by the demonstrated implementation of case management activities to enroll and engage individuals who are or are at risk of homelessness and are not already connected with mainstream services (e.g. substance abuse, mental health, housing, employment, etc.) and focus on housing those individuals and connecting them with mental health and housing focused supportive services.

a. Outreach, including street outreach, is deliberately organizing activities to meet potential PATH eligible individuals where they naturally congregate rather than waiting for them to seek services at a specific place. During effective outreach, the goal is to engage with potential PATH eligible individuals and developing the critical relationships

necessary for supporting transition to housing and/or needed behavioral health services. Collaboration with community agencies is important and may span many sectors, including faith- based organizations, hospitals, correctional institutions, free clinics, law enforcement, meal sites, homeless shelters, libraries, and day centers.

b. Certain providers may have a license to conduct clinical mental health and substance abuse treatment, others may not have this license nor does staff meet criteria. PATH providers who cannot perform substance abuse and/or mental health services must have a relation with their local community providers of SAMH services and there must be evidence of a referral mechanism.

c. Engagement occurs when an interactive individual relationship results in a deliberate assessment or the beginning of a case plan. It is a one-time event, may occur on or after the project start date, and must occur prior to PATH enrollment and project exit. Individuals cannot be enrolled in PATH without being engaged. Although some interactions with an individual may result in a positive outcome such as assisting an individual access a shelter bed, without a deliberate assessment or the beginning of a case plan, those interactions are not considered to be an engagement. The assessment does not have to be of a clinical nature, and neither HUD nor SAMHSA have established minimum criteria for what the assessment must include, other than the individual deliberately engaging with the staff to resolve the housing crisis.

15) Programs should have detailed strategies for providing and/or obtaining housing for PATH eligible individuals. Partner with local resources to link people with safe, affordable housing of their choice. If PATH programs do not directly provide housing, formal agreements with housing organizations outlining prioritization, coordination, and tracking of PATH individuals is required.

16) Provide support services for individuals who have a serious mental illness or serious mental illness and substance use disorder, and are homeless or at imminent risk of becoming homeless.

    In order to ensure an individual is able to maintain stable housing, PATH programs may continue to provide or ensure provision of supportive services for up to 90 working days after a PATH individual is housed. After 90 days, the individual must be discharged/exited from the PATH program. Programs may extend the timeframe if sufficiently justified.

17) HMIS - Data Entry and Collection Requirements. PATH programs must fully participate and enter data in PDX regarding PATH program data and in the Homeless Management Information System (HMIS) for potential PATH individuals and PATH-engaged individuals. The State hosts several different vendors and systems with varying capabilities, and some providers may continue to track data in a secondary system if they are not yet able to extract all required data fields for PATH annual reports from the HMIS system. PATH funds may be utilized for HMIS data migration purposes. The CoCs may provide on-going training and technical assistance for HMIS users in their respective areas. The various software providers of HMIS should also provide technical assistance. HUD provides annual training on updates to requirements for the software to capture data elements as needed. The HMIS and Coordinated Entry System (CES) facilitate placements in permanent supportive housing based on a vulnerability index (i.e.VI-SPDAT) and are tools for agency collaboration. PATH programs are required to collect all of the Universal Data Elements and the relevant Program-Specific Data Elements. The Program-Specific Data Elements to be collected by each PATH program are available in The PATH Program HMIS manual available in PDX.

The manual provides information on HMIS project setup and data collection guidance specific to the PATH Program.

18) Participate in the peer-based fidelity assessment process to assess the quality, appropriateness, and efficacy of treatment services provided to individuals under this contract pursuant to 45 CFR 96.136.

19) Programs are encouraged to prioritize individuals that meet PATH eligibility who are Veterans and/or are part of the annual Disparity Impact Statement target population as well as working with the Managing Entity staff and prioritize efforts to locate and house individuals identified as High Utilizers of the SAMH System. Actively advance PATH services to meet the annual targets established in the Behavioral Health Disparity Impact Statement (DIS).

20) Follow F.A.C. 65E-14.021(4)(k)4.b.(V) when billing incidental expenses.

Performance Measures:

Government Performance and Results Act (GPRA) Measures

The current performance requirements for PATH as specified under GPRA are as follows:

- 3.4.15 Percentage of enrolled homeless persons who receive community mental health services (Outcome);
- 3.4.16 Number of homeless persons contacted (Outcome);
- 3.4.17 Percentage of contacted homeless persons with serious mental illness who become enrolled in services (Outcome); and
- 3.4.20 Number of PATH providers trained on SSI/SSDI Outreach, Access, and Recovery (SOAR) to ensure eligible homeless clients are receiving benefits (Output).

National targets are set annually for each GPRA measure, and the PATH program's nationwide performance is measured in comparison to these targets. Individual provider programs whose PATH Annual Report data indicates that they are below 80% of the target are asked to provide an explanation for their data. SAMHSA Government Project Officers (GPOs) and/or State PATH Contacts may contact PATH providers regarding programs who consistently underperform on these measures. Technical assistance may be considered to assist the provider in improving their performance on certain measures.

Additional information about PATH GPRA measures can be found in the Congressional Justification (http://www.samhsa.gov/budget).

Required Reports:

1) Monthly Reports
    a. The LSF Homeless High Utilizer Search and Update List is prepared by staff from the LSF Department of Housing and Community Inclusion. This list is composed of high risk, high utilization consumers who are experiencing homelessness. This list will be distributed on or before the 30th of each month by the Regional Director of the Department of Housing and Community inclusion and due to the Network Manager and Regional Director of Housing and Community Inclusion by the 10th of the following month. This will give the PATH providers at least 10 days to log information on possible LSF Homeless High Utilizers in the search area if encountered in the area. **The Template for this report is incorporated herein and additional training on the LSF Homeless High Utilizer Search and Update List**

and other PATH monthly or quarterly reports will be provider annual and at request of the PATH provider.

b. The Network Service Provider must submit the PATH Incidental Expenses Summary Report to the Network Manager and Housing Coordinator by the 10th of the month. **The Template for this report is incorporated herein.**

2) Annual Reports
   a. The Network Service Provider must submit an annual report into the PATH Data Exchange by November 17th via the PATH Data Exchange (PDX) at https://www.pathpdx.org/. More information and guidelines for annual report submission may be located at: http://www.pathprogram.samhsa.gov

3) Quarterly Reports
   a. The Network Service Provider must submit the PATH Quarterly Housed Report to to the Network Manager and Housing Coordinator by the 10th day of the month following the end of each quarter. **The Template for this report is incorporated herein.**

PATH Providers

Network Service Provider	County
Mental Health Resouce Center	Duval/Clay/Nassau
Mid Florida Homeless Coalition	Citrus/Lake/Hernando/Sumter/Marion
Volusia/Flagler County Coalition for the Homeless, Inc.	Volusia/Flagler/St. Johns/Putnam
Meridian Behavioral Healthcare	Bradford/Alachua/Gilchrist/Levy/Union/Baker
United Way of Suwannee Valley	Columbia/Hamilton/Lafayette/Suwannee/Dixie

Projects for Assistance in Transition from Homelessness (PATH) Grant will be administered according to DCF Guidance 15 and the Florida PATH Program Manual. DCF Guidance 15 can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities/.

Definitions - For the purpose of the PATH Program Manual, the following definitions apply:

a. **Co-occurring Serious Mental Illness and Substance Use Disorder.** An individual who has at least one serious mental health disorder and a substance use disorder, where the mental health disorder and substance use disorder can be diagnosed independently of each other.

b. **Individual Experiencing Homelessness.** An individual experiencing homelessness must be as least restrictive as defined by the Public Health Service (PHS) Act: "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and an individual who is a resident in transitional housing.

c. **Imminent Risk of Becoming Homeless.** The criteria commonly include one or more of the following: doubled-up living arrangements where the individual's name is not on a lease, living in a condemned building without a place to move, having arrears in rent/utility payments, receiving an eviction notice without a place to move, living in temporary or transitional housing that carries time limits, and/or being discharged from a health care or criminal justice institution without a place to live.

d. **Serious Mental Illness.** An individual 18 years of age or older with a diagnosable mental health disorder of such severity and duration as to result in functional impairment that substantially interferes with or limits major life activities.

Helpful Resources

Projects for Assistance in Transition from Homelessness program details including, the funding opportunity announcement can be found by following this link: https://www.samhsa.gov/homelessness-programs-resources/grant-programs-services/path.

PDX

PATH Annual Report data are collected in the PATH Data Exchange (PDX) during the PATH reporting period, which typically occurs in the fall each year. PATH providers are notified when the reporting period is open and of the date of the federal deadline. The PDX has a "Resources" section where SPCs and PATH providers can access the PATH Annual Report Provider Guide and technical assistance resources. PDX link can be found here: www.pathpdx.org.

SAMHSA

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Link to SAMHSA's website here: https://www.samhsa.gov/about-us.

SAMHSA's Homelessness Resource Center (HRC)

Targeted toward providers who work with people who are experiencing homelessness, the HRC website (http://homeless.samhsa.gov) shares state-of-the art knowledge, evidence-based practices, and practical resources. It provides an interactive learning opportunity for researchers, providers, individuals, and government agencies at all levels. It is an easy-to-manage resource with content that informs, features that engage, and training that is useful. These elements come together to promote recovery-oriented and individual-centered homeless services.

SOAR

SSI/SSDI Outreach, Access, and Recovery (SOAR) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults 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 resources and online training are available at this link: https://soarworks.prainc.com/.

U.S. Interagency Council on Homelessness

The United States Interagency Council on Homelessness (USICH) is an independent agency within the federal executive branch that is tasked with coordinating the federal response to homelessness. A variety of resources can be accessed on the USICH website (http://usich.gov/) including Opening Doors, the

federal plan to prevent and end homelessness, as well as articles, newsletters, videos, and webinars on topics related to preventing and ending homelessness.

WebBGAS

WebBGAS is a web-enabled block grant management system that allows for the submission, review, approval, and archiving of PATH applications. The official WebBGAS website here: https://bgas.samhsa.gov.

Best Practice Considerations: PATH Enrollment

In order to establish consistency across PATH programs it is recommended that the PATH Enrollment Checklist below is used when enrolling PATH participants.

PATH Enrollment Checklist

Enrollment: PATH enrollment implies that there is the intent to provide services for an individual other than those provided in the outreach setting. The term enrolled means that there is a mutual intent for the services to begin. PATH enrollment is when:

1) The individual has been determined to be PATH eligible,
2) The individual and the PATH Provider have reached a point of engagement where there is a mutual agreement that services will be provided, and
3) The PATH Provider has started an individual file or record for the individual that includes, at a minimum:
   a. Basic demographic information needed for reporting,
   b. Documentation by the Provider of the determination of PATH eligibility,
   c. Documentation by the Provider of the mutual agreement for the provision of services,
   d. Documentation of services provided, and
   e. Service plan if the PATH enrollee is receiving case management services.

_____ has been determined eligible for PATH

(Name of Person Served)
enrollment based on meeting the following criteria:

☐ He/she has a mental health diagnosis of _____ OR

☐ There is an informed presumption that the individual has a serious mental illness because:

☐ He/she is experiencing or displaying symptoms of mental illness and is experiencing difficulty in functioning as a result of these symptoms that indicates severity,

☐ He/she has shared or has a known history of engagement with mental health services,

☐ He/she has symptoms and functioning that indicates there is a history of or expected tenure of significant mental health concerns

AND

☐ He/she lacks any housing, OR

☐ His/her primary residence during the night is a supervised public or private facility that provides temporary living accommodations, OR

☐ He/she is a resident in temporary or transitional housing that caries time limits, OR

☐ He/she is in a doubled-up living arrangement where his/her name is not on the lease, OR

☐ He/she is living in a condemned building without a place to move, OR

☐ He/she is in arrears in rent/utility payments, OR

☐ He/she has received an eviction notice without a place to move, OR

☐ He/she is being discharged from a health care or criminal justice institution without a place to live, OR

☐ He/she is living in substandard conditions that could result in 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.