

Program Guide

For ICMS Case Managers

*Permanent
Housing Edition*

HOUSING
FOR
HEALTH

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Introduction & How to Use This Guide



Introduction & How to Use This Guide

WE WROTE THIS FOR YOU. This Program Guide is designed for direct service staff and supervisors at agencies subcontracted by the Housing for Health (HFH) division of the LA County Department of Health Services (DHS) to provide Intensive Case Management Services (ICMS) for households connected to Permanent Housing (PH) opportunities.

Whether you are responsible for a broad range of services or operate in a more specialized role, this Guide is for you. You are truly the champions behind this work. Our hope is that this Guide will support your efforts, answer key questions, and spark ideas that enhance your practice.

Throughout this Guide you will find:

- Key Sections of the [ICMS Statement of Work \(SOW\)](#)
 - The ICMS SOW is a contract document provided by HFH to each provider. It outlines all aspects of how the program should be conducted, including information about expectations for how work will occur, where the work will be conducted, and so much more.
- Helpful Hints
- Best Practices
- Links to Resources, Documents, and Forms

The Table of Contents is clickable to help you navigate easily throughout the Guide.

Why This Guide Matters

Whenever public funding is appropriated, there are legislatively mandated rules and requirements—for eligibility, allowable costs, documentation, and more. These rules may require compliance with additional laws, all of which must be documented and may be monitored. Funders—including LA County, the State of California, federal agencies, philanthropic sources, and others—may also layer on specific requirements tied to their unique missions or community goals.


As a result, DHS and HFH have defined these obligations in the Statement of Work (SOW), a central part of your agency's contract. This Program Guide is intended to help you understand those contractual requirements in the context of good, grounded practice.


Think of this Guide as a mix of “how to,” “what if,” and “here’s what works.” It distills the essential components of the ICMS model within the PH program, tying them directly to the requirements outlined in the SOW.

To make it easier to use, we've incorporated color coding:

Colored boxes denote key information, examples, or emphasis areas to help you quickly locate what you need.

99 Green boxes are direct quotes from the Statement of Work (SOW).

 Orange boxes are "helpful tips, case scenarios, etc."

 Blue boxes are best practices curated from across LA County and around the country.

A Word About Our Rapidly Changing Work

For those of us working within the homelessness response system in Los Angeles, change is a constant. Shifts in funding—both increases and reductions—as well as political developments at the local, state, and national levels all have a direct impact on how we do our work.

The best any of us can do is stay informed and remain flexible, adapting to change in ways that minimize disruption for the people we serve. Our collective goal is to ensure that transitions, even when complex, have the least possible negative impact on participants.

You'll notice a date on the cover of this Guide. That date indicates the most current version, accurate at the time of publication. The Housing for Health team actively monitors program updates and will issue a revised version of this Guide on an annual basis. When updates occur, you will be notified and provided with a summary of the changes.

As you use this Guide, if you come across any information that seems unclear or you have questions about how something applies to your role, please don't hesitate to reach out to your HFH Program Manager for support and clarification.

Lastly, thank you—truly—for your continued commitment, your compassion, and the critical work you do each day in support of our unhoused neighbors.

The Philosophy & Values of Homelessness Work In LA County



The Philosophy & Values of Homelessness Work In LA County

A Bit of History

Years ago, as communities first began responding to the needs of people experiencing homelessness, it was thought that they needed to be taught how to live independently before they could move into permanent housing. They were required to accept treatment for mental health or substance use disorders before they were thought to be “housing ready.” It was easy to believe that these were “core issues” that had caused and maintained homelessness. Unless these issues were modified, homelessness would recur.



Communities used to believe: “Resolve all your problems (lack of job, illness, child behavioral issues, etc.), get sober, and then we will help you find a new place to live.” Even as the gap between income and housing costs grew exponentially, this approach was still utilized. Then everything changed.

Los Angeles has always played an outsized role in responding to the needs of people experiencing homelessness. Housing policies, real estate practices based in racist thinking, and lack of federal investment in affordable housing all came together to create a crisis of homelessness going back decades. But while that crisis was growing, many people were trying innovative approaches starting in the late 1980s.

Skid Row is familiar to us all, but it is worth looking at the history. Between 1950 and 2000, 14,000 residential hotels that had served the working poor, unemployed, disabled, and other marginalized people were destroyed, forcing thousands of people to city streets and shelters.

In 1977, the City of LA Community Redevelopment Agency (CRA), adopted a redevelopment plan for downtown that included preservation of single room occupancy hotels in the area. In pursuit of that plan, [SRO Housing Corporation](#) was founded by the CRA to acquire and rehab SRO hotels. Since its incorporation in 1984, SRO Housing provided Permanent Supportive Housing for our most vulnerable residents.

In 1985, Los Angeles Men’s Place (LAMP) was founded as a night-time drop-in center for men experiencing homelessness with mental health challenges. LAMP was one of the pioneers of the Housing First model by providing affordable permanent housing without a requirement for treatment and providing support services for those who were living in their units. In 2016, LAMP merged with the Ocean Park Community Center (OPCC) to form [The People Concern \(TPC\)](#).

In 1988, [A Community of Friends \(ACOF\)](#), a regional nonprofit housing developer for populations with special needs was founded. They have developed properties throughout LA County with the specific mission of providing permanent, affordable, service-enriched, and supportive housing for homeless adults and families with mental and physical disabilities, senior citizens, and low-income households.”

Not much later, “In 1989, community activists and business leaders of LA’s downtown responded to the alarming disappearance of affordable, permanent housing by creating the Skid Row Housing Trust (SRHT aka The Trust). The Trust quickly mobilized private equity through low-income tax credits, public finance, and conventional debt to salvage hundreds of housing apartments that would have otherwise been lost.” The Trust became one of USA’s pioneers in combining housing and support services on-site (Permanent Supportive Housing).

Following in the footsteps of these giants in LA, **Pathways to Housing in New York City demonstrated** (between 1999 and 2003) that street-dwelling men experiencing chronic homelessness with a mental illness—and often a substance use disorder—who were placed directly into their own housing with supportive services, achieved statistically greater housing stability over four years, along with fewer psychiatric hospitalizations and lower costs, than a control group of the “traditional model.” Here was some solid data in support of [Housing First](#).

Proposition HHH (homelessness reduction and prevention, housing, and facilities bond) was passed by voters in November 2016 to fund the construction of supportive housing for people experiencing homelessness. The funding is primarily spent on construction of Permanent Housing (PH) designed to provide long-term housing that is deeply subsidized and includes supportive services for the most long-term and vulnerable people experiencing homelessness.

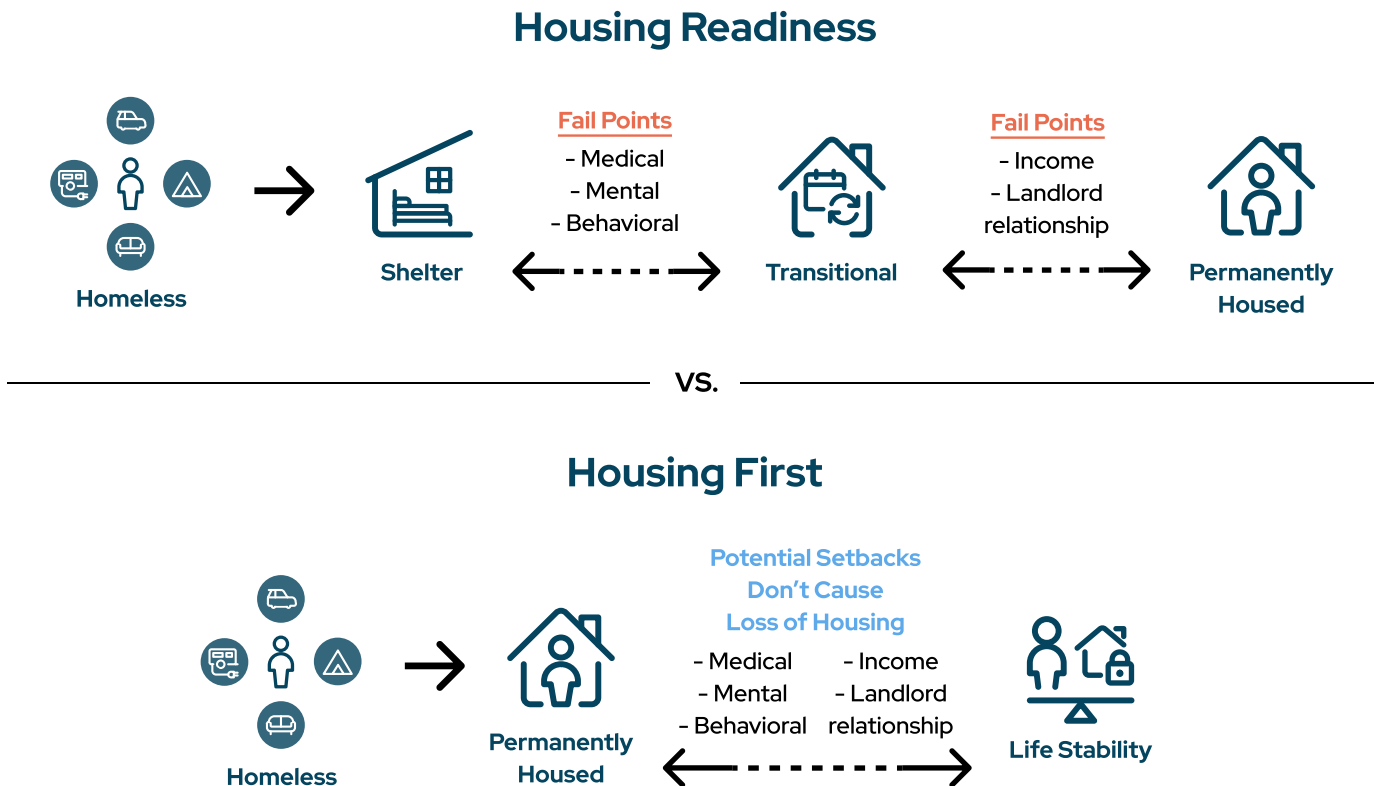
In March 2017, voters of Los Angeles County approved Measure H, a quarter-cent sales tax increase to fund homelessness services and prevention. The measure supported mental health services, rental subsidies, emergency and transitional housing, homelessness prevention, and substance use disorder treatment. Set to expire in 2027, Measure H has been superseded by Measure A, approved by voters in November 2024. Measure A doubles the sales tax to a half-cent, generating an estimated \$1.1 billion annually with no sunset date. This new measure expands funding to include affordable housing development, increased mental health and addiction treatment, and stronger accountability measures, while continuing to support homelessness services across the county.



Philosophical Underpinnings

Housing First:

The primary goal of our housing programs is to assist participants to obtain and retain housing. It is not to solve every life problem or to assure that everyone exits “healthy, wealthy, and wise” (Marybeth Shinn, PhD). Housing First is voluntary, participant-centered, and low-barrier.



Programs may not impose any preconditions to enrollment in housing programs, including obtaining jobs, getting sober, getting mental health treatment, or having a certain income level.

All housing programs operating in LA County homelessness response system are required to follow Housing First approaches. Housing First programs focus on quickly moving people experiencing homelessness into permanent housing and then providing the additional supports and services each person needs and wants to stabilize in that housing. Services are never mandatory and cannot be a condition of obtaining the housing intervention. The basic underlying principle is that persons are better able to move forward with their lives once the crisis of homelessness is over and they have control of their housing. Supportive services focus on the income, resources, skills and tools needed to pay rent, comply with a lease, take reasonable care of a housing unit, and avoid serious conflict with other tenants, the Housing Provider, and/or the police.

Low-Barrier:

Housing First programs do not require persons to prove “housing readiness.” There are no preconditions, meaning access to housing has low barriers. Persons experiencing homelessness are not required to: demonstrate sobriety, engage in treatment, have employment, or have an income to obtain program entry

or for continued assistance. Rules should not be imposed on participants for them to access services. **Low Barrier programs work to make paperwork as simple and unobtrusive as possible.** Stable housing is of critical importance for participants' health, education, employment, and other related quality of life determinants. LA County's Permanent Housing programs all require a low-barrier approach to enrollment. This also means participation in its services is entirely voluntary.

Harm Reduction:

An integral component of the low-barrier design of LA County's housing programs. In accordance with Harm Reduction principles, contracted programs must not require treatment or sobriety. Programs utilizing a Harm Reduction approach do not terminate assistance based solely on a person's inability to achieve sobriety, or because of medication non-compliance, or because they don't want to meet with their case manager. Harm Reduction is usually applied to substance use, but can also be applied to budgeting, participating in case management, job searches, etc. Programs must seek to work with Participants to reduce the negative consequences of the person's continued use of alcohol and/or drugs, or non-compliance with medications (or other challenges). Efforts should include all possible approaches to assist the person to reduce or minimize their risky behaviors, while at the same time assisting them to move into, and stabilize in, permanent housing. Harm reduction is not intended to prevent the termination of a Participant whose actions or behavior constitute a threat to the safety of other Participants and staff.

Crisis Response:

Homelessness is a significant crisis, and the longer it continues, the greater the negative consequences. As a crisis response program, we seek to quickly resolve a Participant's homelessness. However, crisis response also means that programs recognize the range of psychological and neurological impacts of stress overload on Participants. These impacts can, in many cases, affect the person's ability to: (1) make, remember, and carry out plans; (2) shift their behaviors in response to new information; and (3) control their emotions. See section on Trauma and Stress.

Trauma-Informed Care:

All programs must incorporate trauma-informed care policies and procedures into their program design and delivery of services. Trauma-informed care emphasizes physical, psychological, and emotional safety for both participants and agencies, and helps participants rebuild a sense of control and empowerment. Trauma-informed services consider an understanding of trauma by prioritizing participants' feelings of safety, choice, and control. This approach goes together with harm reduction and low-barrier approaches.

Racial Equity:

To effectively address homelessness, we must acknowledge and address the continuing role that structural and institutional racism play in causing homelessness among Black, Indigenous, Latino/a/e, Asian, Pacific Islander, immigrant and refugee communities, many of which are significantly over-represented in LA County's homelessness population as compared with their representation in the county's overall population. Eliminating these disparities requires that resources be targeted, and services be delivered in a manner that addresses these disparities, and that individual organizations and the system of care are accountable for equitable access to services and equitable outcomes.



Trauma-Informed Care: Many people who have become homeless have experienced trauma, either earlier in their lives or after becoming homeless. A trauma-aware organization is welcoming and safe for persons who have experienced trauma. The organization is careful to minimize re-traumatizing program participants by not asking unnecessary intrusive questions and learning and avoiding their triggers. Empowering participants without overwhelming them and using peer support are also good practices.

The same atmosphere and methods that support participants who have experienced trauma are also valuable for supporting participants who have experienced stress overload. Organizations should teach staff about trauma-informed care and stress overload and develop policies, procedures, supervision, and supports that help staff utilize that knowledge in their practice—and in their own self-care.

Culturally Specific and Responsive Services:

All Housing for Health service partners are expected to deliver services in a culturally responsive manner. Culturally responsive services are respectful of, and relevant to, the beliefs, practices, culture, and linguistic needs of diverse consumer/participant populations and communities. Culturally specific services are informed by specific communities, where most members/participants are reflective of that community, and use language, structures, and settings familiar to the culture of the target population to create an environment of belonging and safety in which services are delivered.

Person-Centered Customer Service:

When it comes to Participants, this means that we believe and act in such a way that demonstrates our belief that the Participant is inherently driven toward, and has the capacity for, growth and self-actualization.

In alignment with the National Law Center on Homelessness and Poverty, this means ensuring that the delivery of services must respect the experience, human dignity, and human rights of all persons receiving them. It means demonstrating that we maintain confidentiality, coordinate care, and treat people with dignity.

Person-Centered approaches are sensitive to the needs and challenges (both medical and behavioral health) that participants face. **A “cookie cutter approach” is inappropriate in this program. Each set of services and approaches must be tailored to the individual.** We utilize ongoing assessment and re-assessment to ensure that Participants’ needs are being met.



Most importantly, **we employ a “whatever it takes approach” to assist Participants with transitioning from homelessness into permanent housing.**

99 STATEMENT OF WORK

2.7.4 Deliver services through a strengths-based approach that is culturally sensitive, appropriate, and participant-centered. The contractor staff shall have capacity to provide services in languages for non-English speaking participants (e.g., hire bilingual staff, access to translation services, etc.), provide services in a respectful manner to Participants based on how the Participant chooses to be identified (e.g., lesbian, gay, bisexual, transgender, queer, gay, questioning, intersex queer, etc.) and employ best practices in the provision of tailored services to meet the needs of specific subpopulations (e.g., Reentry Services, Transitional Aged Youth, Families, Participants with Domestic Violence histories, etc.).

CASE EXAMPLE: JOHN

An adult Participant, John, was working with staff (Kerry) to find a new place to live. Kerry had met with him two or three times to gather information about what his needs and wants were for his new home. They had identified the neighborhood, the fact that it needed to be near a bus route, and that he wanted a one-bedroom unit.

Kerry showed four different units to John and he rejected them all. They sat down again and reviewed his preferences. Kerry went out and found 4 more and took John to see them. Again, all were rejected.

Kerry asked for help from their supervisor (Vanessa). Vanessa sat down with John and engaged him in a conversation about his housing search. She asked him, what was getting in the way of him accepting one of the 8 units he had seen.

John looked Vanessa right in the eyes, and said, “I told her my one big request is for a bathtub, and she has only shown me places with showers. I really want a tub I can relax in.”

Vanessa reported this conversation to Kerry and Kerry was horrified. She remembered that conversation, but it had slipped her mind when she was looking at units.

The next day Kerry found a unit with a tub and within 2 weeks, John was all moved in and took a bath his first night in the unit!

Homelessness Definitions



Homelessness Definitions

Definitions of homelessness relate to eligibility for various programs and are in alignment with definitions established by the US Department of Housing and Urban Development.

Category 1 - Literally Homeless

An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning:

- i. Has a primary nighttime residence that is a public or private space not meant for human habitation.
- ii. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels/motels paid for by charitable organizations or by federal, state or local government programs); or

Is exiting an institution where s/he/they have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Category 2 (HUD Prevention Programs ONLY) - Imminent Risk of Homelessness

An individual or family who will imminently lose their primary nighttime residence, provided that:

- i. Residence will be lost within 14 days of the date of application for homelessness assistance.
- ii. No subsequent residence has been identified; and

The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Category 4 - Fleeing or Attempting to Flee Domestic Violence or IPV

A person that identifies as a DV/IPV (interpersonal violence) survivor, or is experiencing trauma or a lack of safety related to DV/IPV, or fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic, or life-threatening conditions related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety of children are jeopardized resulting from someone actively fleeing or attempting to flee and has no other residence, lacking the resources or support networks to obtain other permanent housing. Includes: men, LGBTQI+ individuals and families with teenage boys.

Partners in the Work & Funding Streams



Partners in the Work & Funding Streams

HFH's ICMS program has evolved over the years and continues to expand the range of funding utilized and partnerships leveraged to operate and sustain the most optimal PH programming possible. Due to limited resources and a variety of other obstacles, HFH has continued to find new ways to adapt, including becoming a community hub for PH programming that 'braids' multiple funding sources together while removing the administrative complexities for direct service providers.

HFH's hub model allows for a more standardized implementation of ICMS that is agnostic of the underlying funding stream(s), while also providing access to a larger system of integrated care that is managed by multiple systems partners coordinating together.

Please note: funding sources and program partnerships are subject to change based on evolving priorities and availability of resources. Some of the partners or funding streams listed below may no longer be active, while new ones may have since been added.

- **American Rescue Plan Act (ARPA):** LAC received \$1.9 billion under ARPA. In addition, ARPA funding has also been awarded to each of LAC's 88 cities, for a grand total of more than \$4.5 billion across all jurisdictions. More than \$760 million of the ARPA funds received are dedicated to housing and related services for people experiencing homelessness, for services to prevent people from falling into homelessness, and for affordable housing development.
- **Care First Community Investment (CFCI) Fund:** The CFCI Fund resulted from LAC Ballot Measure J ("Care First, Jails Last") passing in November 2020 to allocate at least 10% of the County's locally generated unrestricted revenues to address the disproportionate impact of racial injustice through direct community investment and alternatives to incarceration.

HFH works closely with funders and operators of PHK sites, including private developers, the LAC Chief Executive Office's Homeless Initiative, the LAC Development Authority (LACDA), the Los Angeles Housing Department, and the Housing Authority of the City of Los Angeles (HACLA) to ensure ICMS is available and delivered on site as projects near completion and lease-up.

- **Homeless Housing, Assistance and Prevention (HHAP):** HHAP is a block grant program designed to provide cities, counties, and continuous of care with flexible one-time grant funds to support regional coordination and expand or develop local capacity to address their immediate homelessness challenges. Spending must be informed by a best-practices framework focused on moving homeless individuals and families into permanent housing and supporting the efforts of those individuals and families to maintain their permanent housing.

- **Homeless Initiative (HI):** The HI has been serving as the central coordinating body for LAC’s ongoing effort—unprecedented in scale—to expand and enhance services for people experiencing homelessness or at risk of losing their homes. Created by the LAC Board of Supervisors in August 2015, the HI is part of LAC’s Chief Executive Office and is primarily funded through Measure H (now Measure A). A core component of the County’s Homeless Initiative framework focuses on providing ICMS and rental subsidies for permanent housing. According to an April 2025 LAC Board of Supervisors ruling, LAC is consolidating the HFH and HI programs into a single County department, with the merger officially taking effect in 2025 2025. This new department will be responsible for addressing homelessness, and it will be funded by transferring LAHSA funding and staff by July 1, 2026.
- **Housing and Homelessness Incentive program (HHIP):** Under HHIP, Medi-Cal managed care plans (MCPs) must file an investment plan with the state which demonstrates a road map for achieving targets in collaboration with local community stakeholders across California. The state expects that MCPs will pass through the incentive funds to local partners by investing in work with local organizations that are leading housing- and homeless-related efforts.
- **LA County Department of Children and Family Services (DCFS):** As one of the largest governed child protective services agencies in the nation, DCFS is responsible for ensuring the safety of more than 2 million children across LAC. DCFS supports children and families in crisis by focusing on three key areas: safety, well-being, and permanency.

Under the federal Foster Youth to Independence (FYI) and Family Unification Program (FUP) initiatives, HFH is partnering with public housing authorities and DCFS to provide housing and services assistance for up to 36 months for youth between 18 and 24 years of age, who left foster care or are in the process of leaving foster care, and who are homeless or at risk of becoming homeless.

- **LA County Department of Mental Health (DMH):** LAC DMH contracts with close to 1,000 organizations and practitioners to provide a variety of mental health-related services to over 250,000 LAC residents annually. Services to adults and older adults are focused on those who are functionally disabled by severe and persistent mental illness, including those who are low-income, uninsured, temporarily impaired, or in situational crises. Services to children and youth are focused on those who are emotionally disturbed and diagnosed with a mental disorder. With the passage of Proposition 1 and the Behavioral Health Services Act (BHSA) in March 2024, county behavioral health agencies will also assume a larger role in addressing homelessness. The BHSA replaces the Mental Health Services Act of 2004 (MHSA). It reforms behavioral health care funding to prioritize services for people with the most significant mental health needs, while adding the treatment of substance use disorders (SUD), expanding requirements for counties to fund and provide housing interventions, and increasing the behavioral health workforce.

DMH is one of HFH’s core partners, including providing BHSA funds to cover some ICMS slots, serving as an important source for ICMS matches, funding some rental PH subsidies through FHSP, and collaborating in the PH Integrated Services Program (ISP) through the provision of Full-Service Partnership (FSP) and the Housing Supportive Services Program (HSSP). Housing for Mental Health (HFMH) is also a partnership between DMH and HFH in which Homeless FSP participants are matched to ICMS that is connected to housing funded by FHSP.



- **LA County Department of Military and Veteran Affairs (DMVA):** LAC DMVA counsels veterans, their dependents, and survivors regarding federal and state benefits such as compensation, pension, education, home loans, burial benefits and license plate designation. DMVA's accredited Veterans Service Officers also connect veterans to comprehensive VA health care.

DMVA hosts a one-stop shop for veterans at Bob Hope Patriotic Hall located at 1816 S. Figueroa St. Los Angeles, CA 90015 that includes support for mental health, employment, clothing, a shower facility, DPSS, legal services, and more, regardless of a veteran's discharge status. DMVA is a key partner for HFH to ensure resources for veterans are coordinated and made available when possible.

- **LA County Department of Public Health (DPH):** LAC DPH protects health, prevents disease, and promotes health and well-being for all persons in LAC, with a focus on the overall population, conducting its activities through a network of public health professionals throughout the community. The Substance Abuse Prevention and Control (SAPC) program leads and facilitates the delivery of a full spectrum of prevention, treatment, and recovery services proven to reduce the impact of substance use, abuse, and addiction in LAC.
- **SAPC's Client Engagement Navigation Services (CENS)** program is available for ICMS Participants seeking substance use counseling and/or linkage to various forms of substance use treatment. The DPH Division of HIV and STD Programs (DHSP) aims to prevent and control the spread of HIV and STDs through epidemiological surveillance, implementation of evidence-based programs, coordination of prevention, care and treatment services, and the creation of policies that promote health. DHSP is a key partner to fund local rental subsidies, the Flexible Housing Subsidy Pool (FHSP), for their population of focus. HFH works closely with DHSP to ensure culturally appropriate ICMS is connected to participants identified by DHSP, bringing supportive services online quickly, and delivering them long-term in permanent housing.
- **LA County Department of Public Social Services (DPSS):** Serving low-income households, DPSS is the second largest governmental department in LAC and the largest social service agency in the USA. DPSS has an annual budget of \$5 billion and provides services to one out of every three LAC residents.

HFH partners with DPSS to braid ICMS with the Housing and Disability Advocacy Program (HDAP). HDAP is a state program established in 2016 to assist people experiencing or at risk of homelessness who are likely eligible for disability benefits by providing advocacy for disability benefits as well as housing supports. DPSS is also a key partner and funder of HFH's CBEST program, which ICMS Participants should be accessing if they need benefits.

- **LAHSA: Los Angeles Homeless Services Authority:** In December of 1993, the LAC Board of Supervisors and the City of Los Angeles mayor and City Council created the Los Angeles Homeless Services Authority (LAHSA) as an independent, joint powers authority. LAHSA is the lead agency in LAC's Continuum of Care (CoC), the planning body that coordinates housing and services for homeless households across LAC. LAHSA coordinates and manages over \$800 million annually in federal, State, County, and City funds for programs that provide shelter, housing, and services to people experiencing homelessness. LAHSA manages the Coordinated Entry System (CES) for Single Adults, Youth, and

Families, which helps coordinate supportive services and housing resources across LAC, intended as a collaborative, no-wrong door network. LAHSA also oversees the LAC CoC Homeless Management Information System (HMIS). LAHSA is the entity that matches all households to HFH for PH. According to an April 2025 LAC Board of Supervisors ruling, LAC is consolidating the HFH and HI programs into a single County department, with the merger officially taking effect in 2025 2025. This new department will be responsible for addressing homelessness, and it will be funded by transferring LAHSA funding and staff by July 1, 2026.

- **Measure A:** Approved by LA County voters in November 2024, Measure A is a half-cent sales tax that took effect on April 1, 2025. It replaces Measure H (a quarter-cent sales tax set to expire in 2027) and expands funding for homeless housing and services, permanent housing with supportive services, and broader homelessness prevention efforts. Measure A enables LA County to address both the immediate needs of people experiencing homelessness and the systemic drivers through investments in affordable housing construction, rental assistance, and support for vulnerable renters. Measure A supports the continued expansion of ICMS by creating a more stable, long-term revenue stream for programs and partnerships throughout the County.
- **Medi-Cal MCPs /CalAIM:** California Advancing and Innovating Medi-Cal (CalAIM) is a Medicaid 1115 Waiver Demonstration in California to transform the Medi-Cal program, make it more flexible, and integrate it more seamlessly with other social services. CalAIM builds on prior initiatives, including the Whole Person Care pilots, Health Homes program, Drug Medi-Cal Organized Delivery System, and the Coordinated Care Initiative. It enables MCPs to couple clinical care with a range of new nonmedical services, which are reimbursed by Medi-Cal, including housing supports, medical respite, personal care, medically tailored meals, and peer supports. CalAIM requires MCPs and incentivizes public health systems to be more responsive, equitable, and outcome focused. Community Supports is a CalAIM program that enables HFH to utilize ICMS participants' Medi-Cal coverage to help pay the ICMS providers for the ICMS being delivered.
- **Pathway Home (PTH):** By leveraging emergency powers and partnerships with local jurisdictions, Pathway Home brings people off the streets and into immediately available interim housing accompanied by a comprehensive suite of supportive services and, ultimately, into safe, permanent homes. The program also removes unsafe recreational vehicles (RVs) and other debris from community spaces, whether freeway underpasses or side streets, returning them to their intended uses. The primary funding source for most Pathway Home projects is Measure A, but some projects in this program are funded by the State's Encampment Resolution Fund (ERF).
- **Project Home Key (PHK):** Administered by the California Department of Housing and Community Development (HCD), PHK is an opportunity for state, regional, and local public entities to sustain, convert, and rapidly expand a broad range of housing types, including but not limited to hotels, motels, hostels, single-family homes and multifamily apartments, adult residential facilities, manufactured housing, commercial properties, and other existing buildings to permanent or interim housing for persons experiencing or at risk of homelessness, and who were disproportionately impacted by COVID-19.
- **Project-Based PH Developers:** LAC's PH Pipeline is made possible with financial support from a variety

of sources. The City of LA's significant increase in PH in recent years is due to Proposition HHH. Passed in November 2016, HHH created a locally generated, dedicated source of funding for the streamlined development of PH in the City of Los Angeles. Supportive Housing Loan Program development proposals use both traditional and innovative financing and construction techniques on this type of housing, often combining HHH loans with other financial resources to pay for the total development costs. DHS HFH works with PH developers and other key stakeholders throughout LAC to create supportive environments in these developments, where residents can build community and thrive.

- **Public Housing Authorities (PHAs):** HFH partners with many PHAs to support in the development and operation PH across LAC. PHA partners of the ICMS program include the housing Authority of the City of Los Angeles (HACLA), the Los Angeles County Development Authority (LACDA), and housing authorities in the cities of Long Beach, Pasadena, Santa Monica, Burbank, Redondo Beach, Inglewood, Culver City, Pomona, Hawthorne, Glendale, Compton, Soth Gate, Norwalk, Pico Rivera, Torrance, Baldwin Park, Lomita, and Hawaiian Gardens.
- **Skid Row Action Plan (SRAP):** Though spanning only 4 square miles, Skid Row has 4,400 people experiencing homelessness, 2,695 of them unsheltered, according to the 2022 Greater Los Angeles Homeless Count. This is the densest concentration of people experiencing homelessness in the County. Developed by HFH in collaboration with stakeholders, business owners, and community members who live and work in the area, SRAP is intended to comprehensively address the need for more interim and permanent housing, behavioral health, substance use treatment, and other services in the Skid Row area

SRAP is leveraging a \$60M Encampment Resolution Fund (ERF) grant from the State, \$125M under the LAC Board of Supervisors declaration of a state of emergency of homelessness, \$40M from the City of Los Angeles, and \$60M in LAHSA resources (which includes a \$15M ERF grant received by LAHSA for its Every Woman Housed (EWH) program). The ERF, administered by the Business, Consumer Services and Housing Agency (BCSH) and the California Interagency Council on Homelessness (Cal ICH) was designed by the State to provide communities of all sizes with the funding to move people living in encampments into housing. The EWH program was specifically designed to utilize ERF grant funds to end homelessness for women and families on Skid Row.

- **The California Department of Housing and Community Development (HCD):** Implemented Housing for a Healthy California (H4HC), established through the enactment of California Assembly Bill 74. H4HC was established for the purposes of providing supportive housing for Medi-Cal eligible households who are experiencing homelessness using the Federal National Housing Trust Fund (NHTF). The goal of H4HC is to improve access to supportive housing, complemented with improved access to primary and behavioral health care services, to reduce inappropriate utilization of emergency departments, hospitals, nursing homes, and correctional resources for eligible Medi-Cal beneficiaries who are experiencing homelessness or chronic homelessness.

ICMS Program Overview



ICMS Program Overview

The Department of Health Services (DHS) Housing for Health (HFH) program is a cohesive team of clinicians, community health workers, program administrators, contract managers, and other professionals who collaborate with multiple County departments, community-based service providers, cities, and other partners to provide housing and critical services to People Experiencing Homelessness (PEH) and those who have previously experienced homelessness. HFH works to meet the needs of people with complex health and behavioral health conditions.

According to the ICMS SOW, “Intensive Case Management Services (ICMS) Permanent Housing (PH) are critical interventions to get people from being unhoused to stably, permanently housed [as] part of a thriving community. The participants served by the [ICMS] Contractor will be people who are experiencing homelessness with complex medical, substance use and/or mental health challenges, requiring a supportive housing intervention to stabilize their overall wellbeing. ICMS shall be designed to assist participants experiencing homelessness with achieving and maintaining optimal physical health, mental health, and housing stability.”

ICMS case managers partner with participants to assist at every step in the process of housing attainment and stabilization. ICMS must be participant-focused and flexible enough to meet the needs of each individual participant in a manner appropriate for each person. The intensity of services shall be regularly monitored and adjusted based on each participant’s needs at various times throughout the time working together. ICMS may range from highly intensive individualized support as participants transition from homelessness to permanent housing, to less intense support for activities related to maintaining their progress.

It is important to prepare each ICMS case manager for the roller coaster of needs that will be found among most participants.

Specific Services Provided by ICMS:

1. Outreach and Engagement
2. Intake
3. Assessment and Re-Assessment
4. Individualized Care Planning
5. Housing Navigation and Move-In Coordination
6. Case Management in the form of Tenancy Supports and Wraparound Services
7. Services to Housing Providers

99 STATEMENT OF WORK (SOW)

2.2.9 Once Participant is enrolled in services, Contractor shall provide a minimum of two (2) month service updates in the County-approved information management system (CHAMP) within three (3) business days of services provided. Documentation shall serve to update housing navigation and tenancy milestones such as, housing application submission date, voucher issuance date (s), move in date(s), move out dates(s), incident report date(s), etc. Services can include but are not limited to meaningful and substantive face-to-face visits, reassessments, ICP updates, and other wrap around services as needed, etc.

Impact of Stress and Trauma



Impact of Stress and Trauma

Before we can really go into the work, we must discuss and prepare for how to operationalize Trauma-Informed Care. Throughout this guide, you will find references to the impact of trauma and stress overload on the participants (and you). We are going to start with a bit of a lesson about stress and trauma on individuals to look at how to implement trauma-informed practices.

Program staff are likely to find that many participants have difficulty accomplishing the tasks associated with housing attainment and retention. It might appear that they are suffering from a mental health crisis or substance use disorder, or perhaps the impact of domestic violence, or a traumatic brain injury. Or it may appear that they are “not motivated” to secure permanent housing. **More likely, it is the impact of trauma/stress overload.**

Biological Impact of Stress Overload	How Stress Overload Affects People’s Behavior
Stress induces a neurological bias in favor of continuing habitual behavior.	The bias means people under stress may automatically continue behaviors, even when change would improve their lives.
Hormones released by stress affect “effort-based decision-making.”	During stress people may automatically avoid “difficult” choices, behaviors, or decisions.
<p>Neurohormones triggered by stress prioritize “fight, flight or freeze” behaviors over reasoning.</p> <p>Cognitive skills thus have less ability to control behavior.</p>	People under stress can react emotionally, and impulsively. They may have reduced ability to solve problems; make and carry out plans; modify plans in response to new information; and control emotions and impulsive behaviors to engage in goal-directed behavior.

Due to genetic differences, parenting experiences, traumatic events and other factors, some people have more resilience to stress than others. Everyone is affected by stress, particularly if the stressful events are important, uncontrollable and last for a significant amount of time. PH program participants have experienced homelessness, and all the threats and dangers homelessness produce; they are very likely to show some of the following signs and symptoms of stress overload (source: [Mayo Clinic.](#))

Stress overload has physical and neurological impacts that have profound implications for ICMS practicionares. For example:



Thoughts and Feelings

Anger, Anxiety, Apathy, Cynicism (pessimism, doubt), Defensiveness, Depression, Feelings of impending danger or doom, Feeling of insecurity, Helplessness, Hopelessness, Irritability, Lack of direction, Mood Swings, Nightmares, Panic, Restlessness, Sadness, Suspiciousness, Worthlessness

Behaviors

Avoiding social activities, Angry outbursts, Being late, Change in religious practices, Change in sleep patterns, Decreased interest in sex, Difficulty concentrating, Excessive worrying, Forgetfulness, Impatience, Increased arguing, Increased complaining, Increased crying, Increased smoking, Increased use of alcohol or drugs, Increased use of sick time, Inability to enjoy activities you used to like, Increase in accidents or injuries, Neglecting responsibilities, Nervous twitch or habit, Overeating, Poor job performance, Poor personal hygiene, Procrastination

ICMS case managers may, unconsciously, view clusters of these symptoms as evidence of a disability. It's particularly important to remember that the person demonstrating these behaviors is at least experiencing stress overload. In programs for persons experiencing homelessness, **it can be helpful to remember that we are seeing a person at their worst, and we don't really know who they have been and who they are capable of being in the future when they are more stable.**

To get a more personal sense of what we are talking about, try this exercise:

EXERCISE

Take a minute to recall an episode in your own life where you faced a serious crisis that continued for an extended time and over which you had no control. How many of the symptoms in the chart (above) applied to your thoughts, feelings, and behaviors? After the stressful event ended, did you quickly return to "normal?" Or were there ups and downs in your recovery? Did you realize that your cognitive abilities were not as sharp during that event? It's not surprising if you weren't aware of diminished cognitive functioning; after all, you would need cognitive skills to diagnose a reduction in your cognitive skills.

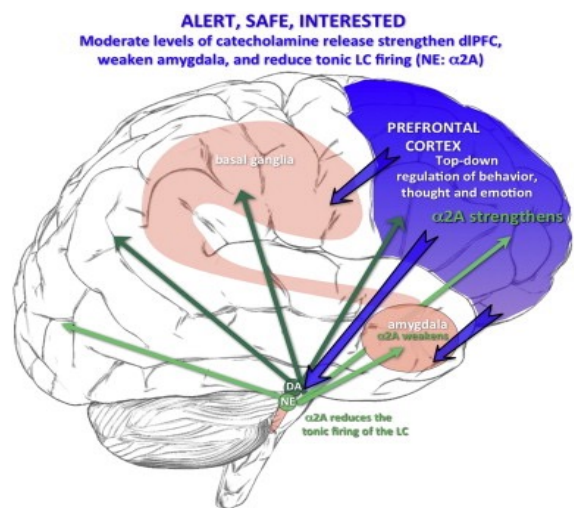
Both program participants and program staff may be experiencing stress overload at any given time. This can affect all aspects of the working relationship between the participant and support staff. Always remember that what you are seeing (and sometimes what you are feeling) can be caused by or exacerbated by the stresses of their experience with homelessness or your own stresses.

Why Does This Happen?

Researchers have been able to examine and demonstrate what is occurring in our brains when we are experiencing stress overload. First, the **prefrontal cortex**, which is the section of our brains responsible for executive functions becomes over-ridden by the part of our brain responsible for the “fight, flight, or freeze response”—the **amygdala**.

Executive function is like the CEO of your brain—it helps you to manage tasks, make decisions, stay organized, and respond to stimuli to change direction appropriately. The prefrontal cortex is also responsible for impulse control (stopping us from blurting out or helping us to resist distractions), flexibility (the ability to adjust when plans change), and self-monitoring (noticing mistakes and fixing them on our own).

Your Brain When Feeling Good

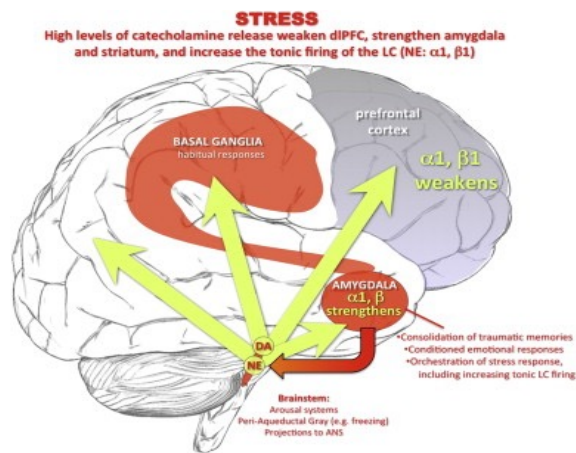


The amygdala is the part of the brain that plays a huge role in how we process emotions, especially fear and stress.

In good times, the prefrontal cortex and the amygdala work together. The amygdala detects emotions and sends signals (like fear, excitement). The prefrontal cortex analyzes the situation logically and decides the best response.

However, when stress becomes overpowering, they clash. The amygdala goes into overdrive and triggers the “fight, flight, or freeze response”. The prefrontal cortex starts to shut down, making it hard to think clearly and make rational choices and control emotions.

Your Brain Under Stress Overload



Source: of stress exposure on prefrontal cortex... (Arnsten, Raskin, Taylor, Connor 2014)

Understanding this, look again at the behaviors and reactions of the people experiencing homelessness with whom we work. Can't you just see it? They are reacting like fight, flight, or freeze.

What makes this particularly difficult is that most people in this condition do not have awareness of what is going on. They can't analyze the situation and say, "Whoa, I'm reacting without thinking." The brain is just not able to.



All of this is to explain why we use trauma-informed approaches in our work. All our work should focus on reducing the impact of stress; understanding the choices that people might make; explain behaviors that they are exhibiting and alter how we work with them to move forward successfully in housing.

Last bit of neurology lesson: Depending on the levels of stress, how long a person has been experiencing this stress overload, their biology, their generational trauma, and their outward environment, people will recover, but it may be an up and down road. Some people recover more quickly than others. But people can recover.

Reducing Stress Overload

Though people have differing levels of resilience, different histories, and differences in the intensity, duration, and controllability of the stressful events in their lives, much is known about how to help people experiencing stress overload and trauma.

- **Remove the stressor.** Housing First is the core principle of ICMS. Since homelessness is a universal stressor the most important step we can take is to show progress towards obtaining new housing and moving in.
- **Avoid additional stressors.** ICMS is a low-barrier and harm-reduction program. Adhering to these principles avoids adding undue stress on participants. Pushing for behavior changes during this period of stress overload can only make things worse. This means pushing an agenda of treatment of any kind at this point in the process may be counter-productive and should be avoided, if possible, until they are situated in their housing.
- **Reduce the perceived importance of the situation.** We can do this by assuring them that there are solutions, that you will be helping them find their solution, and that many others have been able to successfully exit homelessness. Tip: Offering opportunities to obtain support from people who were formerly homeless can be a good strategy.
- **Increase the person's perceived control over the situation.** This means empowering people by "setting them up for success." Ask for their preferences; support their choices, while assisting them to accept that their ultimate "dream" housing goal may first require smaller successes in more realistic housing.
- **Prioritize, plan and pace the action.** Remember that these tasks can be particularly difficult for a person in stress overload. Ask them for input on priorities; give them supplies to take notes and list tasks. If they prove unable to do this (at least right now), make the list for them—give them a copy. Likewise, if they fail to complete their tasks, don't assume they are "uncooperative" or "unmotivated." Assume there were too many tasks, or the tasks were too difficult (at least right now). Adjust expectations.
- **Diet, exercise, sleep, deep breathing, relaxation, and music can make a real difference in managing stress.** There are many online stress management tips. There are mobile apps that offer breathing and relaxation exercises. Tip: These can be useful to staff as well as program participants.

ICMS Case Manager Roles & Responsibilities



ICMS Case Manager Roles & Responsibilities

The job of the ICMS case manager is one of cheerleader, advocate, reality checker, and holder of hope. The ICMS case manager is a key driver of success for the participant.

The main thing to remember is that you must become the participant’s primary cheerleader for success.

That is why excellent staff always tap into their understanding of strengths-based practice. When people are struggling it is hard for them to remember that they have been successful at other times in their lives and with other activities in their life. A large part of our job is to constantly remind them of the sources of strength and resilience they can tap into.

Strengths-Based Work requires paying attention to both our language and our attitudes about the people with whom we work. We can’t and shouldn’t disregard either side of the equation. However, the key for a person in crisis is to emphasize their strengths in your dealings with them.

Look at this chart to frame this discussion:

Strengths-Based Thinking

- What’s working – or has worked before
- Discover and adapt to the situation
- Emphasizing Possibilities
- Persistent
- Understand
- Opportunity
- Celebrate Success
- Dynamic

Deficit-Based Thinking

- What’s wrong
- Predict and Control
- Overcoming weaknesses
- Resistant
- Diagnose
- Crisis
- Punish Non-Compliance
- Stasis

The ICMS Case Manager’s Variety of Roles

One thing we can all agree on is that work as an ICMS case manager is anything but boring. Our participants deserve the best out of us because we are their link to myriad resources offered throughout LA County and because they deserve the best possible chance for success. We hope this guide will help deepen your understanding of your role.



Getting Started

1. Emergent Needs

Work should begin as quickly as possible to identify any critical, emergent needs each participant brings with them. Health, safety, legal, medical, food, etc. should be addressed if for no other reason than to help put the participant at ease. This does not include things that are merely upsetting or bothering the participant, but rather real problems that, if not resolved immediately, will have an extremely negative impact on them. While addressing these, you can still move forward with other aspects of the housing attainment process.

2. Help Them Understand Your Role

ICMS case managers should make no specific promises but rather talk about the different housing options that are available in LA County and how you can help the participant connect to these options. This conversation will stress how you will partner in developing a plan with the steps needed to secure housing and that you will be working alongside them throughout the process of finding (and then retaining) housing.

3. Assess Housing Preferences & Barriers

- » What kind of housing does the participant want?
- » Whom do they want to live with?
- » Are there areas where they do or do not want to live?

The ICMS case manager should also, nonjudgmentally, probe for the circumstances of the participant's current situation as a means of determining next steps. This may include purchasing a tenant screening report and discussing significant findings with the participant. Is the information accurate? What led up to the problems with credit or eviction? When asking these questions, always remind the participant that these questions are just to help them secure housing, not to screen them out of your program. Purchasing a tenant screening report is an allowable expenditure using ICMS Participant Assistance Funds. These reports are available on an individual basis, or through subscription.

4. Facilitate: Development of the Care Plan

ICMS case managers should not expect that one goal or action step will be sufficient and effective in resolving homelessness. A person experiencing the crisis of homelessness can be better assisted by an individualized care plan that includes a series of step-by-step goals and action steps that contribute to and build on success. A series of goals and action steps will allow you to continue to assess, reassess, and update services to correspond with the person's changing needs, preferences, obstacles, and successes. [See the section on Individual Care Plans \(ICP\) for more detail, page 50.](#) This conversation should stress how you are going to work together in developing and updating the Care Plan.

5. Facilitate: Housing Search

ICMS case managers understand that the housing search is not simply consulting the classified ads. Individuals and households who are experiencing homelessness often have multiple housing barriers (often related directly to poverty) that would cause them to be rejected by many housing providers in tight housing markets. You have many resources to assist with this process.



Some of the participants will arrive having been matched to a housing source. There may be a project-based unit already assigned (in which case you will not have to search) or perhaps they will have been assigned a tenant-based voucher which will require a full-on housing search.

6. Facilitate: Financial Assistance

Securing housing is extremely expensive: application fees, security deposits, first month's rent, utility connection fees, and moving or procuring furnishings are all expenses that your program can cover. When people lose their housing because they had a financial crisis and couldn't pay the rent, it is unrealistic to think they have thousands of dollars to secure new housing. [See the section on Financial Assistance for more detail, page 100.](#)

7. Facilitate: Tenancy Supports

Many people who have become homeless understand the requirements and expectations of tenancy. Some have gaps in their knowledge. There can be misunderstandings or conflicts in any housing situation: between tenants or between a tenant and the housing provider. Leases may be unclear. Circumstances may result in a late or missing rental payment. ICMS case managers work collaboratively with all parties to help reach mutual understandings. [See the section on Tenancy Supports for more detail see page 95.](#)

8. Facilitate: Access to Community Resources

ICMS case managers assist people to secure and retain permanent housing—but that is just the beginning. Getting and keeping housing can require brief or longer-term community resources to supplement the work that you do. Examples include **legal assistance** to resolve an arrest warrant (which can get in the way of many things), or to correct errors in tenant screening reports (or the data bases they rely on), or to secure court-ordered child support (to help the participant pay the rent); **job training or employment** agencies (to regain a stable income); **public benefits** to increase income; **credit counseling** (to consolidate debts and/or reduce interest payments), etc. [See the section on Community Resources for more detail page 104.](#)

Outreach & Engagement

HFH prioritizes households experiencing homelessness with chronic illnesses or physical disabilities for ICMS placement. These households are identified through various pathways and enrolled by HFH ICMS into CHAMP slots to receive ICMS services from DHS-contracted providers.

Pathways into ICMS:

- The Coordinated Entry System (CES)
- DHS' municipal hospital system
- HFH's Street-Based Engagement (SBE) program
- HFH's Interim Housing Outreach Program (IHOP)
- Referrals from LAC departments (DMH, DPH, DCFS, DPSS, DMVA)
- Referrals from Medi-Cal Managed Care Plans (MCP)
- Referrals from Veterans Affairs for veterans with other than honorable discharges

Role of HFH ICMS Referral, Access, & Data Team (RAD):

RAD manages ICMS enrollment by:

- Facilitating matches with DHS-funded housing subsidies.
- Referring matched households into CHAMP slots with housing vouchers and ICMS.
- Referring individuals to ICMS slots even without immediate housing subsidies.

Coordinate with your program manager or supervisor regarding how new participant notifications are managed at your agency. Additional enrollment process details can be found in the ICMS Implementation Handbook.

Role of Coordinated Entry System (CES):

CES coordinates homelessness services for equitable and efficient access across multiple entry points, including Access Centers, Outreach Teams, Crisis Housing, Transitional Housing, and Family Solutions Centers. CES services are person-centered, Housing First-oriented, trauma-informed, and aim toward permanent housing.

Outreach

Outreach activities may include:

- Driving around to locate a participant
- Visiting encampments or shelters
- Making phone calls or sending text messages
- Conducting home visits
- Checking emergency contacts, hospitals, or LASD Inmate Locator



ICMS case managers must closely coordinate with referral sources to ensure successful participant contact within seven business days of referral. Outreach attempts must be recorded in CHAMP as either "initial outreach-successful" or "initial outreach-unsuccessful" services.

Engagement

Effective ICMS engagement begins immediately upon enrollment and is essential for securing housing. This process requires patience, positivity, and trust-building. Initial meetings should be prompt yet considerate of participants' stress levels and potential trauma.

Tips for Effective Engagement:

- Approach participants warmly, acknowledging they may be at a challenging life point.
- Provide basic comforts like coffee, water, or snacks to create a welcoming atmosphere.
- Start interactions by getting to know participants personally:
 - Learn about their family, interests, joys, and strengths.
 - Engage in informal activities like walks or casual conversations if participants struggle to concentrate.

Clearly communicate your supportive role and the services you can provide:

- Assistance with housing deposits and rental support.
- Help with housing searches and connecting participants to necessary services.
- Reinforce participants' autonomy and affirm your belief in their success.
- Approach tasks incrementally and reassure participants that you will support them throughout the process.



Building trust is gradual and transactional—always follow through on small promises to demonstrate reliability. Tailor your approach to individual participants and remember engagement is an ongoing, personalized process.



Best Practice

Get to know the participants and their wants, needs and desires. Choosing to work with you and your program can be a momentous decision for many. It is fraught with all kinds of worries based on past experiences. They must put aside those experiences and trust that you are going to do what you say you will and help them find a place to live. It is important to work with a deep connection to and understanding of the stress overload and trauma that our participants bring into this process. The best way to do this is by moving slowly but methodically through all the steps of preparing for new housing.

While completing assessments is important, it is not necessary to complete it all in one setting. Better to take some time depending on the needs/reactions of the participant so as not to overwhelm them. If you notice they are getting uncomfortable, ask if you should stop and restart the next day, or suggest a walk around the block to lower the stress level.



Intake

The **ICMS intake is a face-to-face encounter** that typically involves filling out a new participant paperwork packet with the participant. Its purpose is to provide new participants with an overview of the ICMS program, answer any initial questions, and gather basic information on the participant so that they can be formally onboarded into an ICMS case manager's caseload and as a participant in your organization.

During intake, work with the participants to obtain all the needed consents, authorizations and opt-ins ASAP. Start working to determine available housing opportunities and discuss potential goals and action steps that can be used to develop the Care Plan (ICP).



Always check the CHAMP profile to see if there are any outstanding consents that must be gathered. It will be flagged and listed as "missing". If an item is not flagged as missing in the ICMS Snapshot, the document is already on file and you do not need to gather it again.

Basic Principles of Intake

There are basic principles to the work of finding and enrolling people into ICMS.

They include:

- **Screen In:** We always use a "screen-in" approach to our referrals. Face-to-face meetings should be done wherever it makes most sense for the participant including hospitals, clinics, interim housing, recuperative care, jails, schools, etc. If they ask you to meet them at McDonald's, meet them and get them a cup of coffee and something to eat.
- **Strengths-Based Work:** Watch your language and your facial expressions. Avoid looking like or implying that you are negatively judging them. Strengths-based work requires that we recognize and use participants' strengths to empower them. Strengths-based work establishes building blocks that already exist to use as a foundation to move forward. The most important part of strengths-based work is paying attention to our language and how we frame our views of the participants.

Look at these examples:

DEFICIT-BASED LANGUAGE

- Family is in a perpetual crisis.
- This person resists any intervention by me.
- This person is always looking for things they can get help with.

STRENGTHS-BASED LANGUAGE

- The family's strengths have helped them survive together under incredible stress.
- This person believes in taking care of him/her/their self.
- The person wants to do the best they can while in this process.

Consider Resilience vs. Stress Overload. We know that all our participants are dealing with a large level of stress overload and a high likelihood of a lot of trauma in their backgrounds. That means that at the time you meet them, participants may not be functioning at their best. When they agree to complete a task by the next time you meet them and they show up for your next meeting without having done any of it, try not to be frustrated. Rather than assuming that they are not motivated, assume that they are operating under stress and just not able to.

When this occurs, try these steps:

- Start with small steps and observe how they do with those—don't overwhelm them.
- Adjust plans and provide more direct assistance by you if/when it appears they need it, and
- You can reduce direct assistance if/when the person shows they can manage the tasks independently.
- Don't hang your hat on empowering participants. There is a fine line between empowering and neglecting because they can't manage the work.



To help someone overcome their stress overload, give them small tasks, small steps and then adjust when you see how they do it. If they are not able to, then it's up to you to assist them more. You want them to see that they can succeed and that you are there to assist and cheer them on in their success. Later when they are more able, you can reduce the amount of direct assistance you are providing.

Remember at all times, that this is a Housing First program: our services and housing are not contingent on sobriety. They are not required to submit to any testing or screening for substance and alcohol use.

Intake Process

Have you ever found yourself in the situation when you sat down to do an intake, and you just started pulling out the paperwork and talking about eligibility and on and on? **It is important that we all take the intake and enrollment time as an opportunity to continue to get to know the participant.** Since you are working on building a trusting relationship, it is critical to keep this in mind every time you interact.

Of greatest importance is to get the required consents, authorizations, and opt-in forms.

- CalAIM (California Advancing and Innovating (Medi-Cal) Community Supports



Don't rush the participant Yes, there is a lot we hope to accomplish when we are conducting an intake, but **it is not necessary to complete everything in one meeting** as it can be overwhelming. In fact, with most of the participants with whom we are working, it is probably a bad idea to insist on completing everything in one sitting.

While conducting the assessment, keep these in mind:

- i You are required to complete the Initial Assessment utilizing the County tools within thirty (30) days of enrollment in ICMS/PSH.
The assessment must be done in person.
Get the consents into CHAMP (the database system that allows us to communicate with our community partners).

1. Housing First: please remember that we are a Housing First program which means we do not rule someone out because of “presumed” barriers such as:

- Mental health concerns
- Substance use disorder
- Lack of income
- Appearing uninterested, etc.

2. Emergent Needs: We are always going to focus our intake on ensuring that we are addressing any emergent needs that may be exhibited:

- Medical care
- Legal issue impending
- Needs food and drink

3. Harm Reduction: As a Harm Reduction program, ensure all participants are offered overdose response training, naloxone treatment, and other harm reduction supplies (disposable syringes, pipes, wound care, condoms, lube, etc.) if legally permissible to do so.

4. Shelter: If the participant would like to access interim housing to have a safe place to stay while you work with them on permanent housing, submit an interim housing application via CHAMP as soon as possible.

5. Basic Needs: While conducting the intake, you should also begin the process to determine their needs for basic financial and food assistance through General Relief (GR), CalFresh (i.e., food stamps); and other Department of Social Services (DPSS) services. Make notes for yourself to come back to these for enrollment work.



6. Domestic Violence: Assess for the need of services related to domestic violence, sexual assault, human trafficking, interpersonal violence, and stalking. Remember that a person **does not** have to be actively fleeing at that moment to be eligible for services. Thoughtfully and carefully ask if they feel safe or if they are worried about someone harming them. If they appear to have these concerns, discuss a referral to a Victim Services Provider (VSP). They are not required to do this—this is an offer of additional services and security. [See section on VAWA on page 121.](#)

7. Grievance Policies and Procedures: Remember to discuss the grievance policies and procedures and procedures for termination during intake and get their signature about having received this information.

8. Finally, schedule the initial assessment and Individualized Care Plan meeting.

You can see that this is a lot to cover and how this could be overwhelming. Do your best, take breaks, come back another day to complete steps that have not been completed.



The Statement of Work requires that you enter the intake and enrollment documentation into CHAMP within three business days of having completed that work.

Basic Consents

There are so many consents to get signed that it can easily become overwhelming for the participant. Consents are critical to our ability to share information across providers and various health care systems, etc. Take your time, try to keep the conversation light, answer their questions in a straight-forward way, and just explain why we have these and how they will be helpful to them.

- **Notice of Privacy Practices** is foundational to all consent discussions with participants. It describes the DHS pledge to keep each participant's health information private and secure, the different ways the HFH system of care (including ICMS providers) may use, disclose or share their health information (with or without obtaining the Participant's authorization), and the participant's rights regarding their health information. **All participants must be asked to sign an acknowledgement of receiving the privacy notice.**
- **Acknowledgment of Receipt of the Notice of Privacy Practices:** After discussing the privacy practices, ask the participant to sign the acknowledgement form. Remind them that you can always provide them of a copy at any time.
- **The Universal Participant Information Sharing Consent (aka Universal Sharing Consent):** A signed Universal Sharing Consent form allows all the agencies across LA to share information between one another to successfully provide participants with services and resources. Signing this consent prevents the need to get a new consent form signed every time a participant interacts with another agency.

Declining or Refusing to Provide Information Sharing Consent

The participant has the absolute right to decline or refuse to provide sharing consent. If they do decline, HFH may not be able to share certain information to coordinate supports for them, which could result in a limited level of care and resources. However, state and federal laws already allow HFH to share some participant health information (as described in the Notice of the Privacy Practices) to provide services, obtain payment, and run its operations, even without the participant's consent.

If the participant refuses or declines to sign, ICMS case managers should not share Participant health information outside the HFH system of care when it is not essential to the provision of support for housing navigation and retention.

- Information about substance use care or mental health care should not be accessed and shared outside the HFH system of care without prior approval.
- **Note the lack of approval in the CHAMP profile and never give up.** ICMS case managers should periodically follow up and see if the participant feels more comfortable signing the universal sharing consent. Once you have developed a relationship, they may change their minds.

Revoking Previously Provided Info Sharing

Participants have the right at any time to revoke the Universal Sharing Consent they have previously provided. If they do this, it will have the same effect as a refusal to sign in the first place.

CalAIM Opt-Ins

A truly great thing about the California Medicaid system is that its coverage pays for some, or all the housing navigation and case management supports that enrolled participants receive from the HFH system of care. This is called CalAIM Community Supports (CS).

Opting into CalAIM is voluntary, but it is tied directly to the ICMS services we provide, serving in many cases as the primary funding source of the ICMS program. When a participant agrees to receive ICMS they are also opting in to CalAIM CS, since CalAIM is used whenever an eligible Medi-Cal plan is available to help pay for ICMS.

- » DHS will never charge participants for HFH or CalAIM services, and
- » Participants will not be paid to participate in HFH or CalAIM.

Participants have the right to opt out of CalAIM at any time, however, in doing so, the opt-out may be putting DHS in a challenging position to pay for the ICMS services being provided.



Each time you complete an intake and/or collect any consent, one unit of the "Homeless System of Care Linkage/Coordination" Service should be recorded in the Case Notes in CHAMP.

[CalAIM CS Verbal Opt-In scripts are available in English and Spanish here.](#)

99 STATEMENT OF WORK

2.1.5 Obtain all appropriate and required participant consents, authorizations, and opt-in forms for participation in ICMS PSH and suitable complementary benefits or programming (e.g. California Advancing and Innovating Medi-Cal [CalAIM] Community Supports and Enhanced Care Management [ECM]), and for communication with community partners and entities/individuals who will be part of the Participant's care team (e.g., primary care physician, mental health service provider, substance use disorder service provider, ECM providers, housing navigators, street outreach case managers, family members, etc.). Contractor shall document consents, authorizations, and opt-in in the County-approved information-management system.



Initial Assessment

Assessments are critical to our successful work with the participants. ICMS case managers undertaking an assessment should always be self-aware of any cultural, race, religious, or other differences between yourself and the participant. **We must find the best way to work with each person as an individual ... every case is unique!** The goal of each assessment is to help identify what kinds of supports the participant needs and to help them prioritize efforts on goals and action steps.

When conducting the initial assessment:

- Always try to do it in a place that will be comfortable, private, and welcoming.
- They must be done face-to-face.
- Does the person need something to drink or eat?
- Try to help the person relax. The best way to do that besides starting with some small talk, is to explain what you are going to be doing and why you are doing it.
- Always offer them the opportunity to stop, take a break, or skip over a question or topic. You will have plenty of time to update the assessment the more you work with the person.
- If the participant is not yet housed at the time of the assessment, you only need to complete a 5x5 assessment in CHAMP. If the participant is permanently housed when you do the assessment, both the 5x5 and the Housing Acuity Index must be completed and documented. It is hoped that you will be able to complete this assessment within thirty (30) days of the participant's enrollment in ICMS. These assessments are used to determine the initial ICMS billing rate. You can find the manual to the Acuity Index and a copy of the tool in CHAMP.



Beyond the tools, it is also important to assess any needs they may have:

- Any urgent needs that must be addressed right away.
- Basic food and financial assistance: are they eligible for and enrolled in GR, CalFresh or other DPSS administered services?
- Income should be documented (no matter what kind of income it is) and then updated at least annually.
- Ability to perform activities of daily living (ADLs).
- Social functioning including financial, legal, education, vocational, family, leisure community service/ supports and other strengths/needs.
- Physical environment: Current housing status and housing history.



For each assessment completed, one unit of "Assessment" Service should be recorded in the Case Notes in CHAMP.



Make a note of whether they are currently enrolled in any benefits programs for which they might be eligible. While this is not something that we will jump right into at this stage, (except for medical benefits, which is critical) it is good to know what should be first on our list once they are housed.



A GENTLE REMINDER

This is a good time for a gentle reminder about ICMS being a Housing First program. Which means that we always support the Participants in attaining and retaining permanent housing regardless of any physical health, mental health, sobriety issues or income.



Document Ready

This is also the time when we determine whether the person with whom we are working has all of their necessary documents. It goes without saying that most people experiencing homelessness have a very hard time getting and keeping their documents. With encampments being closed and people living in a variety of interim housing sites, retaining documents poses a huge challenge.

While we never pause enrollment due to a lack of personal documents, it is imperative that we work closely with each person to obtain and maintain their critical documents as soon as possible:

- Birth certificates,
- Driver's license or state ID,
- ID issued by a foreign consulate
- Social Security card
- Birth certificates for children



ICMS Participant Assistance Funds should be used to pay for the cost of applying for any of these documents. Always check with your program manager about the payment process.



Maintaining Contact With Participants

ICMS case managers must maintain ongoing contact with every participant for the purposes of support and/or troubleshooting. This can be difficult. The intensity of the services and frequency of contacts should follow a progressive assistance approach that is based on the current needs of each participant. [See Housing Retention Services page 77.](#)



Especially in the early days of building your relationship, a quick phone call or text message to just check in on how things are going, or as a reminder about an upcoming meeting can go a long way.

Difficulty with Engagement

No matter how hard we work, and often no matter how badly the participant wants a place to live, engagement will likely hit peaks and valleys. Though program staff are expected to put their “whatever it takes approach” into high gear when experiencing difficulty with engagement, not every “failure” in the relationship is related to a failure by a staff person. **However, participant engagement is always the responsibility of program staff. Due to the inherent power imbalance in this relationship, it is up to us to do everything we can to make it work.** This requires that we keep an open mind to the many possible reasons that a participant may disengage.

Trouble-Shooting Engagement

Whether you are new to this work, or you have been doing it for a while, we all have stories about participants that appear to have fallen off the face of the earth. This is particularly difficult in LA County considering myriad Interim Housing sites, ongoing encampment resolution work, and people being moved in to and out of various temporary locations.



CASE SCENARIO

Maryelle is a 24-year-old single mom with two preschool-aged children. Having escaped from her abusive husband, Maryelle finds herself quick to anger. As a result, she lost her jobs and then lost her housing. She doubled up with a series of friends for three months, then lived in her car with the children for a month. She was referred to ICMS when she moved into an Inside Safe hotel space. Initially, she did everything her case manager (Tom) asked her to do—visited units, completed paperwork, got new identification documentation, and met with him every time they were scheduled. While waiting to be approved for a unit she had applied for, she stopped answering Tom’s calls and texts. He went to the Inside Safe hotel and was told that she was in her room, but she did not answer the door. Tom (who is in recovery) told his supervisor that he thinks Maryelle is using and hiding from him.



Try some of these tips when you have lost contact with a participant:

What might be happening with Maryelle? Why might she no longer be willing to talk to Tom?

- We know she is a survivor of domestic violence. Her case manager, an older man in a position of authority, has been increasingly insistent in talking with her. This could be a trigger.
- She could be totally exhausted. She has done everything to take care of her kids. She and her kids may just be trying to recover from “everything.” Perhaps they’re just hanging out watching TV together.
- Maybe one of the kids is sick or injured and she’s been at the hospital with them.
- Tom has brought up alcohol and other drugs nearly every time they meet. She might find this insulting because she has never had alcohol or other drugs.

What possible responses or tactics can be tried to overcome this barrier?

- Be creative and proactive (e.g., bring something for the kids).
- Ask how you can help; “What do you want from the program right now?”
- Ask if you have overwhelmed her and offer more direct assistance by taking on the next few tasks on the ICP.
- Talk with your supervisor and see if another case manager, possibly a female, could reach out to her.



CASE CONFERENCEING: If you are struggling with engagement, do some case conferencing with your colleagues and/or your supervisor. Often other people may have a different take on what is going on that could be helpful.

Due Diligence

We speak about due diligence when we have lost contact with a participant, or the participant has stopped engaging with program staff. Services are voluntary and so ultimately, if the participant chooses to disengage from services or you lose track of a participant, that can be considered their choice. Choice is important in empowerment. However, we also recognize the impact that stress and trauma have on folks’ ability to engage or follow through on agreements/commitments. It is because of these facts that we require that program staff always go the “extra mile” to re-engage with participants who have been lost or have disengaged.

Best Practices in Due Diligence:

1. Examine the reason for lost contact.
2. Use every avenue to attempt to find lost participants.
3. Use every possible tool to re-engage. Try and try again.

1. Examine the reasons

Sometimes when you are frustrated about lack of contact from a participant, it is helpful to brainstorm with others to think of ideas as to what might be going with the participant and ways to break through the impasse.

- Has the participant’s goals for their work with you changed and they don’t know how to tell you?
- Are they sick and in the hospital?

- Have they been incarcerated?
- Are they in another shelter?
- Have they moved away from LA County?

2. Utilize every avenue to find them or get them to talk with you.

- Have you checked the jail?
- Have you checked hospitals?
- Have you tried their emergency contact? Asked their friends?
- Have you asked outreach to check their “hangout spots?”



CONTACT YOUR HFH PROGRAM MANAGER They can help check shelter locations.

3. Use every possible tool to re-engage

- Have you texted and told them that you have a bag of food to drop off for them (if they have moved into housing already)?
- Have you emailed and explained that you need to get some info from them? No response? Send a letter or put a letter under their door (keep it friendly, not threatening).
- If they are in shelter, have you talked with shelter staff about their schedule, about them letting the person know that you are trying to reach them and want to come see them?
- Be straight with them after you have tried all you are going to try. “I really need to talk with you, and we can discuss how we work together.”



DON'T FORGET:

- All attempts to reach them should be **entered in case notes in CHAMP**.
- Continue to **try different ways to engage** and log those in case notes as well.
- If you feel that they really have no interest in the program, consult with your supervisor or Program Manager about what avenues you have available.

Reassessment

As you work with each participant, things are going to change—quickly for some, slowly for others. In addition, you are going to be constantly learning new things as you develop a closer relationship of trust. **It is important to reassess every ninety (90) days after the initial assessment has been completed and entered again into CHAMP.** After you have done this, go over what you are seeing with the participant. They are likely to be pleased with all they have accomplished or how much better they are doing than when they started.



Remember that the assessment should be used to help guide development and updates of the Individualized Care Plan (ICP).

Individualized Care Plan (ICP)



Individualized Care Plan (ICP)

The ICP is the roadmap for your work with each participant. It will be based on the needs, strengths and barriers that have been identified in the initial assessment. After enrollment, and after you have introduced yourself, described the program, and established some level of engagement, it's time to get to work. That work is represented by and updated in the ICP.

The ICP starts with the housing search (for the participant, you may want to refer to it as the housing search plan) and then is updated quarterly, including once the participant is housed and you both can begin to focus on what is needed for housing retention.



BEST PRACTICE

It is important to rely heavily on your understanding of the amount of trauma and stress overload everyone is dealing with. Don't overwhelm them with a plan with numerous goals and dozens of action steps. Break goals into manageable small pieces so you both can see the success. Once you have accomplished a goal, you can move on to the next one. Just because you can see the big picture and how much it is going to take to be successful (find housing), don't think that it will not overwhelm the participant. Each successive goal has its own set of action steps to result in fulfillment.

The plan is owned by the participant and represents their goals. This does not mean that there is one goal from enrollment to exit, with the singular focus of exiting homelessness. Goals help to define what success will look like and allow us to track our progress. Imagine that your plan is to build a house. Workers don't just show up and start hammering. There are stages to homebuilding, and each stage has innumerable tasks (aka "Action Steps"). Even purchasing a lot where the house will be built involves many practical, legal, and financial tasks. No one would think that all these stages and action steps could be listed in one goal.

Likewise, ICPs should be broken down into stages, or goals with action steps that are realistic for the household's current situation. Some people are more resilient; others are exhausted, mentally and physically, by the experience of losing their housing and surviving in a shelter or on the streets. Some have recent and successful rental experience, with decent housing provider references and no criminal record. Other people have limited rental experience, and the experiences they did have were filled with conflict and lease violations, late or missing rent payments, and/or multiple evictions. Others are right in the middle. A household may have three members or ten. These are all factors that will impact how you develop and manage the ICP.



Care Plans Are Individualized

While ICPs are individualized, there are clear commonalities that must be included:

- **ICPs break down the process.** The goals in an ICP are essentially interim goals leading to the overarching goal of securing and maintaining permanent housing. Even compiling necessary documentation may be complicated for people whose homelessness has resulted in lost paperwork and lack of clear memories of past housing providers, addresses, housing provider contact information, etc. When you start the housing search, you may start with gathering documents as one goal and then the action steps needed to accomplish that goal.
- **Plans are informed by, but not driven by, the assessments.** Assessments can inform steps that will enable the participant to secure the best housing they can ultimately expect to be able to retain. **Your job is to listen to the stated needs and wants expressed by the participant and find a way to translate those into something related to housing.** For example, if a participant wants to go to school, discuss why, for what, and how that could be achieved after they have been housed. “Going to school is a great goal, but wouldn’t it be easier to accomplish that from your own home?” **We must always work to elevate the participant’s decision-making abilities but not overwhelm them at a time when their stress level may not let them manage certain activities.** Every participant will have identifiable strengths that show up in their tenant screening assessment. They may demonstrate those strengths, even now, amid their crisis, during your planning meetings. Without seeming condescending, remind the participant of those strengths and reinforce both past and present successes.
- **The goals are “owned” by the ICMS participant.** After agreeing on the overarching goal, the ICMS case manager and the participant work together to define interim goals. Knowing the housing market, ICMS case managers are in a good position to explain how housing providers make decisions, rent costs in some areas, etc. Knowing the person’s situation, the ICMS case manager might ask questions about whether the participant wants to live near people involved in past housing crises or perhaps move farther away from them.
- **The To-Do List.** The ICMS case manager and participant list the steps (“Action Steps”) to get to the interim goal. This is an ongoing process, as some tasks may turn out to be too difficult or impossible, at least at this time in the participant’s life. Sometimes certain goals and/or action steps need to be deferred or paused, which is okay, but the key is to always keep at least some part of the plan in motion. Action Steps may be modified, eliminated, or added as experience dictates. It’s critical to make each new goal or action step in the care plan achievable. **Only by meeting regularly with the participant can an ICMS case manager know how many action steps a participant can handle** and identify if/when the participant’s growing confidence and declining stress level enables them to manage more.

99 STATEMENT OF WORK:

2.4.1 Develop and implement an Individualized Care Plan based on the needs and barriers identified in the Initial Assessment which shall include the Participant's goals, steps to reach goals, time frame for completing goals. The Individualized Care Plan shall be completed within thirty (30) days of Enrollment.

2.4.2 The Individualized Care Plan shall be updated every ninety (90) days at minimum. Updates shall include, but not be limited to, development of new goals, progress made toward achieving stated goals, and any changes to goals or action steps, with specific targets dates and outcomes noted in the County-approved information management system.

- **Who does what?** Assign action steps for each the participant and yourself as the ICMS case manager to complete. **An ICMS case manager does not hand a participant a lengthy list of tasks and check in with them several weeks later.** ICMS case managers develop expertise in many areas over time that can help households exit homelessness more quickly and maintain their housing. **Depending on the participant's current ability and limitations, the ICMS case manager may need to directly assist or take responsibility for some steps.** Some steps you may even decide to do together. This provides a unique opportunity to model behavior or actions.
- **Set timelines.** Work with the participant to develop realistic deadlines and target dates that move the process forward. This will require both sensitivity to the participant's fight, flight, freeze reactions and creativity in making sure that their progress continues. Sometimes this means offering more direct assistance, modifying the To-Do List (aka action steps), and/or reviewing the participant's past successes.
- **Draw attention to every small success.** Each time a task (or action step) is accomplished, or a goal has been achieved, is a time to point out these positive outcomes and celebrate that success.



Remember, the ICP must be updated within 30 days of program entry and then updated every 90 days at a minimum.

ICPs for Unsheltered Participants

Until a permanent housing placement is secured, ICMS case managers should work to address the needs they've identified while focusing on securing and moving the participant(s) into housing. One of the critical needs is where are participants going to be sleeping?

- **Advocate for Interim housing:** Not all participants may be interested in going to interim housing. There are many reasons they may not want to go to interim housing, including:
- **Pets:** If this is a concern, look for shelters with a pet policy that meets the needs of the participant. The rumor mill is rife with stories about what happens to people who helpful at overcoming this barrier if possible.



- **Hours:** Some participants want to look for and hopefully obtain a job even while working with ICMS on finding housing. They perceive that all shelters have restrictive hours when people may come and go which could get in the way of the job search or even going to a job. Again, this is a responsibility of the staff person to assist in finding a place that would work for the participant.
- **Partners:** Is the participant a part of a couple? Interim housing space for couples is in short supply and the couple may prefer to not be split up. Is this something that can be negotiated?
- **Safety/Fear:** It can be helpful to take the participant to visit the interim housing site being considered, so that they can see for themselves whether they can feel safe or not.

- **Too Many Rules:** This may or may not be true depending on the site. ICMS case managers should obtain accurate information about current rules and share them with the participant.
- **Identify Interim housing Options:** There are many types of interim housing, these include:
 - County-funded interim housing including recuperative care
 - Continuum of Care crisis/bridge housing (a LAHSA program)
 - Privately run shelters such as the Mission
 - Motel vouchers (primarily for families)
 - Safe Parking Programs
 - Pathway Home RV Interim Housing Pilot Program
- **Enter Interim housing:** Assist with action steps related to program entry and moving into an Interim Housing site.

- **Coordinate with the Interim housing Staff:** Interim housing facilities have many different staffing patterns. County interim housing has case managers, but most of LAHSA (CoC) shelters do not have case managers and instead have staff whose job it is to keep things running smoothly.
- **If a participant does enter a interim housing site, the ICMS case manager should continue to work with the participant to identify a permanent housing subsidy and permanent housing opportunity they may be eligible for. The best way to support this effort is to arrange regular meetings at the interim housing site.**
- **Collaborate with Interim housing Site Staff:** During (or preferably, before) checking in to the site, the ICMS case manager should learn about the staffing at the chosen site and meet with them to ensure that they can coordinate work with their participant. Explain what you have been working on with the participant (share the ICP) and enlist their support in keeping clarity for the participant about who is doing what. This can be a confusing time for participants, so forming a collaborative care team can go a long way.
 - Interim housing site staff appreciate regular updates from ICMS case managers as things move forward with identifying and eventually moving into permanent housing. In addition, sharing information about any new challenges or barriers that have arisen while in the participant is still enrolled at the interim housing site will also make everyone's jobs easier.



Housing Navigation & Attainment



Housing Navigation & Attainment

The Housing Attainment process is a critical time for the participant—it can be extremely stressful and scary. Here they are, finally facing the opportunity to have a place to live—will they be successful? How will they manage to keep this? How will they be able to manage all the costs? The participant’s mind may be whirling about everything that is involved and they may seem to have a million questions. We are offering you tips, best practices and guidance to try to make this as smooth of a process as possible.

Please note that almost all matches to permanent housing vouchers and opportunities in LA County come with an ICMS requirement. In most cases, if a participant accepts a permanent housing match, they are also accepting participation in ICMS.

There are two paths to housing attainment:

Unit Identification Process

Most of the time, participants enter ICMS having just been matched to a permanent housing subsidy and come to you for assistance with next steps. If they were matched to a Project-Based voucher opportunity, it will be a specific unit. If they were matched to a Tenant-Based voucher opportunity, you will have to work with them on finding an appropriate housing unit.

Unit Assignment Process

This is a process utilized and managed through LA County’s Flexible Housing Subsidy Pool (FHSP) that is provided to some participants based on several factors, including approval date, accessibility needs, household size, location preferences, and rental screening barriers. According to LA County’s FHSP policies, if an ICMS participant is in the Unit Assignment process, the ICMS case manager and participant will be notified.

Declining a Unit Match

A participant may accept or decline any unit match provided by Brilliant Corners. However, after declining two viable unit matches, the participant may not be able to receive an additional unit match and the ICMS Case Manager will need to work to find their own unit.

If the ICMS Case Manager cannot reach the participant about a new unit match before 10 days expires, they should decline the unit match on behalf of the participant. After 10 days, BC needs to put that unit back into open matching for other people.

No matter which housing attainment path is used, there are basic processes that will be followed and com-

pleted which are typically similar.

Likewise, there are two kinds of ICMS referrals your agency may receive:

1. You may receive an ICMS referral for a household already **matched to a permanent housing subsidy**.
2. You may receive an ICMS referral for a household not yet matched to a permanent housing subsidy (**known as pre-housing resource match or “pre-match”**).

Let’s look at the differences between the two in how we provide ICMS:

Housing Navigation Before a Subsidy Has Been Assigned (“Pre-Match”)

In late 2023, HFH expanded the ICMS program to include pre-housing resource match, or “pre-match,” which enables ICMS to be initiated earlier in the homelessness response continuum than it traditionally has been. As we all know, there are not enough housing subsidies for everyone who needs one. While leaders across the county are working to develop more housing opportunities and access more housing subsidies, many people are forced into longer stays on the streets or in interim housing programs while waiting for a housing subsidy. HFH recognized that we could move more quickly in finding housing for people once they get matched to a permanent housing subsidy if we began the prep for the housing search even before they have been matched to the housing subsidy. This approach is crucial for LAC’s homeless response system as it addresses the immediate needs of people with significant health challenges who are experiencing homelessness.

Pre-Match ICMS helps participants secure necessary documents to be prioritized for a permanent housing resource, provides interim housing, assists in accessing health care, and utilizes available resources to stabilize and expedite the transition to permanent housing.

When you are providing pre-match ICMS, you do everything you would do for someone who has already been matched to a housing subsidy and/or permanent housing resource. During this time, focus on getting them into interim housing ([visit HFH’s Pre-Match Info Center](#)) if they are not already there and if they want to go. Then start the process of gathering documents that will be needed for accessing housing; enroll them in health insurance if they are not; get them connected to transportation resources; and connect to services such as medical, mental health, or substance use treatment if they express a desire for these services. Just like all our work, we use a “whatever it takes” approach and remember our Housing First orientation.

DHS is in the process of negotiating with LAHSA to assist pre-match ICMS participants by also enrolling them in the LAHSA’s Time-Limited Subsidy (TLS) Program, which will provide them with a subsidy to pay the rent and expenses while you, as the ICMS case manager, provide them with ongoing case management support. DHS will notify the network when TLS connection is established.

Housing Navigation After a Match to a Permanent Housing Opportunity

Participants engaged in this part of ICMS are those who have already been matched to either a tenant-based housing subsidy (for which you will have to assist them in finding that housing), or they were matched to a project-based housing subsidy, which means there is a particular unit in a particular building already identified for them.



The rest of this section takes you through everything you need to know about providing housing attainment support regardless of whether a participant has been matched to a housing subsidy.

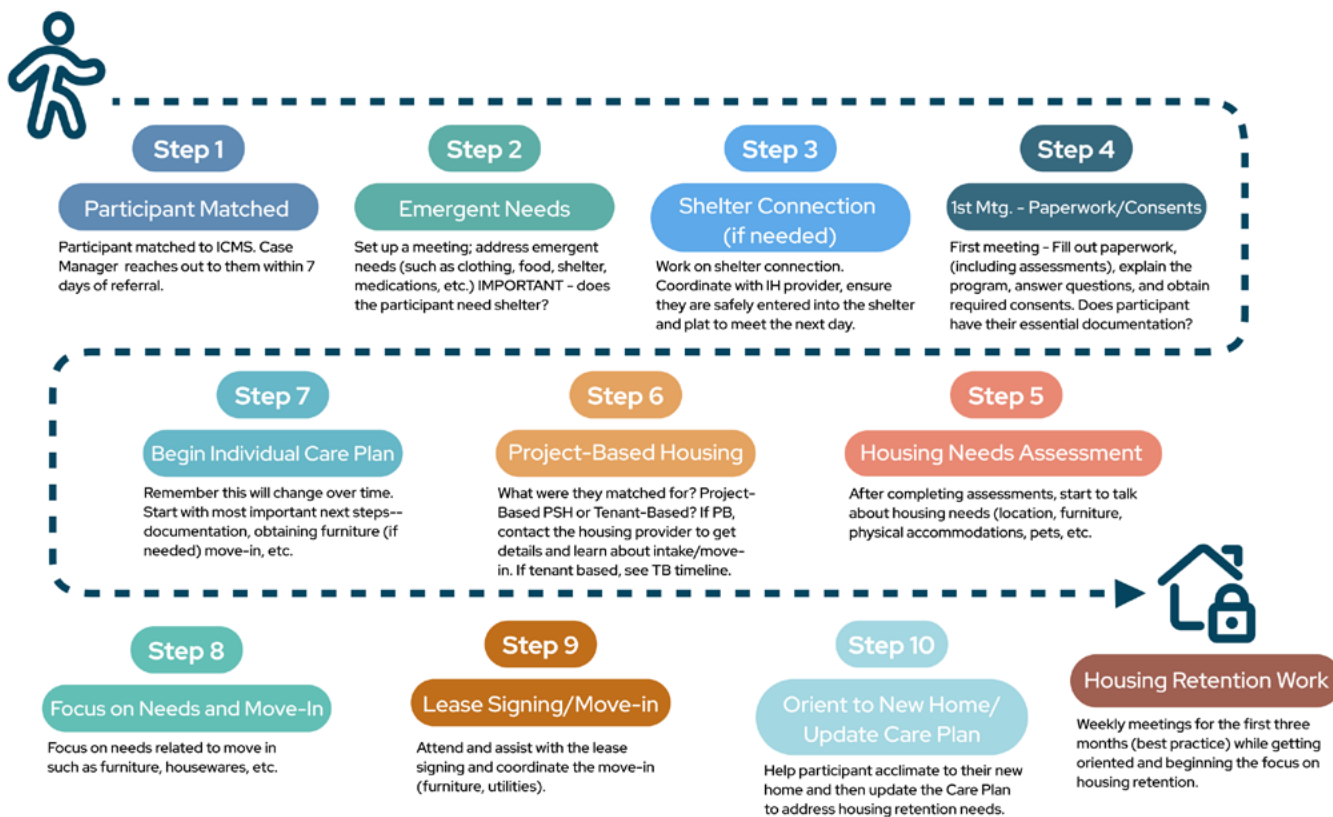
Pre-Match vs. Project Based ICMS Workflows

The workflow for a person with a project-based housing subsidy looks like this:

The ICMS workflow for pre-match and matches to tenant-based housing voucher looks like this:

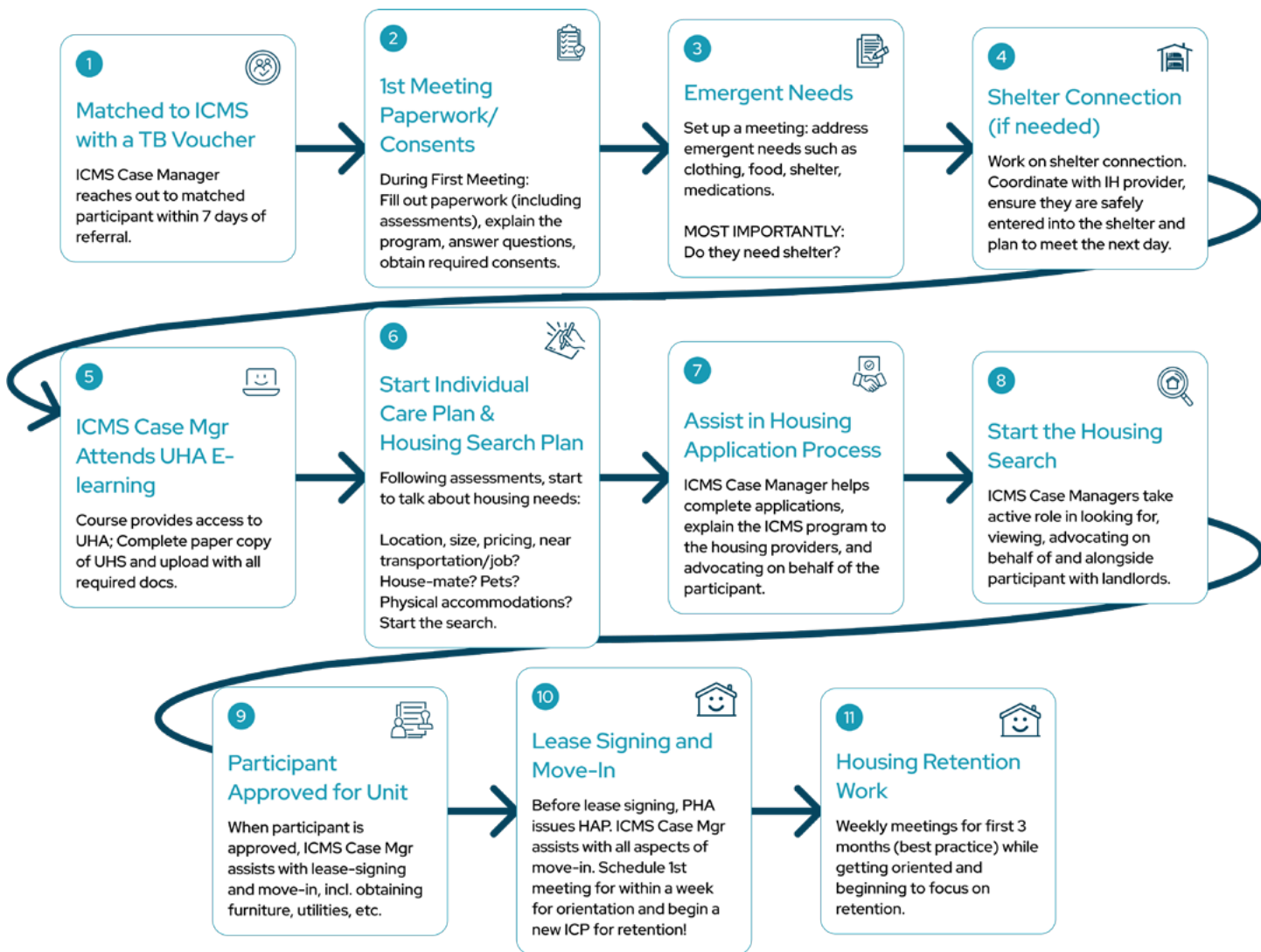
ICMS Project-Based Matched Participant Flow

See ICMS Program Guide sections on Intake, Housing Navigation, and Retention



[Visit this page for a closer view.](#)





[Visit this page for a closer view.](#)

Supportive Services in Housing Attainment

There are numerous activities and action steps associated with finding and attaining housing. It is critical that ICMS case managers provide a high level of support in developing care plan goals and completing key action steps which include:

- Assessing the participant’s housing and health care needs
- Creating a housing search goal
- Finding and engaging housing providers with available units
- Assisting the participant with the application processes
- Meeting with housing providers
- Lease signing
- Planning and assisting with the move-in process
- Working together with care team members assigned to each participant to ensure a smooth and successful move-in.

The level of assistance in finding housing needed by people experiencing homelessness will vary. Some will prefer to do their own housing search. **An ICMS case manager’s responsibility is to work with each participant to find the best fit for what they want, need, and what is reasonable within the limits of available housing units.** As a participant-centered program, we always start with a conversation to learn what a household wants and needs. This should include transportation to and from meetings with the Housing Provider or to view housing units; explaining and clarifying the process and important aspects of the lease, assisting with the move, helping obtaining furnishings, etc. [See more on this in the Move-In Section page 71.](#)

Sometimes, participants may be suffering from the trauma they have experienced and may be under severe stress overload. As a result, a key part of our program is working to assist them in attaining the best possible unit that will fit their desires and goals. Trauma and stress can affect participants’ executive functioning, introducing additional burden to the heavy lift of attaining housing. Within this in mind, ICMS practitioners have an important role to play in this set of services. [See the section on Trauma and Stress Overload on page 26.](#)

Assessing Participants’ Housing Strengths & Barriers

Remember, that most participants have at least one barrier to accessing housing. Some will have many. Using a strengths-based approach to convey that we will be with them, regardless of their challenges, is important.

What are some of the barriers that get in the way of people accessing housing?

- Lack of identity documents
- Low income, unstable income, no income
- History of evictions
- Poor references from past housing providers
- Lack of rental history
- Criminal record

- Poor credit – history of late or missing payments
- Court judgments, especially to former housing providers

Tenant Screening Barriers (TSBs)

Tenant Screening Barriers (TSBs) are the criteria many housing providers use to decide which participants to accept and which to screen out. Housing providers view each of these criteria as a potential risk to their income and/or property, or a possible source of conflict that they will have to resolve. In tight housing markets with high competition for housing like LA, housing providers can set a very high bar for rental decisions. They can select tenants who appear least likely to cause problems. Many providers believe that those are probably not persons with low/no income, poor Housing Provider references, poor credit, and/or experiencing homelessness.

How can a prospective Housing Provider obtain information on these 'red flags'? There are many online companies which provide background checks for Housing Providers. Some of the data the companies review is public. More private information requires permission (which is often included on the rental application). Rental screening agencies charge fees to Housing Providers to compile Tenant Screening Reports, and these fees are generally passed on to the prospective tenant as an 'application fee.' There are some limits to this use under California law. For detailed information and guidelines on tenant screening and housing denials, visit the [Tenant Screening](#) page in the PH Information Center.

Assisting our participants to obtain permanent housing means knowing how competitive **this participant** will be in **this housing market now**. Participants' competitiveness depends on the housing barriers Housing Providers identify in the Tenant Screening Report.

Creating a Housing Search Goal

Along with the housing search goal within the care plan, ICMS case managers sit down with the participant and **develop a preliminary budget** regardless of their voucher status or whether the participant has any income. [Visit HFH's Budgeting Info Center](#) for a sample simple budget. We do this to help educate the participant about their responsibility to eventually assist in paying for the unit and to aid in their understanding of the financial constraints they face when choosing a unit at this point in their lives.



BEST PRACTICE

One used by highly effective permanent housing programs during the housing search (both project-based and tenant-based) is to obtain the Tenant Screening Report (TSR) on each prospective tenant, just as the housing providers do. The TSR can serve as a negotiating tool and helps participants avoid applying for housing they may be refused and find housing providers who are more likely to accept them, especially with the support from the ICMS program.

An additional advantage to using TSRs is that they can often contain errors that can result in a denial of housing, getting a job, or credit. There are ways to correct the databases used by tenant screening companies, which can be done once they are housed, by referring them to a legal services provider.

The housing search goal, and its connected action steps, should be reviewed and updated (if necessary) in the care plan each time there is a meeting between the ICMS case manager and the participant, as well as any-time something has changed, including viewing units, applying for units, or eventual approval/denial.



Always share updates about the care plan with the participant and ensure that the time and date of your next meeting is always a part of this plan.



BEST PRACTICE

Establish a housing search goal in the care plan within three (3) days of the participants enrollment in the program. The care plan is the primary tool used to track a participant's goals, and the action steps that the participant and ICMS practitioner will take to show progress over time. By finding a way to start it soon, you are demonstrating how serious you are about assisting them with finding housing.



Key Elements of Housing Attainment for Case Managers

Rent Payment Standards

If a voucher has been assigned, or there will be a voucher assigned soon, make sure participants understand the rent payment standards that limit the rent that can be paid on units. It is not uncommon for a new participant to express a desire for a very expensive unit in a very elite neighborhood (who wouldn't want that?). So, approved rents must fall within these payment standards and be reasonable compared to other units in the same area with the same set up. HACLA's current Section 8 voucher payment standards can be accessed [here](#) in HFH's PH Information Center. LACDA's current Section 8 payment standards can be accessed [here](#).

Brilliant Corners has negotiated exceptions to the above-stated voucher payment standards. In the following cities within LA County, rent caps for units in these areas will be lower than the maximum rent guidelines:

- Compton
- Harbor City
- Lancaster
- Maywood
- Palmdale
- Willowbrook
- Wilmington



An ICMS Case Manager can submit a Reasonable Accommodation Request to Brilliant Corners if the participant has a need (based on their disability) for approval of a higher rent for a specific unit.

Housing Types & Unit Sizes

Here are some brief descriptions about common housing types utilized in ICMS.

Affordable Housing: Varies from project to project but generally refers to housing units that are made more affordable to households with low to moderate incomes. The goals to ensure that households are not financially burdened by their housing costs. Different affordable housing complexes have varying eligibility criteria based on the terms of the loans they received to build and develop the complex. Typically, these buildings are reserved for households with incomes below a certain threshold. When looking at affordable housing complexes it is important to ask what the income limits are.

They will range like this:

- Extremely Low Income: Less than 30% of Area Median Income (AMI)
- Very Low Income: 30-50% AMI
- Low Income: 50-80% AMI

These ranges will affect whether an ICMS participant can afford the unit. **PLEASE NOTE:** It is always important to check to see if the voucher being held by the ICMS participant can be used in affordable housing. In

many cases, this is not possible because doing so would be considered 'double dipping.'

Shared Room with Roommate: A room in a house or other building where a person shares this space with a roommate for sleeping. Usually, the building has multiple persons renting individual rooms. Bathrooms and kitchens are usually shared among several residents in the building and might have shared living space such as a living room.

Private Room in Shared Housing with Roommates: A room in a house or other building where a person rents a room for sleeping without a roommate. Usually has multiple persons renting individual rooms for sleeping. Usually, the building has multiple persons renting individual rooms. Bathrooms and kitchens are usually shared among several residents in the building and might have shared living space such as a living room.

Very few people living on lower and low incomes can afford a unit in LA on their own. Even many ICMS case managers share their housing with others. That is why it is important to discuss with participants the possibility of sharing their unit with another person as you start the housing search process. Make sure the participant understands the following:

- Each person can have their own room, which can have a lock on it
- You share common space like living room, kitchen and (sometimes) bathroom.
- Each person will have their own lease, so they are not left responsible if the housemate leaves the unit before the end of the lease.
- You will help them figure out how to make it work with shared housing agreements, your home visits, etc.

The other reason why shared housing can be very positive is that it can help with social isolation. Having someone to live with can be more stimulating than living alone, especially if you have been living on the streets or in a shelter for a long period of time.

Single Room Occupancy (SRO): A single room serving as both the living and sleeping area. Bathrooms and kitchens are usually shared among several residents in the building.

Single Room Occupancy Plus (SRO Plus): A single room serving as both a living and sleeping space. Bathrooms are shared as is a full kitchen, but SRO + will have a microwave and a mini fridge.

Efficiency Apartment: Also known as a studio, it is a self-contained living space with a small kitchen (or kitchenette) and a bathroom. The living area, sleeping area, and kitchen are usually combined into one room.

The general preference is to have one-person households move into studio apartments (or SROs) when at all possible. This ensures the affordability for the participant. One-bedroom units are usually more affordable for a two-person household. This is true because a living room can be considered a sleeping quarter. While many people may desire a larger unit than fits this set of standards, work with them to understand that unit size effects price and that, at this point, a smaller unit may be what is most viable for them due to market conditions. **However, this is not a hard and fast rule and if you are able to find a one bedroom that meets the rental standards for the person, then it is worth advocating for that. Sometimes this can be a reasonable accommodation that will work.**

Number of People in Household	Unit Size
1	SRO or SRO PLUS
1 - 2	1 Bedroom
3 - 4	2 Bedrooms
5 - 6	3 Bedrooms
7 - 8	4 Bedrooms
9 - 10	5 Bedrooms
11 - 12	6 Bedrooms

99 STATEMENT OF WORK (SOW)

2.6.4 Provide tailored services that meet the needs of Participants depending upon housing types, e.g., shared housing, tenant-based housing, project-based housing, etc. This may include: coordinating tenant meetings, mediation between Participants/roommates, facilitating roommate responsibilities, and coordination with property management and other County and non-County service providers.



Brilliant Corners determines a participant’s household size based on their FHSP application. If their household changes, the ICMS Case Manager should contact the participant’s FHSP Housing Coordinator and/or Program Supervisor.

Reasonable Accommodations

The U.S. and California Fair Housing laws protect people from illegal discrimination in housing based on their race, color, religion, national origin, sex, familial status, disability, marital status, age, gender identity, and sexual orientation. **Illegal discrimination includes a refusal to make a reasonable accommodation or a refusal to permit a reasonable modification to be made to a housing unit if it would be necessary to afford a person with a disability equal use and full enjoyment of a unit.**

The standards below have been set by HACLA:

Under the Fair Housing Act, a reasonable accommodation is a change or exception to any rule, policy, procedure, or service needed in order for a person with a disability to be able to have equal access to and full enjoyment of their home, such as allowing an assistance animal where there is a no pet policy, or allowing a live-in caregiver when a housing policy states no over-night guests.

- When we think about “reasonable accommodations” we usually think about something structural such as a ramp for a person who uses a wheelchair, or the installation of grab bars or handrails, but this is not all



there is. These accommodations about policies can extend to a request to have the criminal background (or some other part of the application process) waived due to their homeless status.

- Another accommodation is putting aside a rule that is getting in the way of the person getting a unit. One example of this would be Occupancy Standards. Many apartment communities have rules or policies that set how many people can be in a bedroom or what rooms can be considered for sleeping rooms. These are Occupancy Standards, and they could be waived when there is a good reason, such as three siblings needing to share a room.

ICMS case managers should be trained in and understand how to advocate for reasonable accommodations for ICMS participants.



If you run into a barrier with a needed reasonable accommodation, explore case conferencing with the DHS-assigned HFH Program Manager.

Housing Identification Services

1. Identifying available and appropriate “viable” housing units. “Viable” units” are available, meet the rent payment standards, can pass inspection and satisfy the participant.
2. Negotiating with housing providers about participating in the program.
3. Reviewing and negotiating the lease for compliance with HFH standards.
4. Conducting unit viewings and pre-leasing housing inspections (Housing Quality Inspections).
5. Assisting participants in understanding the dynamics of meeting with housing providers and viewing units; and
6. Providing support to the participant throughout the search process.



Each time you provide a housing navigation support/service, enter one unit of the Housing Navigation Support Service in the Case Notes in CHAMP.

99 STATEMENT OF WORK

2.6.1 Timely and thorough completion, submission, and coordination of housing subsidy and/or lease applications, including gathering all necessary documentation (e.g., government issued identification/driver’s license, social security card, tax ID number, consulate card, birth certificate, etc.) and all related paperwork required by Public Housing Authorities, Flexible Housing Subsidy Pool (FHSP), and other permanent housing programs.

Applying for Units

ICMS case managers should assist the participant in completing all applications. There is a lot of information required on these and it can create a great deal of anxiety for the participant. Go slowly, don’t make it a big

deal. If there is information they can't remember or can't access, help fill in the gaps. Whatever we do during this process requires that we keep in mind our underlying philosophies of keeping our programs and actions low barrier and that we 'screen in.' Keep the process simple, overexplain, provide reminders about the process and the timing and constantly check-in with the participant about how they are doing.

Following Up on Subsidy Status

Assist participants with following up on their housing subsidy or other applications with relevant housing authorities. Make sure that you provide any missing or additional information to secure the housing subsidy in a timely manner.

Normally, the housing authorities communicate directly with the participant and don't include the ICMS case manager. Many times, this leads to missed opportunities to move forward or slowing down the process. As the primary ICMS care team member, when you are aware that documents are expected from the housing authority, it is a good idea to ask the participant if they have received anything and ask if they would be willing to share it with you. By doing this you can ensure a steady movement forward with the subsidy. It also helps you to know when to contact the housing provider or owner because the housing authority is awaiting their signature on something.

Preparing for the Housing Provider Interview

As ICMS case managers, we should be prepared to arrange and/or provide transportation to the housing provider interview. Unless the participant or the housing provider/manager objects, you should plan to sit in on the housing provider interview as well. This does not mean that you speak for the participant, but you can offer prompts or ask questions that a person experiencing stress might not think to say:

- You could plan who will say what.
- **The staff person can also explain the housing provider and tenant supports provided by ICMS as a selling point.** This will be very helpful in instances where the housing provider is not already a partner and seems dubious about the individual/household's tenant screening report. The housing provider will purchase their own tenant screening report (or accept the one purchased by your program).
- In many cases, **the housing provider will question potential tenants about the more negative elements in the screening report.** Support staff can prepare their participants that this is likely and they can work out an effective explanation for difficult questions together.
- **Explain the process:** Meet with the participant and explain everything that is going to go on: money will be exchanged for security deposit (any other fees) paid for by your agency, discussion of the lease, and coordinate move-in action steps that include getting furniture (if needed).
- Discuss anything that may be considered "negative" in their screening report or background and how to address it with the Housing Provider.
- **Arrange transportation** for the participant to ensure they are there on time. Best bet would be to go together—either in your transportation, or in a ride share where you are picked up at the same location.

Preparing the Participant for Being Turned Down

- Sometimes a prospective tenant is turned down due to first come first served policies and you were too late. We all know how competitive the LA rental market is.
- Sometimes the housing choice was unrealistic, but the participant insisted on trying.
- Let them know that it might happen in advance and then review the experience after you leave. As a part of the review, talk about how to change your approach and keep the discussion positive and motivating.
- Share your own personal experiences with this kind of disappointment; we've all had them.

Unit Approval & Lease Signing

HOORAY! Time to start updating the care plan to coordinate move-in. But first, have a bit of a celebration with the participant. There has been a lot of stress, and a lot of anxiety associated with everything that has been going on up until this point. Provide positive reinforcement and praise for how they handled the process.

Review the Lease in Advance if Possible

Most leases are lengthy and filled with legal jargon; it may require a tenant organization or legal aid staff person to interpret. However, all ICMS case managers should be able to review a lease and know whether any unusual provisions are not in sync with HFH expectations. If the housing provider is familiar with these programs, they may use a standardized lease for all their properties. Thus, subsequent leases will not require the same level of scrutiny. **Discuss the finer points of leases and lease compliance with the program participant once they have moved in, but make clear the following critical issues before signing:**

- **Terms of the lease:** Is this a month-to-month lease or a year-long lease? How much notice does the housing provider require if/when the tenant moves out?
- **Cost:** What is the rent, what is the participant's share (if any) and are any utilities included? When is the rent due each month? Are there additional fees for parking, storage space, laundry, etc.? What is the fee for late rent, and when does this begin to accrue? What is the policy regarding pre-payment of rent at lease signing (first or first-and-last months' rent), what is the security deposit?
- **Rules:** What are the lease requirements regarding visitors (how long can they stay; is housing provider approval required for more than a short visit), what about pets, smoking, and any other requirements that might be relevant for the participant or important to the housing provider?
- **IN PROJECT-BASED UNITS**, there are also community/ or "house rules" that are usually added to the lease often as an addendum. Make sure you go over these as well. If a private housing provider (tenant-based rental) has "house rules" this is illegal and a definite red flag that discrimination may be occurring.
- **Housemate Leases:** If having housemates is the plan, it is strongly recommended that the program negotiate separate leases for each roommate. This affords greater protection to everyone. If one roommate moves out, the other won't be responsible for full rent until another roommate is found. However, this is exactly why a housing provider might be reluctant to use separate leases. If one roommate moves out, the housing provider only receives half the rent.



BEST PRACTICE

After you have reviewed the lease, don't forget to provide them with written information about the full payment plan for rent. If they have a voucher, the housing authority will provide this, if they are in a project-based building, the property manager will provide it. If you are housing them in a market-rate unit, it makes sense to give them something similar. This contract includes critical information about the rent for the full unit, the amount they will be paying, who will be paying the rest of the rent and what will be their responsibilities. Many case managers like to create a one-pager that explains the most important things to remember about the lease and the rent. They laminate it and find an agreed-upon place to keep it safe for further review.

Attend the Lease Signing

Arrange an agreed upon time with the housing provider for you to bring the participant to the lease signing. All involved parties should attend. The ICMS case manager should always attend and if you have worked in tandem with someone else who has had contact with the housing provider (such as an FHSP housing coordinator or a housing navigator) ask that they attend as well.

This is a good opportunity to make sure that the housing provider understand that the participant is part of a care team, whose roles are what, and when to reach out to each.

**BEST PRACTICE**

Get a copy of the lease in advance so you can go over the main and most important sections with the participant in advance of the lease signing. This will hopefully eliminate some of the stress and fears that the participant is having about signing a lease.

- If you have not been able to review the lease in advance, make sure the lease aligns with California tenant protection standards, which you can read more about [here](#) in [HFH's PH Information Center](#).
- Review the major parts of the lease with the participant to make sure they hear the most important aspects. You will want to do this again after they move in. It's hard to focus when you are experiencing the stress of a lease signing.
 - Their portion of the rent (if any).
 - When the rent is due and where it goes.
 - Building rules, such as quiet hours.
 - Rules about guests spending the night.
 - Pets etc.

Prepping for Move-In

If it appears likely that the participant is going to be approved for the unit, it is a good idea to begin talking about and coordinating the action steps involved in the move-in process. There are many moving parts that you will have to manage together, so it is best to get a head start on this to prevent delays in the participant being able to move in.

- Check on their record with the utilities company if they are going to have them turned on in the participant's name.
- Check to see if they have any arrears (pay them) and whether they will need a deposit or not. Are appliances supplied with the unit?
- Does the participant have furnishing stored somewhere? What is missing that you will need to provide? How does the participant want to move their furnishing if they have them (you will arrange moving assistance as needed).
- Make a list of what you need to purchase for them.
- All these things must be noted, signed by the participant, documented in the participant's file, and then copies must be given to the participant and the housing provider. Your agency probably has a move-in inspection check list they utilize, and you can also download the [Housing Quality Inspection Form](#) in [HFH's PH Information Center](#).



DON'T FORGET TO DOCUMENT ALL THESE ACTION STEPS IN THE CARE PLAN IN CHAMP, including the efforts that have been taken to ensure the participant understands the lease and their obligations.

Supporting the Move-In

Ensure that the participant is not moving into an empty unit with no food or furniture. Make sure that you are there when they move in to help them with move-in activities and getting settled. Also, answer any questions they may have.

Complete a Move-In Inspection with the participant: Aside from the formal Housing Quality Standards Inspection (HQS) that will be completed by the PHA or the FHSP Housing Coordinator, the ICMS case managers must go through the unit with the participant on the day of move-in to note any issues or concerns that do not rise to the level of HQI, but which could cause a problem when moving out.

These include:

- Are there cracks in the walls?
- Is there writing on the walls or a stain in the carpet?
- Is a faucet leaking?
- Broken window?
- Something not working?

All these things must be noted, signed by the participant, documented in the participant's file, and then copies must be given to the participant and the housing provider. Your agency probably has a move-in inspection check list they utilize, and you can also download the [Housing Quality Inspection Form](#) in [HFH's PH Information Center](#).

At move out, this move-in inspection should be updated as the "Move Out Inspection" to verify the condition of the unit at exit.

This is the responsibility of the ICMS case manager and should be put in the participant's file, given to the housing provider, and reviewed if the housing provider requests any risk mitigation funds.

Orienting the Participant to Their New Home

Remember what we have said about the challenges caused by stress overload and trauma. It is entirely possible that the participant is going to feel lonely, frightened, and lost when they spend time in their new unit. To overcome these feelings, take the time to orient them to where they can find key things in the neighborhood. Chances are they are in a place they have never lived before, so they may not know where the grocery store is, or the corner store, or where to do their laundry.

If they are in an apartment complex, show them around:

- Where is the office?
- Where is the laundry?
- Where do they get their mail?
- Where does garbage go?

Make sure they have the numbers of people to call if they need something.

- How to communicate with the housing provider if something breaks or they lose their key?
- How to reach you if they have a problem with a neighbor or don't know where to go for something.
- Are there any services in this complex they should know about? (e.g., recreation, spiritual, etc.)?

If they are in a single unit or house, do the same as above, but enlarge your introduction to include neigh-

neighborhood information such as:

- Where is the laundromat?
- Where is a nearby grocery store?
- Is there a metro or bus stop nearby?
- Do they want to connect to a nearby community of faith? Help them find one.



And most importantly, let them know when you are going to be back. Set a specific day and time. Discuss how they would like you to remind them about the meeting and make it within the next week if possible.

Considerations for a Higher Level of Care

An increasing number of people experiencing homelessness are older and have functional impairments. With the right housing placement and supportive services, formerly homeless people can live safe, healthier lives with more independence.

One of the responsibilities of the CES Matchers is to ensure that the housing match is appropriate for the correct level of care needed by the participant. If a participant has difficulties with their Activities of Daily Living (ADLs), mobility issues, or other physical or mental conditions that suggest they need more than independent living, the Matcher should be making a match to a housing opportunity that fits their needs.

If you receive an ICMS referral for a participant who you believe cannot live independently, you can take the following steps:

- Reach back out to the matcher to discuss your concerns.
- Talk to your agency program manager.
- Discuss this in a case conferencing session with your clinical supervisor.
- Talk to the DHS-assigned HFH program manager for your ICMS contract.

If the program manager(s) believe a further assessment is needed, s/he/they can reach out to HFH or DMH appropriate staff for this support.

Not Everyone with ADL Needs or Mobility Issues Needs a Higher Level of Care

Mobility Issues: Most mobility issues can be adequately supported by requesting physical accommodations from the provider.

Things like:

- Wheelchair ramps into the unit; or ensuring they are on the first floor for easy egress in case of emergency.
- Grab bars throughout the apartment, not just in the bathroom.
- Lower light switches, or another way to allow them to turn on and off lights.

Many assistive devices for people who are hearing impaired are also available:

- Vibrating alarm clocks use vibration or flashing lights instead of sound.

- Doorbell signalers flashlights or activate vibrations when the doorbell rings.
- Smoke and carbon monoxide detectors equipped with strobe lights or vibration alerts.
- Baby monitors use vibration or visual signals to monitor infants.
- Telephone signalers alert users of incoming calls with flashing lights or vibrations.
- Door entry systems are visual intercoms or video doorbells to see and communicate with visitors.
- Smart home hubs with visual alerts compatible with doorbells, security systems, and alarms to provide visual or tactile alerts.
- Smart Assistants (e.g., Alexa, Google Assistant) - Can provide visual notifications and control devices via voice or app.

Interim Housing Outreach Program (IHOP)

For participants staying in homeless shelters, DHS, through the Housing for Health Program (HFH) and the Department of Mental Health (DMH) and Department of Public Social Services (DPSS), offers the Interim Housing Outreach Program (IHOP). IHOP utilizes multidisciplinary assessment teams to evaluate individuals in homeless shelters and provide a range of temporary supports while working on linkage other programs.

IHOP support includes a range of services, such as:

- Comprehensive medical, behavioral, functional and social services evaluations
- Benefits Assessments and Referrals
- Physical Therapy
- Occupational Therapy

These services are provided in the interim housing setting to ensure participants receive the appropriate care to support their needs.

For more detailed information, you can refer to the official IHOP overview document: [Click Here](#)

Additionally, the Department of Mental Health provides information on their Interim Housing Program here: [Department of Mental Health](#)

In-Home Caregiving (IHCG)

Additionally, we offer In-Home Caregiving Services (IHCG) to our participants who require assistance, either while in shelter or after they have been housed.

IHCG services include ADLs and IADLs support such as:

- Grooming assistance
- Bathing assistance
- Laundry support
- Shopping assistance
- Accompaniment to appointments

IHCG is a county program under HFH that provides temporary in-home caregiving services to participants in IHOP, Interim Housing (IH) and Permanent Housing (PH). **IHCG is available in the short-term while participants wait to be connected to IHSS, which becomes their long-term source of in-home support. Please visit HFH's [Caregiving Information Center](#) here to learn more.**

Enriched Residential Care (ERC)

ERC offers housing options for individuals who require daily assistance with Activities of Daily Living (ADLs) or other ongoing care and supervision. ERC places participants into board and care facilities, and licensed residential care settings, such as Adult Residential Facilities (ARF) or Residential Care Facilities for the Elderly (RCFE).

In these settings, residents receive case management and additional services to support their transition to more independent living arrangements as their needs change.

When considering ERC as an option for someone who may need more care than ICMS can provide, there are a few important factors to keep in mind:

- **Transition from ERC Settings:** Yes, it is possible that the person you are referring has come from a previous ERC setting from which they have stabilized.

Although transitioning from such a setting can be challenging, it has been determined that they are now capable of living independently. If this is the case, ICMS case managers should coordinate with the ERC support team to plan the transition carefully.



- **Assessing ERC as a Suitable Option:** If you believe ERC is the appropriate option for the person, follow the steps outlined above and consult with your HDS-assigned HFH program manager for further guidance and assistance.
- **Participant Willingness to Enter ERC:** It is crucial to assess whether the person is open to entering an ERC. If they are mentally capable, they should be included in considering this option. Therefore, it is important to have open discussions early in the process using motivational interviewing techniques to explore their ambivalence. This approach can help them understand the potential benefits of moving to an ERC, especially if it is necessary for their health/well-being and if they are no longer able to live independently, even with ADL supports.

Remember, this transition may require more than the regular once per month check-ins. While the transition is occurring and for some time afterwards, you should be prepared to have anywhere from daily to weekly contact with the participant to assist with the transition.

Introduction to Permanent Housing Retention Assistance



Introduction to Permanent Housing Retention Assistance

Understanding Housing Providers

To be successful in assisting ICMS participants (now tenants) to stabilize and succeed in their new housing, we must consider both you and the participant's relationship with the housing provider. Your job as an ICMS case manager is to also work with those providers to prevent any problems or respond to problems before they reach a level of concern where the housing provider wants the participant out.

Start here:

Housing providers primarily want tenants to:

- Pay the rent on time
- Treat the property with respect
- Treat other people with respect
- Follow the rules in the lease
- Don't get the housing provider in trouble with the police



Any tenant that can do these things will most likely be able to keep their housing.

Lease Compliance

Compliance with the lease is important, especially to housing providers—and anything that is important to a housing provider must become important to the participant (and their housing case manager)! Accordingly, while you went over the major parts of the lease with them before or during the lease signing, remember, people do not exit stress overload on the day they sign a lease. High levels of stress inhibit memory. Also, as may be true in many contracts, sometimes the language in the rental contract is intentionally ambiguous to offer maximum protection to the housing provider.



After move-in, perhaps your first or second home visit, go back over the items that could most likely impact the participant as a tenant with this housing provider, in this unit, and then regular reminders may likely be required.

Monthly Rent and Other Expenses

- What expenses must the tenant pay?
- **Monthly rent.** What kinds of payment are accepted?
 - When is rent due?
- Security deposit. How much?
- **Late fees.** How much are the charges for late rent payments, when are they triggered, and do they

increase after certain number of days?

- **Utilities.** Are any utilities included in the rent? Heat, electric, water, sewer, trash? What is the cost of the utilities not included in the rent?
- **Other expenses.** Parking? Pet fee? Lost key?

Rules That If Violated Could Result in Eviction

- What rules are included in the lease?
- **Guests.** How long can guests stay without housing provider permission?
- **Housemate(s).** How can the tenant add or change housemates? Does each have a separate lease or would violations of one roommate result in eviction of both/all roommates?
- **Pets.** Are pets allowed? Are there rules about the type and size of pets that are allowed?
- **Quiet (or peaceful) enjoyment.** (Described in more detail below.)
 - Quiet hours
 - Disposal of garbage

In some project-based housing sites, the property management company has “house rules” that can also lead to problems and possible eviction. These rules will most likely be found in the Addendum to the lease. ICMS case managers should go over these with the tenant very soon after they move in and refer back to them along the way if the tenant’s behavior is walking a line that could lead to problems.

Tenant Rights & Responsibilities

There will be participants who have a history of lease violations and even evictions. Addressing the specific areas where they have demonstrated an inability to follow the lease is an important responsibility for ICMS case managers—and should be addressed on a one-to-one basis through the participant’s care plan. Learning that is specifically focused on something that is ‘occurring in the here and now’ is usually most effective. Visit HFH’s [PH Information Center](#) to learn more about California’s Tenant Protection Laws.

Peaceful Quiet Enjoyment of the Lease Clause

Many, if not all, leases have a vague requirement like this: “The tenant shall not disturb the peaceful/quiet enjoyment of the premises.” **This requirement is intended to protect the rights of all the housing provider’s tenants to not have to deal with highly problematic behavior of another tenant.** But the wording is intentionally open-ended and can be used to justify an eviction of a tenant who is the subject of conflicts and complaints and even annoying behavior.

- Unfortunately, some tenants think that renting entitles them to do whatever they want in their unit. ICMS case managers should be sure every participant understands the peaceful enjoyment clause whether they have violations in their history or not.
- ICMS case managers can work with participants to list the most pertinent and important requirements of their lease. Otherwise, the lease goes into a drawer and is never consulted again.



Practice Tip

Violations of Peaceful and Quiet Enjoyment Clauses

- A participant has been evicted for “excessive traffic” (which is often code for suspected drug dealing). How can the participant avoid eviction whether they plan to stop selling drugs?
- A participant has very poor housing provider references because the participant’s children play, litter, and make a lot of noise in the hallways. How can the parent/caregiver deal with this in their new housing?
- The participant uses loud music or television to calm anxiety including during late night hours. This has resulted in neighbor complaints, poor references, and two evictions. How can the person manage their anxiety without causing tenancy problems?



Care of Unit

If the participant has little or no rental experience, they may think they know how to take care of a rental unit.... but maybe not! If they are experienced renters, have decent housing provider references, and were able to get their security deposit refunded, they probably know enough!

It's not necessary to develop a curriculum on caring for housing. But there are topics you might want to casually slip into your conversations over the first month or two during face-to-face meetings. Especially if you see one of the following Important subjects:

In most cases, ICMS participants should know how to report damage to the housing provider. The temptation will be to hide the evidence, but it's not likely that will work. And their attempts to 'fix' the problem can make things worse.



Helpful Hints

Plumbing examples

- How do they dispose of grease? (Down the drain—any drain—is the wrong answer).
- Do they flush things down the toilet that don't belong there? Have they had to plunge the toilet when it fills up? Has it overflowed? (Do they know what belongs in the toilet and do they know how to use a plunger?) Old plumbing is less forgiving of large wads of toilet paper. Children's toys, paper towels, and even "flushable" wipes are not flushable.
- If they have any plumbing leaks, do they report them to the property manager—before the flood?

Fire Safety examples:

- Surprisingly, one of the most common causes of home fires is leaving any appliance with a heating element plugged in when not in use. Toasters, hair dryers, coffee pots, etc. all have one tiny micro-switch that keeps the electricity from flowing into the heating element when not in use. This switch fails more often than you can imagine!
- Candles near curtains or bedding
- Smoking in bed or smoking on anything flammable when sleepy or drinking!
- Space heaters that draw more current than the outlet can handle
- Leaving food cooking on the stove without supervision (e.g. "I'll just run to the store.") Major fire ensues.
- Heating the unit with the oven on and door open or with the burners on.
- Electric bicycle batteries have been known to spontaneously catch on fire. Advise your tenants to find a place outside to store these.



Conflict Avoidance or Resolution

An ICMS participant may be very conflict-avoidant and live in a building with a calm housing provider and friendly tenants. However, ICMS case managers must be prepared for potential conflicts, just in case they arise.

First, remember that the person has been experiencing homelessness and has likely been living with a high level of stress, possibly for months or even years. Moving into new housing is yet another change that will often exacerbate their stress overload symptoms—at least initially. That means they will generally have less control over their emotions and may react with ‘fight, flight or freeze.’ They may cause or escalate small conflicts with their housing provider or fellow tenants.

If you have seen any signs of over-reaction or frustration while getting to know the participant, you may want to prepare in advance for some conflict in the new housing. **While you are discussing the person’s housing history, you may want to talk about the kinds of arguments or problems they may have experienced in the past with neighbors or a housing provider.**

Ask things such as:

- How did it start?
- What did you do?
- What did they do?
- How did it get resolved, if it was resolved?

Let the participant know that if something like that starts happening in their new housing, you can help them handle it, especially if you know about it before there’s a big blow-up. Then, during face-to-face visits, you can casually ask if there have been any issues with the neighbors or the housing provider. If so, ask for details and then talk through options for responding the issue.

Many times, the situations that cause conflict are ubiquitous for tenants:

- Rent was late.
- Too much noise—loud voices, music, television, guests.
- Children’s behavior.
- Garbage or litter not properly managed.

It can be helpful for ICMS case managers and/or supervisors to occasionally brainstorm situations like these and various ways program participants can avoid the conflict, apologize, or at least de-escalate.

If/when the participant wants to make a complaint about the housing or other tenants, offer to help them figure out the best way to do so.



A written complaint can be drafted and fine-tuned. A face-to-face complaint can be practiced. The participant may not be able to totally avoid 'fight/flee/freeze,' and sometimes a disagreement will escalate quickly. There will be times when ICMS case managers have to mediate a participant-housing provider conflict. It is always best to start by contacting the housing provider, listen to their concerns, ask for time to come up with a solution with the tenant, and then get back to them within a few days.

**BEST PRACTICE**

Some agencies have invested in low-cost refrigerator magnets made with pertinent information from the lease for each tenant. This could include:

When rent is due and where.

No dogs and/or only a cat with the explicit permission of the housing provider.

No overnight guests for more than three nights.

Quiet time is at 10 p.m. each night.

My case manager's phone number is: XXXX

Effective Case Management Strategies



Effective Case Management Strategies

Our job is multi-faceted: support, seek resources, advocate, reality checker, and holder of hope. These are difficult roles to blend and maintain. It’s important to tap into how much you know about finding units, about the kind of support that people require to move from homelessness to housed, and about the community resources that are available to help build on sustainability. But don’t worry—perhaps you are a new to ICMS and feel you know less than you need to know. That’s why we have colleagues to learn from, supervisors to ask for support from, and the thrill of research and discovery.



The key is to remember that you must become one of the participant’s primary cheerleaders for success. That is why excellent ICMS case managers always tap into their understanding of strengths-based practice. When people are struggling, it is hard for them to remember that they have been successful at other times and with other activities in their lives. A large part of our job is to constantly remind them of their strengths and evidence of resilience they can tap into.

Strengths-based work requires paying attention to both our language and our attitudes about the people with whom we work. We can’t and shouldn’t disregard either side of the equation. But the emphasis for a participant in crisis is to emphasize strengths in your dealings with them. Look at this chart to frame this discussion:

Strengths-Based Thinking	Deficit-Based Thinking
What’s working – or has worked in the past	What’s wrong?
Discover and adapt to the situation Emphasizing Possibilities Persistent Understand Opportunity Celebrate Success Dynamic	Predict and Control Overcoming weaknesses Resistant Diagnose Crisis Punish Non-Compliance Stasis

Permanent housing retention work is where the strong relationships we’ve started building will be crucial for the success of the participants. Once people are in their new homes, things will change. They are now housed, they are in their home, and when you visit, you are a guest. The power imbalance will start to shift when you start to make home visits.

For many of our participants, they have experienced less than positive interactions with a variety of authority



figures e.g., police, psychiatrists, doctors, housing providers. As a result, it is often difficult for them to trust authority figures who have such a large amount of power over them. As we are starting to develop our relationships with ICMS participants, these past relationships can get in the way. You may not feel that you have power over them, but you hold a great deal of information and access to what they perceive will get them housing.

As the relationship shifts, be aware of this and try to reinforce the participant's control over their housing, their plan, etc. Now, we need to make sure the services we provide and the information we share matches their hopes, needs, and goals. This is also the time when collaboration and coordination is important. From this point forward there are many players to keep in the loop and depend on for support for you and the participant. You are providing ICMS as part of LA County's PH Integrated Service Program (ISP), which is an "Integrated Services Model" (sometimes known as wraparound services). This means we try to surround the participant in the various unique services they may need to successfully maintain their permanent housing. **This does not mean that ICMS case managers are responsible for providing services for all the needs of each participant. Instead, this is where additional community providers come into play and why our collaboration with them is so necessary.**

Progressive Assistance

The concept of progressive assistance in case management and tenancy support is not a one-and-done approach. Only careful monitoring will enable an ICMS case manager to ascertain how much help the household needs, right now, at this time and in these circumstances. The participant's history will provide some clues about potential problems. Although, it is not enough to assume that the participant can manage this crisis, this time, because they have managed to solve problems in the past. This situation may test the participant in new ways or they may be more vulnerable this time—due to stress or trauma, illness, and/or other co-occurring and stressful life events.

So how does an ICMS case manager assess the need for support? **One key is a careful review of the tenancy screening assessment.**


If there have been housing crises in the past:


- » What caused them?
- » Is there a pattern?
- » Does the pattern suggest a need for information, rehearsing ways to deal with similar situations in the future, or agreements about how the ICMS Case Manager will act as an intermediary for conflicts?


ICMS should not automatically provide every household with eight hours of education on housing provider-tenant rights and responsibilities, or on budgeting and financial literacy. **Tenancy support should be based upon each household's abilities and challenges, as demonstrated by past problems or when observed as current problems.** Ideally, an ICMS case manager's assistance would decline over time as the participant assumes greater responsibility and independence. However, failures and mistakes are not 'learning experiences' if they result in a traumatic return to homelessness. So, it is important not to pull back quickly or allow a long period to go by without checking in. Ideally, the participant slowly recovers from stress overload after they move into permanent housing and have the income they need. When this happens, an ICMS case

manager may reduce the intensity and frequency of social supports.

Understand that not everyone will follow this path. There will be deviations. Your monthly (or more often) meetings and visits offer a chance to continue to build engagement with the participant and discuss what is

 The need for assistance will often go up and down as new challenges are encountered. Close attention and engagement may enable the case manager to recognize the symptoms that stress has escalated or a new crisis is brewing.

 How many signs of stress overload does the participant show? This requires some testing. The case manager must pay attention to indications that the participant is able to sustain attention on the conversation and to remember what was said. Does the participant show an ability to have some control over their emotions? Or do they react, verbally or nonverbally, with anger, fear, or freezing?

 The participant's history may give you some idea of their strengths, such as a good job or a positive reference from a housing provider. But also remember that stress overload may result in obstacles to the participant's competence and independence—problems the participant can't recognize or acknowledge. Keep in mind that the participant's prefrontal cortex, the part of their brain that makes decisions and plans, follows plans, remembers important information, and controls emotions, is not functioning normally under stress overload. And a brain temporarily made less functional often cannot recognize its limitations.

happening.

“Voluntary Services”

ICMS must always be participant-centered and voluntary. However, there are some limits on the “voluntary” nature of services. **ICMS case managers must conduct a minimum of one face to face visit each month after the participant has moved into their housing.** It is important to make this clear to ICMS participants up front, so they understand the requirements of the program. If the participant's willingness to engage in services changes (and it well might), it is the ICMS case manager's responsibility to do “whatever it takes” to find a way to re-engage them by increasing attempts at engagement.



Consider this: “How would I feel about having someone so deeply involved in my life after being on my own for so long?”

Go back and look at the section on re-engaging on [page 37](#) for some tips about how to do this. Never underestimate the help you can get from your colleagues and supervisor, all of whom may have a different take on what is going on.

99 STATEMENT OF WORK

2.6.5 Educate participants on tenant rights and responsibilities including, but not limited to, how to communicate effectively with ICMS PSH staff, property management staff, and other entities; when and how to report maintenance problems, or disclosure of financial problems; importance of complying with lease agreement, program policies, and house rules; importance of paying rent, budgeting appropriately, and participating in representative payee system; responsibilities for apartment/house maintenance; getting along with neighbors; and crisis services and resources.



Case Conferencing

As we have been discussing throughout this Guide, many ICMS participants will likely have complex multidisciplinary needs. Case conferencing provides an opportunity to discuss their current needs, address concerns, and strategize solutions with everyone directly or indirectly involved with their care. Collaborative case conferencing will support the integration/coordination of participant care and reduce duplication of services.

At a minimum, case conferencing should be conducted once every six-months from participant's ICMS program entry and coincide with clinical supervision in your agency. It should include, but is not limited to, mental health and health care professionals, community partners, and County staff when appropriate. Case conferencing documentation may be entered in several places and systems including CHAMP. Discuss with your supervisor where case conferencing documentation is to be entered.

**BEST PRACTICE**

Six months can be a long time to go without getting input on the work you are doing with your ICMS participants. Many agencies have weekly or bi-weekly team meetings and include time for case conferencing among the members of the team. It is always helpful to get a fresh perspective on something you are struggling with, and members of your team have a myriad of experiences they can tap into that might provide different thoughts about how to break a logjam, engage a participant, or assist a person to take a hard next step.

99**STATEMENT OF WORK**

10.4.1 Case Conferencing shall be conducted at a minimum, once every six (6) months from the time of enrollment. CC shall occur in concert with Clinical Supervision... and include but is not limited to the inclusion of mental health and health care professionals, community partners and County staff when appropriate.

10.4.2 Documentation of Case Conferencing (e.g., team meeting notes, Clinical Supervision notes, individual progress notes, etc.) shall include, but not limited to the following and shall be maintained within the Participant record.

- A: Date of CC and Participant name or ID #
- B: Name, title and signatures of CC p participants.
- C: Psychosocial issues and concerns identified, and
- D. Description of interventions to be implemented.

Distinguishing the Roles of the ICMS case manager & the Housing Provider

ICMS case manager	Housing Provider
<p>Primary Role: Manage the on-going relationship with the tenant and housing provider to drive a successful care plan that supports housing retention and assists the ICMS participant in being successful as a tenant.</p>	<p>Primary Role: Manage the property upkeep including common areas landscaping and security, enforce the lease, partner with the support services staff for conflict management.</p>
<p>Housing Stability Support: Assist ICMS participants in maintaining their permanent housing through conflict resolution, budgeting, and connection to community resources. Includes home visits.</p>	<p>Tenant Screening: Assess applications for eligibility, including background checks and income verification.</p>
<p>Life Skills Training: Education about tenant rights, responsibilities, lease requirements; coaching on managing behaviors that may negatively affect housing, cooking, cleaning, personal hygiene to enhance self-sufficiency, and making maintenance requests.</p>	<p>Rent Collection: Ensure timely rent payments and manage any arrears or payment plans. Coordinate with ICMS case managers, as needed.</p>
	<p>Unit Maintenance: Oversee maintenance requests, inspections, and ensure unit meets habitability standards.</p>
<p>Education and Workshops: Educate and coach ICMS participant about budgeting, employment readiness, and community building/resources.</p>	<p>Policy Enforcement: “Enforce” lease agreement and any community rules, including issuing warnings, making repairs, and initiating evictions when necessary. Coordinate with ICMS case managers, as needed.</p>
<p>Tenant Advocacy: Advocate on behalf of ICMS participants with the housing provider/property manager (and FHSP housing support staff) on issues related to health, safety, unit maintenance, and tenancy concerns.</p>	<p>Communicate with ICMS and Housing Support Staff: Maintain regular communication with tenant and support staff to assist staff in addressing tenancy issues.</p>

ICMS case manager	Housing Provider
<p>Service Coordination: Be the primary contact person with other service providers (healthcare, employment, legal aid, etc.) to coordinate services and verify homeless/disability certifications.</p>	<p>Occupancy Management: Track occupancy rates, handle move-ins, and move-outs, and address tenant compliance issues.</p>
<p>Crisis Intervention: Address immediate crises related to mental health, substance use, interpersonal conflicts and/or lease violations. Coordinate eviction prevention work.</p>	<p>Participate in Conflict Resolution/mediation: attempts with tenant and support staff to resolve conflicts at lowest level.</p>
<p>Mediation: Facilitate resolutions between ICMS participants and housing site staff, or between ICMS participants and their neighbors to promote a harmonious living environment. Support problem-solving, conflict resolution/mediation.</p>	<p>Fair Housing Compliance: Ensure compliance with fair housing laws and ADA requirements.</p>
<p>Occupancy Management: Track occupancy rates, handle move-ins, and move-outs, and address tenant compliance issues.</p>	<p>Reporting: Maintain records of tenant payments, repairs, and other operational data.</p>

ICMS Collaboration With FHSP Housing Coordinators

While the chart above focuses on the responsibilities of ICMS case managers, it is possible for ICMS to share some responsibilities with the FHSP Housing Coordinator if they have been involved from the start of the housing attainment process.

FHSP Housing Coordinators can provide an extra layer of support for all parties. Once the participant has moved into the unit, FHSP coordinators will likely have less interaction. Nonetheless, Housing Coordinators are required by the FHSP SOW to have regular check-ins with the participant after move-in. So, it is possible that Housing Coordinators may learn about some tenancy concern before an ICMS case manager does, simply because of the timing of contacts with the participant.



The very best way to manage the housing care team is to sit down and work through the various responsibilities that involve supporting a participant's housing stability and agree on who will do what and (most importantly) how and when you will communicate with each other.



Get Creative:

- Perhaps there is a ‘good guy/tougher guy’ approach you can share when you have a particular problem with a housing provider or a participant.
- Perhaps the FHSP Housing Coordinator has a long-standing relationship with this housing provider and can take the lead on advocating for a positive outcome to a conflict or disagreement between the housing provider and the participant.

ICMS participants usually have the closest relationship with a participant due to the many months of working together. Use that to your advantage.

Nonetheless stay in close communication with the participant’s FHSP coordinator. Share new challenges and great successes, little conversations where something came up, etc. Hopefully neither one of you will be caught off guard by something that is brewing when making an innocent visit or a check-in call to one of the other parties.



It is strongly recommended that you have 1 phone call with each other (ICMS case manager and FHSP Housing Coordinator) per month but also hold an occasional in-person meeting to ensure everyone is on the same page.

You should be sharing information about things such as:

- The participant was late with rent
- The housing provider is threatening an eviction
- There are outstanding maintenance requests
- There is conflict between the participant and other tenants, etc.

Occasional joint meetings with the participant can greatly increase your effectiveness and go a long way to preventing staff splitting. The same can be said for meetings with the housing provider.

**POSSIBLE SCENARIOS FOR COLLABORATION**

Each of us may learn things along the way that are important for the other partner to be aware of. For example, if the housing coordinator receives a call from the housing provider that the tenant has not paid their share of the rent a particular month, they should inform the ICMS practitioner so that together they can follow up, troubleshoot the situation, and ensure that the housing provider is “made whole” for the missing rent.

At the same time, if the ICMS practitioner is attempting to mediate with the housing provider about the repayment of the missed rent but is finding the provider being less than flexible or engaging and threatening to evict the tenant, the housing coordinator and ICMS practitioner should be working together on the approach to the housing provider.

FHSP Hotline

Brilliant Corners provides continuous support to participants and partners including ICMS and housing providers. They provide an After-Hours Hotline service number where they can be reached after hours or during holidays. and partners.

ICMS Case Managers can use this hotline for the following reasons:

* Emergency maintenance issues, such as:

- Flood
- Fire
- Clogged toilet (if only one toilet in the unit)
- Client reports smelling gas. or
 - * Urgent payment issues
 - * Client threatens to harm themselves or others.
 - * Child/Elder/Dependent Adult Abuse
 - * Death or serious injury of a client

Collaboration With Other Partners

Mental Health or Substance Use Disorder Providers

In some Project-Based Sites there will be a clinical team assigned to the property to assist with providing services to tenants with such needs. You should get to know them, clarify their role and discuss how you can both work together. It will be important you agree that you will keep each other informed if there are any housing-risk behaviors or actions occurring that you could work on together.

In Tenant-Based Units it will be your responsibility to make connections to these kinds of resources when they are needed. You should be as actively involved in those connections as possible to ensure that the services are provided, that the participant is comfortable with the services, and keep each other informed as the work moves forward.

Other Collaborations & Care Team Members

- Health care providers/primary doctors
- Recreational connections
- Social connections
- Employment providers

All of these are the kinds of collaborations that you must foster and assist with creating the engagement for the participant as they express interests and needs.

Diving Deeper Into Permanent Housing Retention Assistance



Diving Deeper Into Permanent Housing Retention Assistance

Our ultimate goal is to assist participants in not only gaining but retaining their permanent housing. This is the core of your work and requires a good partnership between you and the participant.

There are many aspects to Permanent Housing Retention assistance:

- Assessing and reassessing needs no less than quarterly
- Driving the care plan
- Ensuring connection to available benefits through [CBEST](#)
- Assisting with budgeting and income
- Connecting to community resources
- Health care management and engagement
- Financial assistance
- Assisting in community connections for improved quality of life
- Preventing eviction for lease violations
- Supporting ADLs (Activities of Daily Living) through connection to [caregiving](#)



All of these elements should become a part of the individualized care plan over time, which will evolve with the participant's readiness. [See the Individualized Care Plan section on page 50.](#)

Face-to-Face Meetings

Housing retention visits must be conducted on a regularly scheduled basis and occur face to face. The location of the meeting is up to you and the participant, it can be at your office (if it is easy for the participant to get there); in a private room in a project-based PH building; in their home; or in some public location such as a McDonald's or library; or even in a park.



BEST PRACTICE

The SOW requires you do an in-home visit at least two(2) times a month.

HOWEVER, best practices suggest that at least until the participant has really stabilized (which could be more than a year in), you should have a home visit no less than once a month.

Certain issues should always trigger an in-person housing retention visit, such as:

- Past due rent
- Multiple maintenance requests
- Participant unit condition and habitability issues
- Participant health and well-being concerns

Hopefully, these kinds of urgent visits will be few and far between and most of your work and your visits will be about moving the care plan forward to achieve greater housing satisfaction and stability.

The Housing Retention Goal

To be successful in your permanent housing retention assistance, you will want to continue to build on your engaged relationship with the participant. They are in ICMS because their housing barriers indicate the need for ongoing housing case management. This is a long-term commitment and one that can be very fulfilling.



Consider these aspects of this work:

- Driving the care plan
- Assessing and reassessing barriers to stability
- Ensuring connections to appropriate resources
- Assisting with raising income
- Community connections for stability
- Social and emotional supports

Driving the Individualized Care Plan

As has been discussed in the care plan section ([see page 50](#)), the care plan should be based on the wants and needs of the participant and should be more their plan than yours. If the plan doesn't fit their own perception of what they need and want, this could lead to disengagement.

99 STATEMENT OF WORK

Every quarter, the Housing Acuity Index and the 5X5 assessment should be completed with the Participant which will have a big impact on your Individualized Care Plan. This is a great way to assist the Participant to see their own progress, or new places they need assistance.

✓ BEST PRACTICE

You will likely find that some of your participants will have a hard time articulating goals, especially if they have a traumatic brain Injury or another kind of cognitive impairment. Therefore, you must help frame the goals based on the assessments you are doing ... but always anchor them with the participant. Do they understand what you are suggesting? Does it resonate with them or make sense to them?

Remember that some goals, especially in the beginning, can be tiny and short-term with only one or two action steps associated with them. This will allow them to have some early successes which will build their morale and may be all that a person can manage.

Assessing & Reassessing Needs Regularly

The care plan must be updated at least every ninety (90) days. Updates will include changes in goals, new action steps, action steps marked as completed, and notes on general progress. Since it is also a requirement to reassess every ninety (90) days, it is efficient to make sure your care plan update coincides with that reassessment. This way the changes that are noted on the reassessment tool can inform the changes in the care plan.

Many participants may have a hard time with the idea of open-ended goals. These assessments were designed to help lead the conversation on goal development. **Remember: Goals don't have to be super ambitious; they can be small.** It's all about helping people feel like they are moving forward.



The assessments: The 5x5 and the Housing Acuity Index (HAI) are both found in CHAMP. Don't forget to also document the individualized care plan updates in CHAMP.

Ensuring Connection to Available Benefits & Resources

This is an area with a multitude of possibilities, so it is important to target these needs in the care plan. As you know, sometimes accessing benefits can be very frustrating. **ICMS case managers should be prepared to take a very active role in this referral and connection process.** You are likely to be a good judge of what kinds of services each participant needs, but remember, the plan is ultimately theirs and we want to empower them with making these kinds of decisions. **Sometimes it takes your best motivational interviewing skills to assist them in realizing the benefit of various referrals.**

At the same time, we should never assume that participants know about what is available, how it could be helpful to them, and how to access them. It is a good idea that when a barrier, need, or challenge comes up in your discussions and visits, that you share with participants what kinds of supports might be worth pursuing. You can explain the eligibility criteria, and whether you believe they will be determined eligible.

Warm Handoff Referrals

The ICMS case manager's role in coordinating referrals for participants is critically important. As participants are likely still recovering from their trauma and stress overload, they may have difficulty remembering appointments, remembering what occurred during referral meetings, remembering to take their meds, and other executive functioning actions. **Referrals for services and supports requires much more than writing down contact information or even calling the resource to let them know you are making a referral.**

To assure the referral goes smoothly:

- Set up the appointment (along with the participant),
- Arrange transportation,
- Accompany the participant to the site of the appointment,
- Facilitate introductions; and
- If the resource and participant agree, sit in on the initial meeting.

Part of your role is to initiate all referrals after the participant has agreed, monitor the progress and outcomes of the referrals, and ensure the ongoing maintenance of those additional services that were accessed.



WARM HANDOFFS/REFERRALS

The warm handoff essentially means a face-to-face connection between you, your program Participant, and the representative/staff of the community resource. Some agencies, particularly government agencies that authorize income benefits, require a significant amount of information from applicants. The application process will be more efficient, and quite possibly more successful, if the case manager assists their Participant with gathering the information needed and participates in the meeting. Making sure that a critical referral actually results in the needed services or benefits is central to the work of good case management.



TOP PRIORITY will always be health insurance benefits if a participant does not currently have them, immediately followed by those benefits that increase their income or assistance in the home.

Referrals can include the following:

- **Department of Public Social Services**
 - [General Relief](#)
 - [CalWorks](#)
 - [CalFresh](#)
 - [In-Home Support Services \(IHSS\)](#)
 - Restaurant Meals Program (for homeless, disabled and elderly-age 60+)
 - Women, Infants and Children (WIC) for moms with babies or children
- **Department of Health Services (Housing for Health)**
 - [CBEST](#)
 - Interim Housing
 - IHOP
 - Enriched Residential Care (ERC)
 - Medical Care Management
 - Street Outreach
 - Step-Up Team
 - [Prevent Homelessness, Promote Health \(PH²\)](#)
- **Health Insurance Benefits**
 - [Medi-Cal](#)
 - [Denti-Cal](#)
 - [Medicare](#)
 - [Veterans Administration \(VA\) Health Benefits](#)





If the participant does not have the appropriate documentation to be able to apply, gathering the necessary documentation will be your first step.

Help With Benefits Enrollment

The County has a lot of help for you and the participant for accessing benefits that they are eligible for but not yet enrolled in. The Department of Public Social Services (DPSS); [Covered California](#); [BenefitsCal](#) for assistance in enrolling in food assistance, cash aid, and other resources such as immunizations, family planning, etc.; and HFH's [Countywide Benefits Entitlement Services \(CBEST\)](#).



BEST PRACTICE

As the main support person for each of our participants, we should always accompany participants to appointments in the process of applying for benefits, appointments with medical providers, mental health providers etc. This may be difficult, but if you have created a solid relationship with your participant, you should be able to help them understand why having you there will be helpful. You can discuss your role, whether they want you to help them answer questions, or help them explain their concerns, etc.

CBEST

THIS IS YOUR NUMBER ONE FIRST PLACE TO START ASSISTING THE PARTICIPANTS TO GET THE BENEFITS to which they are entitled. CBEST is staffed by HFH with benefits advocates, clinicians, and legal and social service partners who provide wraparound services to support successful connection to benefits.

CBEST staff are experts at assisting unhoused people, individuals at risk of homelessness, and formerly incarcerated people in applying for:

- Supplemental Security Income (SSI),
- Social Security Disability Insurance (SSDI),
- Cash Assistance for Immigrants, and
- Veterans Affairs benefits.

The **CBEST team knows the requirements**, can assist with gathering required documentation, (including medical records or doctors' statements), and can advocate with Social Security/other government offices to move forward successfully.



[For more information on CBEST go here.](#)



Medi-Cal Benefits for People Experiencing Homelessness

Under the California Advancing and Innovating Medi-Cal (CalAIM) Medicaid Waiver demonstration, the State instituted new benefits that include Community Supports (CS) and Enhanced Care Management (ECM) in December 2021. ECM will coordinate all care for the highest-risk participants who are enrolled in CalAIM with complex medical and social needs, including across the physical and behavioral health delivery systems. This means that your case management work will be a part of what CalAIM will pay for.



As of January 2024, all California residents of any immigration status are eligible for MediCal. If you have participants who have been denied previously or never applied due to being told they were not eligible because of their status, it is important to try again.

Medi-Cal Enrollment

[Log in to Your Benefits Now or take the participant to DPSS](#)

[Find a certified enrollment center](#)

[Managed Care Plan Enrollment](#) (1-800-430-4263)

In many of these instances, the ECM benefit will be additive, improving management of care across delivery systems, and comprehensively address any unmet medical and/or social needs. From time-to-time, ICMS Case Managers may provide certain services under this SOW to individuals who are also enrolled in, and receiving, the ECM benefit (or other services like those approved under 42 C.F.R. § 438.3(e)(2)). Therefore, Case Managers must coordinate with **medical providers**, as appropriate, to ensure that there is neither interruption nor duplication of services. ICMS programs may not bill more than one payor for its provision of services.

ICMS Case Manager should consult their program managers to ensure they understand any procedures or guidelines related to CalAIM and their agency's billing practices.



For the funding of case management services to go into effect, the participant must be enrolled in your program no later than 30 days after move-in.

In-Home Support Services (IHSS)

The In-Home Supportive Services (IHSS) program provides in-home assistance to eligible elderly, blind, and disabled individuals as an alternative to out-of-home care and enables recipients to remain safely in their own homes.

In LA County, the Department of Public Social Services (DPSS) manages this process. It can be very difficult and confusing to apply for this benefits, but you can obtain key information and guidance about it by visiting HFH's Caregiving Information Center [here](#). If you continue to have questions, please reach out to your DHS HFH Program Manager.



The health insurance companies who handle CalAIM—known as managed care plans—can help with accessing both the care, the associated transportation support, and adult day care, among other services. As the ICMS Case Manager, you should get a release of information to talk with each participant's managed care plan (such as LA Care). Be sure to make use of these services, which are currently underutilized.

Assistance With Income

It's no surprise that a recent study by UCSF shows that the primary causes of homelessness are economic. The #1 reason people with a lease fell into homelessness was loss of income. The median monthly household income preceding homelessness was \$935. According to Rent.com, the average monthly rent in LA was between \$2,172 and \$3,717/month in 2023.

Some financial services companies believe it is impossible to spend 80% of one's income on housing in LA while also managing all their other expenses, let alone save for emergencies.

Impact on Pre-Match Voucher: Most of our ICMS participants will eventually wind up with some kind of affordable housing, either a voucher or a project-based unit. But for participants participating in pre-match ICMS, it may take some time. This is why we are discussing income and budgeting. While we are not expecting ICMS case managers to perform miracles, there are some participants who are interested in and able to increase their income—either from benefits programs or even employment.

When you start to approach the subject of a household budget after a participant becomes permanently housed, remember this: many low-income households have never worked with a budget. However, many households do use 'spending plans,' which helps them determine what they should pay and when. **One goal of working on spending plans with ICMS participants is to try to put housing costs first before any other expenses.**



Participant Employment & ICMS

Given the average participant income level at ICMS intake (zero to very low), this is usually the #1 area to focus on for significant and ongoing case management. While not every participant will substantially increase their income during their involvement with the ICMS program, life will be much easier with some kind of income.

For those with employment experience or job potential, timing is everything. A participant who has been living in their car or under a bridge for many months may not be ready to make a good impression in a job interview two days after they receive the key to their permanent housing! And someone who has not had any work schedule to keep may not be able to change their patterns overnight. It may take time, supportive ser-

vices, and/or coaching to help participants prepare to get a job and keep it.

Start by remembering this is a Housing First program—employment is never a requirement. **Many ICMS participants who are homeless have previously worked jobs for many years. Others may have worked in the past, but have been unemployed for decades. Start the conversation about employment by learning their history:**

- When were they last employed?
- How much did they work?
- Are they currently interested in getting a job?
- What kind of job would they be interested in?
- Would they like some help thinking about what kind of a job?
- Did they enjoy the work? Was there a job they really enjoyed doing?
- Does the participant have the prerequisite skills/experience to do the job?

That last question is key because if the participant is interested in working, but unsure whether they have needed skills, employment services and job readiness training available throughout LA County might be a good place to refer them to start. The services help participants assess their skills and interests and help them determine a “best fit” employment setting.

These employment resources often help with applications, clothing, practicing interviewing skills, training, and much, much more:

- [America’s Job Center](#)
- [Chrysalis](#)
- [Business Source Center \(youth\)](#)
- DPSS Training for In Home Health workers
- [Online employment profiles at O*Net online](#)
- [CA Department of Rehabilitation](#)
- [Downtown Women’s Center \(Day Center\)](#)
- [UAI \(United American Indian Involvement\)](#)
- Classes on Indeed
- Google classes Free on coding and secretary
- [Sanctuary of Hope for TAY contact Lawrence](#)
- [Skill Up LA](#)
- [WLCAC](#)
- Goodwill.... referral through CalFresh

99 STATEMENT OF WORK

2.7.6 Assist participant with securing and/or increasing employment or vocational training. Contractor shall establish partnerships with employment services providers such as the Employment Development Department (EDD) or Work Source Centers, etc.

Budgeting and/or Spending Plans

It is best to start with the simplest template you can find for creating a budget. If your agency doesn’t provide you with one, you can find many samples that are fillable online.

- Start with income and gather all income sources:
 - Primary sources (job, benefits, etc.)
 - Secondary sources (child support, side jobs—e.g., braiding hair) and even under the table sources.

- Then proceed to the known “fixed expenses”: rent, utilities, food, internet/phone, insurance (health, car, rental) and, meds, garnishments.
- Lastly, go through and make a list that fits each household to develop those expenses which can be more flexible such as loan payments; childcare; groceries, dining out, entertainment, transportation, clothing, personal care, miscellaneous (e.g., expenses for the kids).

Visit HFH's [PH Program Information Center](#) to access a [sample budget](#) for reference.

Harm Reduction in Budgeting

As a Housing First program, participants are not required to be sober or participate in treatment. We also talk about harm reduction in relation to spending and budgeting. The budget should reflect a participant's priorities. If the budget does not match the participant's priorities, it will be a useless exercise. This doesn't mean that you can't discuss the subject of their uncontrolled spending on, say, shoes, but the approach should be closer to harm reduction.

For example:

i A participant drinks a six-pack of beer every night with his closest friend, a man who stayed in the same encampment with him for nearly a year. This is the high point of his day and relaxes him so he can sleep at night. Is there a way he could reduce this expense?

- Could he and his friend split the cost of the six-pack or take turns buying?
- Could he buy a cheaper beer?
- Could he pay for his six-pack by binning and selling the bottles and cans to recycling?

i A participant has been getting a pedicure every month. It makes her feel good about herself. It's the only time she feels attractive, and she really enjoys relaxing and chatting with the other women. What can she do?

- Can she reduce her appointments to every two months?
- Can she cut anything else in her budget?
- Can she switch to clothing shelves and food pantries to save enough money for the pedicures?

i A single parent feels guilty about being homeless and splurges on new clothing and toys for the children for birthdays and holidays. What can she do?

- Could home-made treats, cards, decorations and games replace the shopping splurges?
- Could the presents be bought at a thrift store instead of stores at the mall?
- Some nonprofits have gently used or new clothing and/or toys to donate (or sell at a steep discount); could these be substituted?

Free & Reduced Cost Goods & Services

The next step is to talk about where expenses can be reduced and how. Participants may have fantastic experience with cutting expenses. Don't assume they do not know how to do this. Seek out their ideas, what have they done in the past, and what has worked best. This is a definite type of cash supports. By being able to reduce spending on essential needs, the participant will have more of their cash income to pay rent.

Examples:

- Daycare subsidies
- Free or cheap cell phones/services
- Reduced fare for bus or rapid transit
- Food pantries/Clothing shelves
- Low Income Energy Assistance programs

Credit Counseling

Credit counseling organizations ([click here](#)) are usually nonprofit organizations that provide advice on money management and debt relief. They often offer free educational materials and workshops. An initial counseling session typically lasts an hour, with an offer of follow-up sessions.



BEST PRACTICE

Here are some other questions to explore when talking about spending:

- Can debt payments be renegotiated? (Legal Aid can assist with this).
- Are they signed up for all subsidized utility programs?
- If they are in an employment program, they often assist with clothing and transportation.

If you have a participant who has a great deal of debt and no possible way to pay it off, seeing a credit counselor will be a helpful step. **Credit counselors can work with the participant to set up a debt management plan (also called a payment plan) for all their debts. They can't erase the debts.** Under a debt management plan, a person can make a single payment to the credit counseling organization each month or pay period. The credit counseling organization then makes monthly payments to the creditors. Credit counseling organizations are permitted to charge reasonable fees for their services.

Under debt management plans, credit counselors do not always negotiate reductions in the amounts you owe. Instead, they work to lower your overall monthly payment. They might get the [creditor](#) to lengthen the time you have to repay a loan. They might also get the creditor to lower the [interest rates](#). Visit the [Consumer Financial Protection Bureau \(CFPB\)](#) to learn more.



Never suggest that ICMS participants work with a credit reduction company that is NOT a non-profit. Non-profit organizations are approved by the federal government.

This is what non-profit credit counselors can do:

- Advise on managing money and debts.
- Help set up a budget for your repayments.
- Sets up a payment plan for creditors, including getting creditors to agree not to pursue collection efforts or charge late fees while on the plan.
- Works to lower your overall monthly payment, rather than trying to negotiate reductions in the amounts owed.
- **Never advise a participant to just stop paying a debt.** Click [here](#) to learn more. Of course, they may have already stopped. Talking with a credit counseling agency will give you some ideas of possible.

How to Choose the Right Agency:

- Always check their accreditation. They should be accredited by the National Foundation for Credit Counseling (NFCC) (<https://www.nfcc.org>) or the Council on Accreditation (COA).
- Verify Approval: Make sure the agency is approved by the U.S. Department of Justice if the Participant is looking for pre-bankruptcy counseling.
- Check out the reviews and complaints of the agencies by checking online including checking with the Better Business Bureau (BBB).

Connecting to Community Resources

A large part of permanent housing retention assistance is ensuring that ICMS participants know and are connected to community resources that may be helpful and useful to them.

As you work more with a participant, you will notice things that hint to their needs. Since all our services are voluntary, you are going to have to approach questions about what a participant could use or what they need carefully and with respect. The longer you have worked with a participant and gained their trust, the easier this will be.

Part of our role is to educate ICMS participants about things that we observe they need help with understanding. This could be related to health and wellness, life skills, or community participation. Assist participants with gaining, restoring, improving and/or maintaining daily independent living, social/leisure, budget management, and personal hygiene skills.

Social & Emotional Supports

ICMS supports must include social and emotional supports. This is particularly true when the participant is living in a project-based unit. Most project-based units have an in-house staff person whose job it is to create and encourage participation in a wide range of social and emotional support activities.

**BEST PRACTICE**

When it comes to housing retention, if these kinds of situations (mental health, substance use disorder episodes, etc.) become untenable and are threatening their housing, then a team approach is best to assisting the participant in considering their options. Case conferencing with DHS, your own team, or consulting your supervisor is a great first step.

However, please remember this: Having a substance use disorder (or mental health concern) does not, by itself, mean their housing is threatened. It's the specific behaviors that we must focus on.

There are plenty of renters in the housing market who have lived forever as substance users or with mental health issues and are **NOT** formerly homeless.

In scattered site units, this work is usually the direct responsibility of ICMS case managers. Especially in the early days of moving into a new housing unit, the participant may find themselves feeling at loose ends. What do they do? With whom? They find themselves missing the people on the street that they used to hang out with. Because of this, **it is critical that ICMS case managers stay in very close touch during this transition time and work together with the participant to find things they might like to do and assisting them with connecting with relevant resources.**

Sometimes the smallest things can help:

- Offer to take them grocery shopping. Just having you along may make them feel better about doing it.
- Go on a tour of the neighborhood, pointing out the place to do laundry, where the food pantry is, where to get a free hot meal, and even recreational facilities.
- If they are going to be traveling by bus but have never done that before, travel with them by bus to a place they need to go---just to reassure them.

Social Supports in Project-Based PH

Helping to improve quality of life is a huge part of our responsibilities as ICMS case managers and often this can be the hardest part for our participants. If they have been lucky enough to get into a project-based PH building, there will likely be social activities and educational opportunities provided by the building. They also have medical care, counseling, even mental health and/or substance use disorder services that come into the building.

When providing ICMS to someone in those buildings, introduce yourself to the staff of the building and learn how you can be kept aware of activities being offered. Work together with that staff to try to get the participants involved. You can even offer to assist with creating something that the participant has mentioned they wished they could do (e.g., card games).

Social Supports in Tenant-Based PH (Scattered Site ICMS)

In Tenant-Based PH community integration can be more difficult. Engage with the participants to learn what might interest them. Would they enjoy a walking group? Or group exercise? Would they prefer to go have a hot meal with other people? What about volunteering? Many Participants in these programs enjoy "giving



back” by volunteering at food pantries or used clothing providers.

This is all part of the ‘getting to know you’ phase of your work with the participant (which is never ending). Most importantly, don’t wait until you notice that the participant has been sitting at home with the lights off and the TV on for multiple days to approach this topic. Jump in early in their new housing situation and perhaps explore the possibilities nearby they might try out.

Where can you find these:

- Google
- Community Centers nearby
- Senior Centers nearby
- The Salvation Army may have activities.
- The YMCA
- If they are interested in joining a community of faith, help them find a church, synagogue or mosque and go with them to check it out
- What else can you think of?

Care Coordination

When the participant connects to community support services or a health service provider, your role is essential in maintaining effective care coordination. This ensures the linkage remains solid and the participant



BEST PRACTICE

A large part of an ICMS practitioner’s job is helping participants keep up with their health care (including mental health) by breaking down the normal barriers and assisting them in getting comfortable with this kind of treatment. Excellent case managers accompany participants to their medical, mental health, and/or other care providers on a regular basis.

You may believe a participant is going to their scheduled appointments, and they may well be. However, to ensure that they are understanding and receiving the best care services they are entitled to, attending these meetings at least once a quarter is a best practice.

receives appropriate services. Stay in regular contact with their care team providers, and don’t hesitate to seek assistance from the care team if challenges arise.

If you recognize that a participant may not be taking their medications, have a supportive conversation about it and inform medical staff accordingly. If a participant expresses dissatisfaction with an employment program you connected them to, collaborate with them to identify and resolve the issues.

Health Care Coordination

Many of our participants have chronic physical health conditions or behavioral health concerns, often struggling to manage their appointments or medication independently. Assisting participants to access and sustain health care is crucial to our role as ICMS case managers.

Participants may be hesitant due to past negative experiences with health care systems, especially if previously homeless or sheltered. ICMS case managers play a vital role in bridging these gaps by integrating supportive activities into regular participant interactions.

Connecting a Participant to PCP of Choice

DHS Clinics: [Full list of DHS clinic locations](#)

Steps to designate a DHS clinic as the participant's primary medical care home:

1. Visit the eligibility area of the chosen clinic (usually M-F, 8AM-4:30PM—call to verify).
2. The participant must bring their ID, Medi-Cal card, and/or SS#.
3. The eligibility worker will assist the participant in completing necessary paperwork.
4. Once established as the medical home, the eligibility worker schedules the initial appointment with the new PCP.

Community Health Clinics (and Other Clinics Accepting Medi-Cal):

Many privately operated clinics throughout LA County accept Medi-Cal and specialize in serving low-income and homeless populations.

Steps for community clinic referral:

1. Visit www.CCALAC.org and click "Find a Clinic."
2. Enter the participant's zip code and the acceptable travel distance.
3. Once a clinic is selected, schedule an eligibility appointment by phone.
4. After the eligibility appointment and medical home designation, an appointment with the new PCP will be scheduled.

Medi-Cal HMO's Websites:

- Participants can also search for local providers via their Medi-Cal HMO's plan website, typically under sections like "Find a Doctor" or "Find Care."
- Examples of notable providers include Venice Family Clinic, Saban Community Clinic, Hollywood LGBT Center, JWCH/Wesley Health Centers, St. John's, and AHF/AIDS Healthcare Foundation.

ICMS Responsibilities:

- Maintain a current list of prescribed medications including new medications prescribed from medical office visits and/or hospital discharge.
 - Medication lists can be obtained by contacting your participant's medical provider or pharmacy. Medication lists may also be noted on hospital discharge summary and participant after visit summary from PCP visit.
- Facilitate follow up appointments with primary care provider and specialists' including hospital discharge follow up appointments. As a person they trust, it will be important for you to go over the discharge instructions with your participant. Remember the impact of stress on people's ability to remember things and remind them about their meds, etc. from time to time. As needed, collaborate with other case managers working with the participant in ensuring appointment adherence.
- Ensure that there are enough meds. They should have a 30-day supply post any hospital discharge

unless noted by the clinician. For participants with home health orders (this may include PT/OT) ensure that home health providers are seeing participant as ordered and providing care.

- Facilitate receiving durable medical equipment when ordered by medical provider, if needed.

Transition Of Care (TOC)

Transition of Care is the assistance we provide when a participant has been hospitalized, coordinating discharge, and providing follow-up support post-discharge. We never want to leave someone hospitalized without a visit, and a discussion with their hospital care team is important to ensure that it is safe for them to return to their unit and to understand what will be needed.



In order to fulfill these responsibilities, you will have to have a Release of Information signed by your participant, giving you permission to talk with the medical providers and the hospital social work staff.

TOC involves contacting the participant within 24 hours of learning of their hospitalization and visiting them, if possible, to attempt to coordinate their care at home. **Once the participant is discharged, you must visit them no later than 72 hours after their discharge.**

TOC Steps Include:

- Prepare for the visit by learning as much as you can about the admission. Ask the participant if they have received any paperwork, request the hospital records (ensure that you have information sharing consent on file in CHAMP), check the Hospitalization Log in the ICMS Snapshot, also check the Countywide Homeless Information Portal (CHIP), and ask the DHS assigned HFH program manager if any additional information is available.
- Key info to try to gather includes reasons for hospitalization; any discharge instructions; significant medication changes (including have they been given to them or need to be ordered); any follow up appointments required (and need to be scheduled); and if any home health equipment of assistance/ resources were ordered.
- By knowing this all before they get home, the visit can be focused on action steps and helping ensure that the participant understands their situation.
- During the visit, review the treatment recommendations (including dietary changes, or dressing changes needed) and look to see if the participant is feeling worse or if they appear ill.
- Contact the participant's PCP to share significant findings or concerns from the TOC home visit and document information about this communication in CHAMP.
- Ensure the participant is scheduled for an appointment with their PCP within 2-4 weeks of discharge and accompany them to the meeting.

Beyond these specific TOC steps, don't forget about assisting with transportation to appointments or for getting around, the participant's ability to feed themselves and/or make meals, and how personal hygiene may be impacted. **This is a critical part of your job.**



Providing this ongoing support and coordination is something you will want to track in the care plan with appropriate action steps and with recording Services in Case Notes. Visit the [Transitions of Care landing page](#) in HFH'S PH information Center."

Financial Assistance Resources

Often, our participants need some financial assistance. Perhaps they get a new job, and they are going to need transportation assistance, or money to purchase new clothing, or work boots, or special equipment. Perhaps their car breaks down and needs repair.

A part of our job is to assist in responding to these needs:

- We usually will start by assisting the participant to think about whether they have any access to a person or organization who might be able to help them. We want them to build on this kind of strength.



Remember, most participants have dealt with these issues before they became homeless, so we don't want to take away the creative ways they have done this in the past. However, we want to assist them in thinking through this so that they don't spend their rent or other living expenses.

- Participants may have a family member or friend who is willing to assist; there may be a member from their community of faith who may have funds that they share with their congregants from time to time for specific needs; or there may be other avenues such as collecting cans/bottles and returning them, doing hair, baby-sitting for a friend, etc.
- There are a few funds run by nonprofits in LA County such as the United Way, or Jewish Family Services (not just for Jewish people), or even your own agency may have an 'emergency fund' to fill this need. Ask your coworkers for ideas of where you might access some funds.
 - The LA County Homeless System of Care also has some available funds. These are just some of the funds available.

FHSP General Assistance Request Funds

FHSP has a general assistance request (GAR) fund that is available as a part of the support provided to housed participants. It can be accessed by following the steps (below) if no other funding resources can be found from DMH, DHS, or other personal resources of the participant. General assistance does not include any costs associated with move-in or damage mitigation. Visit HFH's ICMS Information Center to learn more about the [FHSP GAR policy](#), and about eligible expenses under GAR. For a detailed explanation of the types of funding available.

ICMS Participant Assistance Funds

For each active CHAMP slot assigned to an ICMS provider, the expectation is to set aside \$200 per year, at minimum, for various needs. These funds should be used only as needed. **Common use of these funds includes, but is not limited to transportation, application fees, groceries, clothes, and laundry.**

LAHSA Problem-Solving Funds

Problem-Solving Assistance Funds (PSAF) are a LAHSA one-time, limited financial assistance service that seeks to resolve housing crises. This is open to all participants in LA County. Using the foundations from the [Problem-Solving intervention](#), PSAF is utilized when all other interventions and programs have been exhausted.

Trained Problem-Solving Specialists can access the funds with your assistance in the event a participant has a minimal financial need necessary to resolve their housing-related crisis rapidly. Financial assistance can encompass:

- Move-in assistance
- Rental arrears
- Emergency housing assistance
- Grocery cards
- Employment assistance
- Other items directly connected and necessary to a participant resolving their crisis or homelessness.

Most agencies have a Problem-Solving-trained staff person available for you to consult with. Check to see if someone in your own agency has received this training.

United Way Flex Funds

Since the launch of the Coordinated Entry System (CES), United Way of Greater LA's (UWGLA) Home For Good (HFG) Funders Collaborative has invested Regional Client Flex Funds grants into Los Angeles County homeless services providers to help support the costs of moving people experiencing homelessness towards/ into housing through CES.

Flex Funds are a resource for homeless services providers that have exhausted all other types of funding sources, yet still face financial challenges in assisting a person's transition into housing.

The Flex Funds grants are managed by the CES Adult Lead in each of the eight SPAs. Providers in each of the SPAs coordinate directly with their CES Adult Lead on the requests and issuance of Flex Funds. UWGLA ultimately empowers each of the CES leads to manage their SPA.

Preventing Evictions



Preventing Evictions

We're going to start out this section on eviction prevention by talking about supports for housing providers because we all know how important those relationships are to participant success.

Housing Provider Collaboration

It is critical to the success of the participants that you develop and maintain a solid relationship with all the housing providers with whom the participants are housed. **We must think about the housing providers as our secondary participants.** If we build the same engaged relationship with them that we do with our participants, it will assist in preventing any negative surprises coming from the housing provider. [See Best Practices for Housing Provider Supports below.](#)

Main Concerns of Housing Providers

Pay the rent on time

Maintain their unit

(including reporting any maintenance issues to property management)

Reasonably get along

with other tenants and Housing Provider

Follow the lease

Housing Provider Communication

Sometimes we get caught in the rut of thinking of all housing providers as evil. Hard not to when you have seen the awful things that can occur with participants trying to get housed. However, it is critical that you build a solid, respectful relationship with the housing providers.

As with the participants, the best way to build this relationship is through communication. This means regular, ongoing communication, not just crisis communication. Since you want to ensure that the participants are the best tenants they can be (not perfect, just the best they can be), checking in with the housing providers to see whether they have any concerns will help you to avoid crisis surprises.



BEST PRACTICES

Consider these “Customer Service Supports for Housing Providers”

1. Ensure that your housing provider has all the information needed to reach you and clearly understands your role and responsibilities.
2. Make sure they have an emergency contact to reach out to if they cannot reach you.
3. Regularly and proactively connect with the housing provider. Stop by when you are doing a home visit with your Participant.
4. Check in with them each month to ensure that they have received the rental payments (both from the voucher and the Participant if they have a share). Don't wait for them to call you. They are too busy managing all those rental payments.
5. If you can catch a missed payment, you will be able to avoid late-fees and outstanding rent piling up to the thousands.
6. Seek to resolve conflicts around lease requirements, complaints, etc. Respond quickly to their calls or emails. Even if you don't have an answer right away, respond and let them know when you will get back to them with more information.
7. Coordinate with the housing provider if your tenant has to move. Do not let them be the last to find out.
8. Be friendly, drop off cookies; send holiday cards; appreciate their work by recognizing them with a certificate or a letter from your agency's leadership; etc.

Housing Retention Barriers

While supporting ICMS participants with finding housing, you may have learned about some Housing Retention Barriers (HRBs) they have experienced in the past. HRBs are those behaviors and patterns that have previously contributed to the person experiencing a housing crisis or housing loss. Addressing these HRBs are something that should be a part of any care plan from a prevention perspective.



The patterns may be due to:

- Lack of information (about leases, responsibilities)
- Lack of skills (care of the unit, poor reading comprehension)
- Interpersonal communication styles (initiates/escalates conflict)
- Poverty (couldn't pay the rent)
- Bad luck (company closed, serious illness)
- Problematic friends and/or relatives

When listening to participants describe what has occurred in the past that caused their homelessness, listen for the patterns. Be careful not to attribute something there is no control over such as poverty and high cost of rent to being a housing retention barrier you can address in the care plan. But, if there is a pattern of conflict between them and their neighbors or with the housing provider, or they made noise after quiet hours, these patterns can and should be addressed as a part of your permanent housing retention assistance.



When discussing HRBs, we need to be cautious. A participant may have a personal problem or a disability, but if it has not directly affected their ability to retain permanent housing, it is not an HRB.



TIP

Take these two examples:

1. A participant with schizophrenia who hides in her room with the lights out for two days when the voices occur does not have a housing retention barrier.
2. A participant with schizophrenia who turns up the TV full volume 24/7 to drown out the voices may have a housing retention barrier.

All housing retention barriers are individual and should be looked at as what has occurred in the past.

Prevent Homelessness, Promote Health (PH²)

PH² is a joint program between HFH and DMH to provide additional support for permanently housed ICMS participants who are at risk of eviction and in need of higher level medical and/or mental health care.

- **If only physical or medical assistance is required:**
 - Send the completed form to HFHmedicalcasemanagement@dhs.lacounty.gov.
- **If only behavioral or psychiatric assistance is required:**
 - Send the form to PHsquared@dmh.lacounty.gov.
- **If assistance for both is needed:**
 - Send the form to both email addresses. HFH's PH² Information Center can be accessed [here](#).



Eviction Diversion/Mediation

One thing many of us have experienced is the frustration felt when a housing provider doesn't reach out and inform us about a concern or lease violation. To them, it is a business. Housing providers know that due to the lease, they will get their money no matter what, and because of the housing market, they can re-lease the unit easily. So, we must be the proactive one and check in with our housing providers regularly.



If you learn that the Housing Provider or property manager is upset about something, or threatening eviction, it is time to jump into action:

- Start by sharing the information with the ICMS participant and hearing their side of the story
- Discuss how the situation could be resolved and start planning
- If applicable, contact the FHSP housing coordinator and get their input and thoughts about how to respond. Perhaps they will want to talk to the Housing Provider because they have a solid relationship with them.



What if a Participant Loses Their Housing?

Unfortunately, no matter how hard you work, create collaborative conversations, or provide training and education about tenancy to participants, some will be faced with losing their housing due to lease violations.

It is critical that ICMS case managers work together with housing providers and ICMS participants to leave on as good of terms as possible when the participant is required to move out.

This may mean (among other things):

- Moving to another location and paying the housing provider the lost rent if there is still time on the lease.
- Providing the housing provider with [damage mitigation](#) assistance through FHSP.
- Negotiating how quickly the person must leave (to buy time to find another unit).
- And most importantly, mediating so that the participant does not get an eviction on their record.



When facing a potential eviction, ALWAYS reach out to your DHS-assigned HFH program manager for assistance and guidance.



Exits From ICMS

For participants who are successfully exiting ICMS, ICMS case managers coordinate activities with other County and non-County service providers to ensure that the participant receives assistance with relocation to other affordable housing and linkage to ongoing primary health care, behavioral health, and/or other needed services.

Successful exits from ICMS include exits for the following reasons:

- Moving into housing opportunity outside of LA County.
- Family reunification.
- Receiving a different voucher or the participant's name has come up on an affordable housing complex they've been hoping to move into.



BEST PRACTICE

Many homeless service providers have some of their housing staff trained in mediation. Mediation provides a good opportunity for having a third party to manage the situation between the property manager/housing provider and the participant/tenant.

Brilliant Corners, the FHSP, provider can be very helpful in this way if you have tried on your own but are not able to help the two parties come to better outcome. Of course, this requires that both parties agree to the mediation.

Moving Out of the Area

Sometimes people who have been looking unsuccessfully for housing decide they want to move to an area that is less expensive, or an area where they have friends and/or family (family reunification).

ICMS services are only available to people who find housing in LA County. While LA County is vast and diverse, it remains one of the most expensive housing markets in the country. If a person finds a unit outside of LA County, ICMS cannot provide supportive services. However, our job is to try to assist participants with connections to appropriate resources they may need or want in that new destination community.

Take these steps:

- Contact your DHS-assigned HFH program manager for advice about how to handle this.
- Talk with the participant about what resources they hope to access in their new community (e.g., doctor, mental health services, housing voucher, etc.).
- If they have already been matched to a voucher and it is a tenant-based voucher, contact the housing authority to discuss the possibility of "porting" this voucher to a housing authority in the participant's targeted community. **Porting is the process for switching a voucher from one jurisdiction to another.** Porting is not necessarily a hard process, but it requires agreement of the originating voucher housing authority to make the port, and agreement on the part of the receiving housing authority to receive it. These decisions are affected by the inventory of vouchers each has and whether they have the staffing to manage the switch (among other considerations).
- Try to confirm that the services or resources the participant needs/wants are in fact available to them in the

new destination community. This is where your role as the ‘truth teller’ comes into play. Ultimately, this is the participant’s decision, but we must try to assist them in understanding the reality of their decision.

- So often, another community looks great (jobs, low rent, friends, etc.), but the participant may not have enough information or the resources to really judge how well s/he/they will be able to manage living in the new location. Help them develop a stronger understanding of what to expect upon moving to a new area.

Family Reunification

More often than you may know, people who have been homeless for years, can be reunited with family members and/or friends. When a participant has been housed and begins to have their basic needs met, their defenses that may have been in the way of a relationship with their family can begin to subside. It can be helpful for ICMS case managers to keep talking about family and friends with each participant. This is the kind of conversation that you will want to have when you have developed a solid relationship.

If a participant decides they would like to reach out to family or friends, feel free to assist:

- Help them think about how they would find their family.
- How they would want to start the conversation.
- What kinds of reactions they might expect to receive if they do reach out.
- Help them sort out their feelings about this.

Your agency and HFH may be able to assist with the cost of reuniting with family. But of course, there are some things that we need to think about before we commit to that kind of financial support:

- Is there a safe, permanent place for the participant to live?
- Has the family member really committed to allowing the participant to move in with them and providing them with support while they get on their feet?
- What kinds of supports might the participant need when they move to the new area? Chronic health conditions that require regular medical care; support finding a job, etc.?
- What is the most economical way to help the participant move to this new area?
- Will the participant need someone to accompany them during the travel to the new area? Who can do that?



BEST PRACTICE

If someone does move out of the area (reunifying with family/friends or just moving to another area) do not exit them right away. It is not unusual for these things either to not work out or never happen. If it is approved that the participant’s ICMS case can stay open for a bit even after moving away, you should do a check in with them no later than 30 days after you thought they were leaving. If they are still here, or are returning back, they can remain enrolled in ICMS and pick up where they left off.



ICMS Exit Request Process

We work very hard NOT to exit participants.

However, there are going to be times when we may have to do so:

- **Unconnected Referrals:** Referrals come in from across LA County and sometimes it is very hard to get in touch with a participant that was placed in one of your agency's ICMS slots.
 - If you have reached out to a newly enrolled participant and made multiple attempts to contact them, but you are not able to make any contact within 30 days of receiving the referral, you can work with your agency to determine whether an exit request should be submitted to HFH for review.
 - **HOWEVER, we want you to try everything you can to find and contact referred participants.** Please do your due diligence and describe those efforts in detail in CHAMP. Talk to the agency or outreach point of contact who referred the participant.

Where did they hang out, who are their friends, etc.?

- Check HMIS
 - Check CHAMP
 - Check CHIP
 - Check with shelters
 - Check with hospitals
 - Check with emergency contacts and interested others on file
 - Ask other care team members to help find them
- If you have made at least **one successful contact** with the participant and then lost contact, **we ask that you spend 60 days** doing your due diligence to get back in touch with them.



For more information on this see the Due Diligence [Section, page 48](#).

Exits in CHAMP

Exits are completed by the RAD Team's designated ICMS exit manager.

This is done so that HFH can ensure that billing, outcomes tracking, and system housing resources availability information are updated properly and in alignment across all systems.



ICMS Case Manager, the BC Housing Coordinator and the HFH Program Manager must meet for a case conference to review the reasons for exiting a particular participant. This case conference should occur within 3 business days of the Exit Request Submission.

ICMS must complete the following steps:

1. The ICMS case manager or the supervisor (or whomever is designated in your agency) submits the [ICMS Exit Request Form](#).

2. Upon submission of the exit request form, you will receive a confirmation email.
3. The ICMS exit manager (at HFH) reviews the request to ensure it meets standards for an approved exit.
4. If approved, the ICMS exit manager completes the exit in CHAMP. If the exit is approved, you will receive record of when the exit was completed via the Exit Log in the ICMS Snapshot and via the Exit Log in the ICMS Program Summary Report. If the exit is not approved, the ICMS exit manager will contact you with an explanation for denying the exit request, including providing guidance on how to fix the exit request, when applicable.
5. For CES-connected ICMS slots that become vacated after an exit, the exit manager also declines the CES match for the participant and notifies the CES matchers that the slot is ready for a new match.
6. For non- CES-connected ICMS slots that become vacated after an exit (e.g., FHSP, SRAP, pre-match), the exit manager notifies the responsible HFH referring team that the slot is ready for a new referral.



Special Topic:

Domestic Violence, Interpersonal Violence, Human Trafficking & Stalking



Domestic Violence, Interpersonal Violence, Human Trafficking & Stalking

Domestic violence and sexual violence of all kinds are identified as significant factors in homelessness for women, children, families, and LGBTQI+ persons. Domestic violence is often life threatening; in the USA, 3 women are killed each day by a former or current intimate partner. Survivors must often flee their homes to escape danger, yet they do not have the resources to obtain independent permanent housing. Complex relationships exist between housing insecurity, sexual assault, and power; homelessness and sexual violence often affect the most vulnerable members of our society. When access to basic needs such as housing and safety are compromised, individuals can experience heightened risks of violence.

“The intersection of homelessness and domestic and sexual violence is compounded for women of color and LGBTQI+ communities, particularly Native American and African American women. Native American and Alaska Native Women face both a lack of housing and disproportionate rates of violence. According to the [NLIHC 2021 Advocates Guide](#), African American survivors of violence are disproportionately impacted by discriminatory “nuisance ordinances” resulting in evictions and homelessness because of their victimization.” Nuisance Ordinances are local laws that allow charges to be brought for frequent calls to police or excessive noise. These laws can unfairly affect renters or victims of crime.

In LA County we provide both support and assistance to survivors of sexual violence in two ways: (1) through domestic violence specific organizations (Victim Service Providers-VSPs) who are the true experts in our community in responding to the needs of these survivors, and (2) by ensuring that survivors are well served by all other providers of homelessness services.

VAWA (Violence Against Women Act)

VAWA is an incredibly important tool for all housing providers and participants. This section will not give you all the information you may need to correctly work with a survivor of domestic violence or other interpersonal violence, but it should at least give you a road map with some important information to help you be prepared to act. If you are interested in more training, you can reach out to the LAHSA DV Coordinator or one of the VSPs in your SPA.

VAWA is a federal statute that provides funding and protections for survivors of Domestic Violence (DV), sexual assault, human trafficking, and stalking and all intimate partner violence (IPV) who are applying for or living in federally assisted housing. VAWA transfers are available for a “parallel transfer” within interim housing programs as well.

VAWA applies to any survivor of IPV. Federal, state, and local laws protect individuals from discrimination based on actual or perceived race, color, religion, national or ethnic origin, sex, familial status, marital status, citizenship or immigration status, primary language, age, disability, actual or perceived gender identity or expression, sexual orientation, genetic information, source of income, military or veteran. status, and other bases. Visit HFH's [VAWA Information Center](#) to learn more.

Here is a snapshot of the protections available in VAWA:

- Not be denied admission to, not be evicted from, and not have their assistance ended because of the violence committed against them.
- Request that a perpetrator be removed from the lease and housing where applicable.
- For participants with housing choice vouchers, assistance to move away from the perpetrator while continuing to receive their HCV subsidy.
- Request an emergency transfer to get away from the perpetrator and get a new unit.

This is true in the following programs:

- Project-Based Housing
- Scattered-Site Housing
- Tenant-Based Housing
- Emergency Shelter
- Project Roomkey
- Bridge Housing
- Safe Parking
- HCV (Section 8 Vouchers)

Under California law, survivors have additional protections:

- Applies to all rental housing.
- Early lease termination.
- Lock changes.
- Cannot be evicted due to violence they experience.
- Cannot be evicted for calling 911 and emergency assistance.

VAWA Training

All staff who work directly with participants must be trained and well versed in the various aspects of VAWA including how to request VAWA protection; VAWA occupancy rights; prohibitions against eviction or denial of admission; how to determine whether a condition (such as poor credit, poor rental history, criminal record, or failure to pay rent) is the direct result of domestic violence and the right to lease bifurcation.



TIP: The HUD Exchange (www.hudexchange.info) contains myriad online training modules related to VAWA, working with survivors of domestic violence, etc. Start here to see available training resources.

99 STATEMENT OF WORK

2.2.6 Employ the Violence Against Women Act (VAWA) to protect survivors of domestic violence, stalking, sexual assault, and human trafficking living in subsidized shelter or housing from being discriminated against because of their victimization. Survivors shall be protected regardless of sex, gender identity, or sexual orientation.



Special Topic: Decluttering



Decluttering

Distinguishing Between Clutter & Hoarding

Clutter is anything we don't need, want, or use that takes our time, energy or space, and destroys our serenity. Cluttering can become so substantial and severe that it compromises the safety of a living space, and it can sometimes be connected to serious disorders, such as hoarding. Hoarding Disorder is a mental health diagnosis characterized by the persistent difficulty of letting go of possessions, household items, or animals due to a strong emotional attachment or perceived need.

Potentially Contributing Factors to Cluttering

No single physical or mental health condition causes cluttering; it can arise in many scenarios. And no two scenarios are identical; consider the unique circumstances, such as:

- Thought processes including: perceiving items as valuable or a source of security, fear of loss, perfectionism, indecisiveness, etc.
- Housing unit not designed for long-term tenancy
- Family history, cognitive impairment (e.g., dementia), learning disabilities, mobility challenges
- Depression, anxiety, PTSD, ADHD, OCD, psychosis, substance use

How Do I Help With Decluttering?

Hoarding Disorder is both a mental health diagnosis and a public health issue. Typically, it is not an immediate crisis. Cluttering behavior will build up over a long time and working quickly to 'fix it' will not work. **This is one of the reasons we do home visits.** If you do a home visit and notice that it looks like the unit is in serious disarray and items are starting to pile up and you are worried about this signaling concerning level of cluttering, stop and talk with the participant. Ask what is going on with the collection of things you see on one wall (for example). Listen closely to what they say then you can try to offer some assistance. HFH promotes a harm reduction approach to decluttering, with a focus on making homes safe, healthy, and comfortable. Rather than trying to remove as much clutter as possible, take steps to promote participant safety in their living space.

Remember to:

- Always be respectful and gentle. Let them tell their story.
- Respect the meaning and attachment to the possessions by the person which may be quite intense as affections to humans.
- Evaluate for safety (to yourself, the participant, and living space/building)
- Go slowly and expect gradual changes.
- You can offer to get them some storage bins to put things in, help them sort through items, and store them in an organized fashion with labels on the bins, etc.
- Keep up this work. This is going to require that you meet at their home more often to try to prevent it from getting out of control.
- Don't be critical or judgmental about the environment.



- Don't press for information if they appear uncomfortable sharing with you.
- Don't be negative, tease, or sarcastic.

Remember, to always reach out to your team, your clinical supervision, and other community recourses for both advice and assistance. Whether to involve the housing provider is a question to make a careful decision about. If you feel that you are getting on this early enough that you are likely to be successful in containing the materials, then go forward with your work.

However, if you suddenly find the entire unit filled with pets and/or 'stuff,' and it appears to be both a safety and fire danger, you are going to have to get assistance much quicker and play it by ear about when to involve the housing provider. Chances are the housing provider is going to learn about this because of a maintenance issue. It's best to get on top of it sooner rather than later.

Understand that sometimes addressing participant cluttering behavior requires some specialized knowledge and may entail collaboration with the participant and other outside agencies/supports such as Department of Mental Health, Adult Protective Services, the housing provider, animal control (if appropriate), involved family/friends, and more. Visit HFH's [Decluttering Information Center](#) to learn more.



Case Studies in Decluttering



HASTY INTERVENTION

Negative results can occur when interventions are not carefully planned with a group of professionals with hoarding knowledge. Mr. Y was an 82-year-old male widow living in his own home. Mr. Y began collecting and hoarding tools, parts and other equipment. The living space became so limited he slept on chairs. The family called the police for assistance. Eventually, several agencies were independently involved with the family. The lack of collaboration and lack of knowledge about hoarding led the family to order dumpsters and discard the items. After his possessions were thrown away, Mr. Y was arrested because of the rage, anxiety, and delusions he developed.



PLANNED INTERVENTION

Ms. X was a 96-year-old female with poor vision. She lived alone with dozens of cats, dogs and parrots. In addition, some dead cats were found in the freezer. The house was filthy and foul smelling. Ms. X had several pending citations with heavy fines, eviction and faced possible jail time. A mental health assessment uncovered that Ms. X suffered from isolation, significant depression and moderate memory loss. After several weeks of building a relationship, a geriatric mental health professional, in coordination with the other agencies, developed an intervention plan. Ultimately, Ms. X received the support needed to feel safe enough to agree to have the house professionally cleaned and in keeping with laws and regulations, kept a couple of animals.

Special Topic:

Fair Housing, Equal Access Rule (EAR) & Reasonable Accommodations



Fair Housing, Equal Access Rule (EAR) & Reasonable Accommodations

The Equal Access Rule

HUD's Equal Access Rule (EAR), which was expanded in 2016, ensures that HUD's housing and shelter programs are open to all eligible individuals and families regardless of sexual orientation, gender identity, or marital status. Too many LGBTQIA+ youth and adults meet the standards to receive services and have nowhere to turn other than programs such as ICMS providers who welcome them. Acknowledging their need for assistance and seeking help is often its own struggle for those who have sacrificed so much to simply recognize themselves.

Fair Housing Act

Federal Fair Housing Laws protect people from discrimination when they are renting, buying, or getting a loan for housing. These laws make it illegal for landlords, banks, or real estate agents to treat someone unfairly because of their **race, color, religion, sex, disability, family status (like having kids), or national origin.**

Some examples:

- A landlord **cannot** refuse to rent to someone just because of their race or because they have children.
- Banks also **cannot** deny a loan based on these protected categories.

Again, the main law that enforces this is the **Fair Housing Act**, passed in 1968, which ensures everyone has a fair chance at finding a home.

In **California**, fair housing laws go even further than federal laws to protect people from discrimination when renting, buying, or getting housing:

- The **California Fair Employment and Housing Act (FEHA)** covers everything in the federal Fair Housing Act but also adds protections for:
 - Sexual orientation
 - Gender identity and gender expression
 - Marital status
 - **Source of income** (like housing vouchers)
 - Citizenship or immigration status
 - **Age** and other factors.
- The **Unruh Civil Rights Act** also applies to businesses, including landlords and real estate companies, making it illegal to discriminate in housing transactions.

California has some of the **strongest** fair housing protections in the USA, making it harder for landlords or sellers to unfairly deny someone a place to live.



Fair housing is your right.

Talk to a housing counselor today.

Housing Rights Hotline:

1-800-477-5977

TTY: 1-213-201-0867

California Department of Employment and Fair Housing (DFEH): Enforces California’s civil rights laws, including fair housing laws. You can contact DFEH by calling (800) 884-1684 or emailing contact.center@dfeh.ca.gov

US Department of Housing and Urban Development (HUD): You can contact HUD’s Office of Fair Housing and Equal Opportunity (FHEO) by calling (800) 347-3739 or filing a complaint online.

Reasonable Accommodations

Federal law (ADA) and California law protects people with disabilities from discrimination in all types of housing, including rental unit, shelters, condos, and houses. Under the Fair Housing Act, it is discriminatory for a landlord to refuse to make a reasonable accommodation.

What Is a Reasonable Accommodation (RA) in Housing?

An RA is a change in rules, policies, practices, or services that can reasonably be made by a landlord or the shelter that ensures equal access to people with disabilities. A person requesting an RA must qualify as a person with a disability. Reasonable accommodation requests are considered on a case-by-case basis.

Structural changes made to existing premises are **reasonable modifications**. Under the Fair Housing Act, it’s discriminatory for a landlord (or a shelter provider) to refuse to permit a reasonable modification, at the expense of the participant with the disability.

Some examples are:

- An assistance animal for physical or mental disability, even if the landlord has a no pets policy.
- A dedicated parking spot that is close to the unit, if there is a mobility disability.
- Allowing rental payments on the 15th of the month instead of the 1st if the tenant receives their disability income after rent is due.

These housing laws protect people with physical or mental disabilities that substantially limits at least one major life activity.

Examples of life activity include limitations with:

- Seeing, hearing, speaking, or breathing;
- Walking, climbing, lifting;
- Thinking, concentrating, interacting with others, learning;
- Self-care (including eating, bathing, and using the bathroom); and
- Alcoholism/drug use disorder(s)

Special Topic:

People Who Are Transgender



People Who Are Transgender

Transgender people are impacted by violence and discrimination in ways that both contribute to their homelessness and keep them from accessing necessary shelter and services. One in ten transgender people report being evicted based on their gender expression. One in five reports being denied an apartment or home based on gender expression. Even when seeking shelter, transgender people are at significant risk of harassment and physical and sexual assault.

CALIFORNIA PROTECTS THE CIVIL RIGHTS OF LGBTQ+ PEOPLE

FACT SHEET



Civil Rights
Department
STATE OF CALIFORNIA

In California, LGBTQ+ people have equal civil rights, dignity, and worth. The Civil Rights Department (CRD) is here to help.

It is unlawful for employers, landlords, businesses of all kinds, health care providers and insurers, homeless shelters, state-funded programs and services, and others to discriminate against anyone or treat them unequally because of their sexual orientation, gender identity, gender expression, or sex. Similarly, it is against the law to assault or threaten anyone (or their property) with violence because of these characteristics.

If you have experienced discrimination or violence because you are, or are perceived to be, or are a friend or family member of an LGBTQ+ person (or any other sexual orientation or gender identity), file a complaint with CRD. Likewise, if you have experienced

discrimination or violence because of how you express your gender, such as the clothes you choose to wear or how you do your hair, file a complaint with CRD.

And, don't forget that California law protects everyone (including LGBTQ+ people) from discrimination and violence based on race, national origin, disability, and other protected characteristics.

EXAMPLES OF UNLAWFUL DISCRIMINATION/VIOLENCE

- Your co-workers harass you because you're gay or bisexual
- Your employer prohibits you from using the restroom consistent with your gender identity
- A hotel or restaurant that regularly hosts weddings refuses to host your wedding to someone of the same sex
- A health care provider treats you unequally because you're lesbian or gender non-binary
- A state-funded youth program fails to stop bullying of you because of how you express your gender
- A landlord won't rent to you because your child appears to be LGBTQ+
- Staff at a homeless shelter treats you unequally because they think you are LGBTQ+
- Your neighbor keys your car because he doesn't approve of your "lifestyle"

ADDITIONAL EXAMPLES OF UNLAWFUL DISCRIMINATION

- A state-funded program for small businesses turns you away because of bias against transgender and/or lesbian women of color
- A bank gives you less favorable loan terms or denies you a loan because you have a same-sex partner who doesn't speak English and is an immigrant
- A housing provider tries to evict you because you have a Section 8 voucher and a pride flag in your window
- An employer won't even consider your application for a job because you're an older LGBTQ+ person

TO FILE A COMPLAINT

Civil Rights Department

calcivilrights.ca.gov/complaintprocess
Toll Free: 800.884.1684
TTY: 800.700.2320

If you have a disability that requires a reasonable accommodation, CRD can assist you by phone or, for individuals who are Deaf or Hard of Hearing or have speech disabilities, through the California Relay Service (711), or you can contact us below.

Nearly 30% of transgender people experiencing homelessness report being turned away from shelter due to their transgender identity and 22% report experiencing sexual assault perpetrated by staff or other shelter residents.

As a beginning step in creating transgender and gender non-conforming (TGNC) inclusive environments, experts have identified terms that convey respect when discussing diverse gender identities and expressions. Using affirming language communicates that a program welcomes all eligible residents. However, it is important to remember that residents make the final decision about how to identify and express themselves, including pronouns and other terms of address.

Language Matters

Firstly, thank you to the staff of the [LA LGBT Center](#) for their editing assistance in this section, and for their kindness.

“The LGBTQIA+ acronym refers to the following sexual orientations and gender identities: lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, and other identities.

According to the HUD Exchange’s Inclusive Communication Guide (as of the date of this publication, this Guide is no longer available on the HUD Exchange), since the 19th century, when terms such as “lesbian” and “gay” emerged, society’s understanding of LGBTQIA+ community has evolved and the acronym has expanded. This understanding has not only grown to encompass a person’s sexual orientation, but also gender identity. It is important to recognize that all people have sexual orientation, gender identity, and gender expression (SOGIE), not just LGBTQIA+ people. The “+” symbol acknowledges that there are other sexual orientations and gender identities not currently covered in the acronym. The language of the LGBTQIA+ community continues to evolve. Because LGBTQIA+ people best know their own identities, it is important to understand and recognize how LGBTQIA+ people view and describe themselves.”

“Transition”: “Transition” is a transgender person’s process of aligning their gender expression with their gender identity.

Transition can include, but is not limited to:

- Coming out to one’s family, friends, and/or providers;
- Use of a different name and pronouns;
- Socially and/or legally transitioning.
- Sometimes gender affirming care, which may include hormones and/or surgery.
 - However, not all transgender people can or do undergo medical transition.

Transitioning looks different for all people.

Pronouns: An important part of affirming language is the use of pronouns. A pronoun is a word that takes the place of a noun, in this case someone’s name. Common pronouns include she/her/hers/ella, he/him/his/el, and they/them/ theirs/ellx.

Pronouns are not specific to someone’s gender identity or expression. Staff should always refer to participants

by the name and pronouns they request. A participant's pronoun may change, they may use multiple sets of pronouns, or they may simply use their name.

- **You should not assume** and will not know a participant's pronouns by looking at them. Asking and correctly using a participant's pronouns is one of the most basic ways to show your respect for them.
- **Try modeling and asking:** "I use she/her/hers. What pronouns do you use?" or "Can you remind me what pronouns you use?" It may feel awkward to you at first, but it is better than making a hurtful assumption.
- It is important to remember that by asking everyone you encounter which pronouns they use, you can help to create a more normalized and safe way for others to share their pronouns, which they may not have been able to do before.
- Also, asking someone "Can I use these pronouns for you in front of other people?" is a good way of making sure you do not accidentally out or misrepresent someone.

Invasive Questions: As a general standard, you should avoid asking personal questions unrelated to the provision of housing or shelter, especially regarding medical treatment.

- **A participant's physical characteristics, clothing, and name** do not indicate a participant's gender identity. Asking questions about how a participant identifies or would like to be referred to is a practice that creates an inclusive environment.
- However, intrusive questions about a participant's body, sexual orientation, or gender identity are typically unnecessary.

Promoting an Affirming Environment

Helping to create an affirming environment where anyone will feel seen, heard, and respected takes work and a bit of humility. Inclusive language is a way of communicating to ensure that all people are respected, included and valued. It takes into consideration all races, sexual orientations, gender identities and disabilities.

What should you avoid asking?

- Never ask a participant about their body, medical procedures, or medication status (e.g., hormones). This is intrusive.
- Do not ask LGBTQIA+ participants about their HIV/STI status or other medical conditions, as you should not ask anyone about their medical information.
- Do not ask LGBTQIA+ participants unnecessary questions about their family, partners, or children.
- Do not expect LGBTQIA+ participants to educate you. While some participants may be happy to speak about their perspectives, others may not.

Using participants' correct names, pronouns, and titles is an inclusive way to affirm all individuals' identities. A participant's affirmed name, pronouns, and title communicates the way in which they would like others to

receive and acknowledge them. For LGBTQIA+ participants, inclusive and respectful language is an important cue that they are safe and respected.

We all make mistakes, and this is a learning process. If mistakes come up, apologize, do not minimize a participant's concerns, and continue the conversation. However, over-apologizing is similarly stigmatizing and makes the apology about you. Simply apologize and move on with the conversation. Say "I'm sorry", correct yourself, and keep the conversation going.

For more information about these topics, try these resources:

- » [LGBTQIA+ Resource Center—Pronouns and Inclusive Language](#)
- » [Preventing Harassment in Housing Fact Sheet for Public Housing and Voucher Programs](#)

Special Topic:

Cash Assistance Program for Immigrants (CAPI)



Cash Assistance Program for Immigrants (CAPI)

CAPI is a state-funded program designed to provide monthly cash benefits to aged, blind, and disabled non-citizens who are ineligible for Supplemental Security Income/State Supplementary Payment (SSI/SSP) solely due to their immigration status.

The amount of CAPI benefits is equivalent to the amount of SSI/SSP benefits.

CAPI recipients may be eligible for Medi-Cal, CalFresh, and In-Home Supportive Services (IHSS), but they must file for these benefits separately.

Eligibility

A participant may be **eligible for CAPI if they meet all the following conditions:**

- Are a non-citizen and meet the immigration status criteria in effect for SSI/SSP as of 8/21/96:
 1. Entered the US prior to August 22, 1996, or
 2. Entered to the US on or after August 22, 1996; and
 - o Has a sponsor who is deceased or disabled; or
 - o Is a victim of abuse by the sponsor or the sponsor's spouse.
- Are 65 or over, blind or disabled.
- Are ineligible for SSI/SSP solely due to their immigration status. (This means they must either apply for SSI/SSP and have a notice of denial based on their immigration status alone or submit other proof of ineligibility from the Social Security Administration.)
- Must reside in California.
- Their income must be less than the CAPI standards.
- Their resources must be below the allowable limits of \$2,000 for an individual or \$3,000 for a couple.
- They must successfully complete the application process.



As with all government regulations, they are complicated and require a specialized knowledge. If you want to assist someone with obtaining these benefits reach out to:

C-BEST: Monday-Friday 7:30am-5:30pm 323-274-3600

Or CAPI@dss.ca.gov

<https://www.cdss.ca.gov/capi>

Special Topics:

Significant Incidents, Grievances, Customer Satisfaction/Feedback



Significant Incidents, Grievances, Customer Satisfaction/Feedback

Significant Incidents

No matter how hard you and the participant work, you may run into an event that should be handled as a “significant incident.”

Examples include:

- Domestic violence;
- Incident involving law enforcement (whether an arrest was made or not);
- Injury;
- Death;
- Disturbances;
- Property damage; and
- Other circumstances where you and your program manager feel that the County should be aware of this due to the potential for negative publicity.

For crises and serious incidents, HFH expects the ICMS provider to:

- Swiftly assess the situation,
- Identify immediate threats; and
- Prioritize actions.

Each Provider’s ICMS team should develop a clear action plan, assigning specific roles to on-site staff. If necessary, contact the [Psychiatric Mobile Response Team \(PMRT\)](#) or law enforcement.



TIP

The Psychiatric Mobile Response Team (PMRT) in Los Angeles County, you can call the ACCESS Help Line at (800) 854-7771. This line is available 24/7.

- PMRTs are teams of licensed clinical staff from the Los Angeles County Department of Mental Health (LACDMH).
- PMRTs respond to psychiatric emergencies that don't require a 911 response.
- PMRTs can also provide information, referrals, and other support.
- PMRTs have the legal authority to apply for involuntary detention for people who are a risk to themselves or others.

Incidents of this nature should be documented in the case note(s) in CHAMP, as well as with the completion of a detailed [Significant Incident Report Form \(SIR Form\)](#). A copy is to be provided to the DHS



for Housing for Health program manager within 24 hours of the incident taking place and maintained in the participant file.



SIR Forms must be completed and submitted within one business day of the incident. In addition, a service must be recorded in CHAMP with a case note and a copy of the SIR put in the participant's file.

99 STATEMENT OF WORK

2.2.7 Contractor shall discuss the Grievance Policies and procedures and the Termination policies and Procedures during intake, obtain signature of the participant acknowledging receipt and a copy shall be offered to the participant.

Grievances

Every ICMS Provider is required to have a grievance policy that can be used by participants if they have a problem with actions or decisions that are made about their participation in the ICMS program. HFH defers to the ICMS Providers to manage these policies and procedures appropriately.

ICMS case managers need to know exactly how the grievance policy within their agency works, and what they are allowed to do when a participant wants to make a grievance report.

At the very least:

- All ICMS case managers must ensure that the participant has had the policy explained to them and given to them early-on during the intake and assessment process. **There should be a form they are asked to sign that they had the policy explained to them and that they received a copy of the policy.**
- When a participant expresses dissatisfaction about their services (whether it is about you or not), **remind them of the grievance policy and offer to assist them with filing a grievance (to the extent you can under your agency policies).**



BEST PRACTICES

When faced with a possible grievance, ICMS practitioners must work hard not to take the complaint personally and remain open to listening and assisting participants to resolve the situation. Keep these things in mind:

- Respond quickly and acknowledge their concerns.
- Respond calmly.
- Provide a safe place for the Participant to express their concerns fully.
- Practice active listening and document the conversation accurately including details as needed.
- Keep the Participant informed about the status of their grievance.
- Provide an open and empathic ear.
- Make sure they understand where and how to file their complaint.

- If you are not allowed to be involved according to your agency's policies, introduce the participant to the person that can assist them with filing a grievance.



- If the grievance policy has timelines associated with how and when a participant must file the grievance or appeal a decision about the grievance they filed, **make sure that they understand those timelines.**

Additionally, we must use our best strengths-based and trauma-informed approaches when responding to a participant who is unhappy with something about his/her/their participation in our programs.

Brilliant Corners Grievance Procedures

If a participant has a grievance about their treatment by the FHSP program related to staff or policies of Brilliant Corners, their grievance should be made to Brilliant Corners (not the ICMS provider). The ICMS Case Manager should ask the FHSP Housing Coordinator to provide information to the participant about their grievance process.

It is important to the success of the overall ICMS program that we are completely transparent and willing to quickly respond to complaints about the work we are doing and the services we are providing participants.

Customer Satisfaction Feedback

As a participant-centered program, ICMS programming requires regular assessments of participants' satisfaction with the services and support they're receiving. This can be done through one-on-one conversations, meetings, or through a satisfaction survey.

A Participant satisfaction survey must be developed by each contractor and approved by HFH. Survey responses should be compiled every six months, at a minimum. Your agency is required to have policies and procedures about the implementation of these surveys, so ask your agency supervisor about this process.



Providers are asked to share their survey results and findings with HFH at least twice a year and discuss with your DHS-assigned HFH program manager any intended operational adjustments based on the survey findings.

99 STATEMENT OF WORK

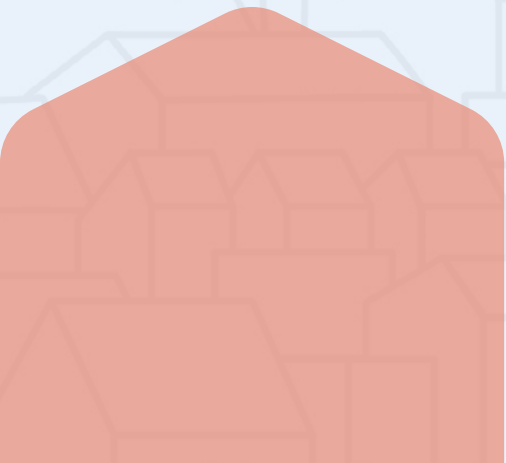
3.1 Assess Participant satisfaction on a continual basis through feedback gained via one-on-one conversations and Participant/tenant meetings and via Participant satisfaction surveys administered in conjunction with the County.

3.2 Develop, conduct and analyze a DHS-approved survey to assess Participant satisfaction with the Contractor and provide the County with copies of completed surveys, a report of the survey results and findings every six (6) months or as required by the County. Services should be adjusted as necessary, based on survey findings, while maintaining appropriateness based on County input and approval.



Special Topic:

Documentation & CHAMP



Documentation & CHAMP

Documentation of the services provided to participants is an important part of our ICMS delivery. Your documentation protects participants by ensuring that they receive the proper supports. Documentation also protects ICMS case managers by demonstrating what was provided to participants, including what the outcomes were. In turn, this strengthens the entire ICMS program by documenting what it takes to successfully assist people experiencing homelessness to find, attain, and sustain housing.

All ICMS data are tracked in CHAMP. You can access [CHAMP here](#).

What is in CHAMP?

Participant and overall program information is tracked using the Comprehensive Health Accompaniment Management Platform (CHAMP). CHAMP continues to expand and currently includes:

- Enrollments
- Referrals
- Housing subsidy details
- Provider assignments
- Funding
- Billing
- Demographics
- Info sharing consent
- Identifying info
- Contact info
- Emergency contacts
- Household composition
- Service animals
- Emotional support companions
- Health insurance coverage
- Homeless history
- Income
- Employment
- Housing
- Service engagement
- Assessments
- Care Plan
- Service records
- Case notes

Service Delivery & Documentation

ICMS delivery and the connected documentation on ICMS delivery is expected to begin immediately after a household is enrolled by HFH in the ICMS program. All ICMS data are tracked in CHAMP, which is the DHS-approved information management system for ICMS. It is important that all ICMS case managers receive training on the use of CHAMP and when to appropriately enter data on the work they are doing with ICMS participants.



According to the ICMS SOW, each participant record in CHAMP must include, but not be limited to, case notes with services recorded at a minimum of two (2) times per month to track the provision of services to the participant.

LAHSA & Data Management

LAHSA, who is serving as the LA County Continuum of Care (CoC), utilizes a Homeless Management Information System (HMIS) known as Clarity.

If an ICMS case manager would like to locate additional relevant information about a participant (say, they were staying in a LAHSA shelter before you received the referral) it is possible to access this helpful information in Clarity.



ICMS case managers should access HMIS information that may be useful to them by consulting with their DHS-assigned program manager from HFH.

Case Notes

Good case notes are critically important to providing excellent care management and support. Case notes promote continuity of care and can serve as valuable communication for other members of the care team.

Case notes in CHAMP are a part of the services functionality. This section allows space for adding qualitative details that can help identify themes, patterns, and challenges in each case. **Think of case notes as a tool that allows you to provide context that explains why and how certain interventions were or were not carried out.** Case notes should be written in connection to any documentation in CHAMP including providing a service, conducting coordination, or even attempts to provide support or service.

Permanent Housing Status Updates

The Permanent Housing Status (PH) Update is a core component of ICMS documentation. The PH Update is used to update or confirm key details about an ICMS participant's case, which is used for service and resource coordination among multiple partners within the HFH system of care, and for tracking key performance indicators and outcomes.



A PH Update must be completed (Click "Save" and never click "No Changes") for each participant enrollment once per month, at minimum, and should involve adding or confirming the following information:

- Current Status; **AND**
- ICMS Case manager (this is where you assign the case manager); **AND**
- Subsidy Application Date if the participant has been matched to subsidy but has not yet been housed; **AND**
- Move-In Date (homelessness end date) if the participant became permanently housed; **AND**
- Address where the participant is currently staying or residing (including unit # if applicable); **AND**
- Service Planning Area (SPA) of participant's current location.



For each Permanent Housing Status Update completed, one unit of the "Homeless System of Care Linkage/Coordination Service" should be recorded in the Case Notes.

Types of Services in CHAMP

The following are the only “eligible” ICMS service options to use in CHAMP:

Service Options & Definitions

Common Case Mgr. Action Steps

i If Care Plan Goals or Action Steps aren't progressing, explore making them smaller to be more achievable.

Homeless System of Care Linkage/Coordination

Coordinating enrollment and/or notifications in LA County's homelessness response system.

- Intake
- Opt-In
- Pre-Match Request
- Demographic Profile Update
- Alternate Voucher Request
- RMS Update
- PH Update
- Universal Consent
- Incident Report
- Exit Request

Assessment

Conducting an HFH-approved non-clinical assessment to evaluate participant functioning and self-sufficiency.

- HMIS Assessment
- 5x5
- Housing Acuity Index
- Psychosocial
- LA HAT

Care Plan Development / Update

Updating Care Plan content based on assessments, achievements, and participant feedback.

- Create SMART Goal
- Assign New Action Step
- Update Action Step Status
- Update Goal Status

Housing Navigation Support

Gathering and submitting key housing eligibility applications and documents, assisting with housing search, and facilitating move-in to permanent housing.

- Basic Needs Assistance
- CES Linkage
- Document Support
- Submit Subsidy App
- Resolve Debt
- Arrange Transportation
- Housing Search
- Coordinate Move-In
- Housing Deposits Coordination

Mainstream Benefits Assistance

Assisting with connection to safety net programs, including health care, income, and nutrition.

- CBEST Referral
- Medi-Cal / Medicare Application
- GR / CalFresh
- Unemployment Income Connection
- VA Coordination
- Social Security Benefits Assistance

Health, Mental Health, Substance Use Linkages

Linkage to and/or coordination with health care providers.

- Connect to PCP
- Connect to Specialty Medical Care
- Connect to Mental Health Care
- Connect to Substance Use Care
- PH² Referral
- Case Conference / Follow-up with Care Provider
- Appointment Reminder

ISP Care Coordination

Linkage to and/or coordination with PSH Integrated Services Program (ISP) providers.

- Submit CENS Referral
- Submit HSSP Referral
- Submit FSP Referral
- Case Conference / Follow-up with ISP Provider

Accompaniment – Health Care

Attending a health care visit alongside a participant.

- Arrange Travel to Appointment
- Attend Participant Appointment
- Debrief with Participant After Appointment

ICMS TOC Visit

Visiting a participant in their home within 72 hours of hospital discharge.

- Hospital Visit
- Coordinate Hospital Discharge
- Home Visit Post-Hospitalization

Permanent Housing Retention Assistance

Ongoing support, advocacy, and interventions for permanently housed participants to promote long-term tenancy, wellness, and self-sufficiency.

- Build Rapport
- Health & Safety Visit
- Tenancy Education
- Life Skills Coaching
- Budgeting
- Reasonable Accommodation Support
- Family Reunification
- Connect to Caregiving
- Engage Property Manager
- Re-certify Voucher
- Moving On Application
- Decluttering Support
- Resolve Arrears
- Submit FHSP GAR Request
- Safety Plan
- Mediate Dispute
- Crisis Intervention



Participant Privacy

Every participant has a right to privacy. To earn their trust, we must protect their health information according to the Health Insurance Portability and Accountability Act (HIPAA). In addition to HIPAA, there are other laws defining how participant information should be appropriately handled.

The entire HFH system of care follows all privacy and security practices in CHAMP to ensure:

- Participant health information is protected in all forms, including paper, electronic, verbal, video, and photo.
- Participants can access, inspect, and request copies of their protected health information (PHI).
- Participants can file a complaint.
- Participants can obtain a copy of the Notice of Privacy Practices.
- Participants can request a list of where/with whom the HFH system of care shared their PHI.
- Participants can contribute to governing the use of and disclosure of their information.

Mandatory Reporting

The only exceptions to the high level of attention that the ICMS program pays to participant privacy comes into play when there is a requirement for mandatory reporting of child abuse or neglect or dependent-adult elder abuse. **Each ICMS provider is responsible for ensuring that all their ICMS staff are trained in the details of and responsibilities for mandatory reporting.** You can [learn more about mandatory reporting](#) in HFH's ICMS Information Center. Please check with the DHS-assigned HFH program manager if you're seeking more information about this topic.



There is no law or policy that requires ICMS case managers to report health statuses of ICMS participants to housing providers. Under no circumstances should an ICMS case manager share health, disability, mental health, or substance use treatment information with them. If the participant is being housed in a building for or with a voucher reserved for people with disabilities, there will be specific information that is required. That would be the only time it would be allowable to share this info.

Special Topic:

Who to Contact at DHS Housing for Health Support



Who to Contact at DHS Housing for Health for Support

Training

There are many requirements for training to ensure that you can do your job in the best possible manner. As an ICMS case manager, if you have questions about or feel a need for more training, reach out to your supervisor. There are many resources for trainings available locally and nationally.

The DHS Community Programs Training Team

The DHS Community Programs Training Team's mission is to deliver transformative educational opportunities to support community partners' programs and their workforce. Their focus is to advance skills and knowledge about doing the work of supporting our participant households, families, and the communities in which we work.

The Community Programs Training courses and calendars are accessible [here](#) in HFH's ICMS Information Center. ICMS staff can keep track of their own learning records and completion certificates in this one convenient location: TalentWorks.

Training courses that are available in Talent Works include, but are not limited to:

- HFH 101
- ICMS Core Tennent's
- CHAMP training (self-paced)
- ICMS Documentation
- Instructional videos on ICMS Health Promotion, direct service troubleshooting and process groups
- Capacity Building workshops including equity, diversity, inclusion and anti-racism.

LAHSA'S Centralized Training Academy

The LAHSA Training Academy has many in-person and on-line trainings available to all providers across LA County. To access their trainings, you must register for an account, then you can go into the site and select the trainings you are interested in. Many of the sessions are conducted by Homeless Health Care LA. [To access the CTA, click here.](#)

The screenshot shows the LAHSA CTA website interface. At the top, there is a navigation bar with 'LAHSA CTA' on the left, 'ENGLISH', 'REGISTER', and 'SIGN IN' on the right. Below the navigation bar is a header section with the text 'Browse LAHSA's courses & learning plans' and 'Own your future by learning new skills'. The main content area features a search bar and a grid of course cards. The 'SERVICE' category is selected, showing 'Best Practices and Practice Labs'. The grid contains six course cards, each with a thumbnail image of people in a shelter setting, a title, duration, and delivery format. The courses are: Document Acquisition Training (EN, ILT Instructor-Led Training); Universal Housing Application Training (EN | 1h 30m, ILT Instructor-Led Training); Problem-Solving in Interim Housing Training (EN | 6h 00m, ILT Instructor-Led Training); Los Angeles Housing Assessment Tool (LA HAT) Training (Virtual) (EN | 4h 00m, ILT Instructor-Led Training); Housing Instability & Substance Use (EN | 1h 30m, E-learning); and Los Angeles Housing Assessment Tool (LA HAT) Training (In-Person) (EN | 4h 00m, ILT Instructor-Led Training).

Sessions include:

- [19 courses for newly hired ICMS Case managers](#)
- [Motivational Interviewing Full-Day Workshop](#)
- [Basics Of Renting & Tenant Protections Workshop](#)
- [Best Practices in Case Noting](#)

Dozens of additional sessions including self-care, equity and inclusion, HMIS training, conflict management, and more are also available.

Other Available Online Training

Several national organizations supporting work in homeless services offer on-line training. In fact, most of them offer non-profits a break in the cost if they want to send all their staff. Look into:

- [Corporation for Supportive Housing](#) provides live webinars, on-demand learning and training plans and series on a variety of topics from trauma-informed care, permanent housing support services, and much more.
- [National Alliance to End Homelessness](#) center for learning offers a variety of online courses from racial equity, street outreach, shelter, harm reduction, and more.
- [The Homelessness Learning Hub](#) provides free learning materials for the homeless serving sector.

Required Trainings for ICMS staff

The following trainings are required for all ICMS case managers:

- HFH 101/Whatever It Takes
- Case Management Training by Homeless Health Care LA
- PH/ICMS Documentation Series
- ICMS Assessments
- Care Plans
- Case Notes and Services
- CHAMP 101

Technical Assistance

There are several different avenues for receiving Technical Assistance from HFH staff.

They include the following:

- **ICMS Program Info Center:** One stop shop for all informational resources across Information Management Systems and Search Tools, Housing Navigation Information, Permanent Housing Retention Information Forms and much more.
- **ICMS Program Glossary:** Key program terminology, acronyms, and phrases are explained in this resource.
- **ICMS Data Glossary:** Subcomponent of the ICMS Program Glossary to assist with interpreting ICMS data reports and using them effectively.
- **The Focus Newsletter:** is generated by HFH with a focus on sharing out key program announcements, participant success stories, and links to program resources. Generally, the Focus is distributed at the beginning and the middle of each month. The “Focus of the Month” is a highlight at the beginning of each month to ensure that all ICMS stakeholders focus together collectively on key program priorities as they arise. It will explain the priority, why it is important, and share ways to help maximize documentation credit while achieving these key program priorities. An [archive](#) of previous releases of The Focus can be accessed in the ICMS Information Center.
- **Office Hours:** A variety of office hours are available for registration and/or drop-in on an ongoing basis to support ICMS staff. The goal of office hours is to build an understanding about accessing and utilizing resources available within the HFH system of care. A few example Office Hours spaces focus on CHAMP; Bridge the Gap for case conferencing support; using FHSP for accessing move-in and general assistance support; CalAIM housing deposits; and Enriched Residential Care (ERC). Calendars for office hours and registration links are available [here](#) in the ICMS Information Center.
- **Visual Aids:** HFH continues to develop more visual aids (e.g., cheat sheets, share sheets, and guides)

to support ICMS case managers with a clearer understanding of ICMS requirements and to deliver higher quality and more efficient support. You can access a repository of all available [HFH guides and cheat sheets](#) in the ICMS Information Center.

- **ICMS Quarterly Meetings:** A 90-minute meeting facilitated at the beginning of each fiscal year quarter by HFH for all ICMS providers and staff (including direct service and administrators) to learn about key policy and procedure updates, resources newly available within the HFH system of care, and useful tips for improving ICMS practice. Learn more about upcoming and previous [quarterly meetings](#) in the ICMS Information Center

DHS-Assigned Program Managers

Each ICMS provider is assigned a specific point-person on the HFH team as their point of contact for questions, concerns, and consulting. Ask your supervisor who your HFH program manager is and how you can get a hold of them. HFH program managers can provide an array of technical assistance.

Ongoing Check-Ins for New Project-Based Permanent Housing Lease Ups

HFH staff play a crucial role in the PH lease-up process for new project-based buildings by ensuring efficient and effective operations. This includes coordinating and collaborating with all project partners, including the housing authorities, property management, PH developers, ICMS providers, and CES providers. Additionally, ICMS staff receive technical assistance and training during this process to ensure they are well-equipped to manage their roles, while HFH develops, recommends, and supports implementation modifications that continually improve outcomes and streamline processes.

Ongoing Check-Ins for General Project-Based and Scattered Site ICMS

The DHS-assigned HFH program manager plays a crucial role in promoting high standards of care, accountability, and innovation within the HFH framework. Regular check-ins between DHS-assigned HFH program managers and ICMS Providers involve discussing key programmatic updates, ongoing monitoring activities, technical assistance, support with collaboration and integration, case conferencing, collaborative problem-solving, and identifying operational areas where the provider will benefit from advocacy.

The program manager's support includes:

- Regularly reviewing ICMS implementation to ensure that each ICMS Provider's operations align with DHS requirements,
- Offering guidance on best practices and strategies for enhanced service delivery, initiating collaborative solutions to operational challenges with ICMS Providers and other partners for cohesive work toward common goals,
- Addressing any PH building-related concerns,
- Coordinating multi-disciplinary team meetings, discussing challenging participant cases, recommending strategies for overcoming barriers to care,



- Facilitating linkages to various resources within the HFH system of care; and
- Navigating and troubleshooting systems issues.

By maintaining open communication and fostering strong partnerships, DHS-assigned HFH program managers strive to help build a seamless and integrated service delivery system and support ICMS Providers with continuously increasing capacity to improve outcomes for participants impacted by homelessness.

Integrated Services Program (ISP) Support

The PH Integrated Services Program (ISP), launched in 2017, was developed as part of LAC's Homeless Initiative and Measure H to provide housing subsidies and essential support to households matched to permanent housing opportunities. Aiming for long-term stability and improved health and well-being, PH ISP is comprised of a range of critical interventions, including ICMS overseen by DHS HFH, the Full-Service Partnership (FSP) and Housing Support Services Program (HSSP) overseen by the LAC Department of Mental Health (DMH), and Client Engagement Navigation Services (CENS) for linkage to substance use treatment support overseen by the LAC Department of Public Health Substance Abuse Prevention and Control division (DPH SAPC). HFH works closely with DMH and DPH SAPC to coordinate setup of PH ISP operations at PH sites across LAC, and to support effective collaboration between ISP providers. ICMS check-ins between the ICMS Provider and the assigned program manager from DHS HFH may also include ISP providers, and/or DMH, and/or DPH SAPC to support case conference of cases, or to help with program set up strategy.

Special Topic: Case Scenarios



Case Scenarios

#1: John, 45 has been living in shelters and encampments for nearly two years. He freely admits that he and his friends are heavy drinkers. He has a history of being evicted four times, a very poor credit history and a bench warrant for failure to appear in court for nuisance violations associated with public intoxication and sleeping outside. He has been unemployed for four years and has no income.

- What community resources might John want and need to obtain and keep housing?

Consider:

- HFH's ICMS program is a low-barrier Housing First program. **John's ability to enroll and to continue to receive services is not conditioned on his willingness to accept treatment or achieve sobriety.**
- Many participants experiencing substance use challenges live in housing: inebriety is not an absolute barrier to housing. Alcohol is a common tool for managing stress. Drinking might not have caused his homelessness; it may have been the result of his homelessness. Either way, it's John's choice if, when, and with whom he would receive SUD services.
- He has **poor credit**, but remedying credit history or achieving financial literacy takes time. There are housing providers who will accept participants with poor credit histories if they are working with an ICMS program or there may be a Project-Based PH opening. These are services that may or may not be something John wants after he is stably housed.
- A bench warrant is very serious, and John would need immediate **legal assistance**. A **bench warrant** is a legal document issued by a judge that authorizes a person's arrest; **this is a major tenant screening barrier and would affect John's ability to secure housing.**
- **John will need some source of income to pay for some of his needs.** Depending on his situation, he might qualify for **disability benefits**. Otherwise, he may need assistance securing **employment**.

#2 Mary, 23, and her two children, ages 5 and 4 have been staying in a family shelter for three months. They lost their housing when Mary's partner, who was the sole source of income for the family, abandoned them. Mary has never read a lease or been responsible for paying rent or utilities. She is overwhelmed and seems unable to focus on the steps she needs to take to obtain housing. When she is given a list of tasks to complete for her Housing Plan, she procrastinates.

- What community resources might Mary need and want to get and keep housing?

Consider:

- It looks like Mary has **stress overload**. Connecting her immediately to additional people and programs could cause her even more stress. An ICMS case manager might start with assessing any emergency/urgent needs for each member of the family.

Is she able to cope within the shelter or does she need quieter surroundings—with family, friends or Bridge Housing? The ICMS case manager assigned to Mary should provide reassurance, perhaps involving peer support. **Tasks would initially be limited, simplified, and written down.** Frequent reviews and more direct assistance may be necessary. An ICMS case manager may likely need to make arrangement to visit units with her and assist with other aspects of the housing search.

- A housing search may begin relatively quickly but Mary will need to understand the basics of leases and housing provider-tenant rights and responsibilities. This would likely not involve a series of classes with in-depth tenancy education; **adults experiencing high levels of stress do not readily retain or recall that much information.** Learning activities would occur as the situation evolves with the understanding that refreshers, handouts, and more in-depth discussions would follow as Mary is better able to absorb the information.
- After she has moved into permanent housing (and hopefully her stress levels have begun to subside), she will need to have an income.

This will also likely require community resources:

- Affordable childcare,
- Job training and/or job search support,
- Public benefits, if eligible, such as food supports; and
- Support budgeting her income to be able to pay rent, utilities and cover family expenses.

ICMS Program Guide

Acknowledgement

As an ICMS case manager, I acknowledge that I have received a copy and agree to utilize the Fiscal Year 2025-2026 Program Guide for ICMS Case Managers [Permanent Housing Edition] in my work. I also acknowledge that all activities I perform under my agency's ICMS contract are subject to HFH contract monitoring, as described in the ICMS Statement of Work. Any questions I have regarding this Guide will be directed at my supervisor.

Organization _____

Name _____

Signature _____

Date _____

