CHAMP Cheat Sheet | PSH ICMS

UPDATED 04-30-25

HOUSING FOR HEALTH

Consents

Notification of Privacy Practices

Universal Information Sharing Consent **Valid until expired or revoked*

- Limited or Full Consent: All ICMS service and documentation requirements can be completed.
- Missing/Expired/Declined/Revoked Consent: All ICMS documentation requirements can be completed, but health care coordination support or referrals to other services is not allowed.
- Please review our job aids to learn more about how MH and SUD info can be shared based on consent type.

CalAIM Community Supports Verbal Opt-Ins

ℹ Only needed if flagged in the ICMS Snapshot
CS Housing Navigation & CS Tenancy and Sustaining Services

Client Demographics

- Name, SSN, DOB, HMIS ID, Gender, Sex Assigned at Birth, Citizenship Status, Race/Ethnicity, Primary Language, Phone Number, and Veteran Status
- **Please don't use special characters in any text field:**
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Why Track Demographics/Household Composition?
This helps us understand the needs of the communities we serve and guides our provision of resources more equitably.

Household Composition

Select Household Type: Single, 2 Person, Multi-generational, etc.

List Member(s)

↳ Name, DOB, Birth Date Quality, Race/Ethnicity, Gender, and Relationship to Head of Household (HoH)

ℹ The participant in the ICMS slot is usually HoH, but sometimes for housing subsidy eligibility purposes, the participant in the slot isn't the HoH.

Assessments

ℹ Only use if permanently housed when assessing

HMIS Assessment	5x5	HAI
At Intake & Annually	At Intake & Every 90 days ⬆ Score = ⬆ Challenges	At Intake & Every 90 days ⬆ Score = ⬆ Stability

ℹ Never assess if you haven't been in recent contact with the participant.

Unsuccessful Outreach Attempts

Record the Unsuccessful Outreach Attempt (or Initial Outreach - Unsuccessful) Service in a Case Note if:

- Searching for a missing participant with no success.
- Participant doesn't respond to a phone call or text.
- Visiting an IH facility, or shelter, but participant is MIA.
- Participant doesn't answer the door during a home visit.
- Checking emergency contacts, HMIS, CHIP, hospitals, Medical Examiner, & LASD Inmate Locator w/o success.

Permanent Housing (PH) Updates

CURRENT STATUS
Select one of the following:
1. Active/Attempting to Engage
2. Active/Engaged in Housing Placement
3. Active/Housed

ICMS CASE MANAGER
Update Assignments Here
❌ Never click "Care Team"

SUBSIDY APPLICATION DATE
Key Housing Navigation Milestone

VOUCHER ISSUED DATE
Date of Eligibility to Obtain Subsidized Permanent Housing
ℹ Vouchers will expire if left unused

MOVE-IN DATE
Homelessness End Date
ℹ Doesn't change when a housed participant relocates to a new unit

ADDRESS
Always include SPA/City/State/ZIP
ℹ If unhoused, write "Homeless" in Address Line 1
Especially important to have on record in cases of natural disaster, emergency, etc.

WHEN SAVING PH UPDATES
✅ Always click Save
❌ Never click No Changes

Complete 1 PH Update Per Calendar Month
For each PH Update completed, record the "Homeless System of Care Linkage/Coordination" Service in the Case Note.

ICMS Exit Requests

- Please **never** enter an "Inactive" status or "Inactive Date" or "Check-Out Date." These functions are connected to ICMS Exits and are to be completed by **HFH staff only**.
- If a participant is deceased or not yet housed, and you're unable to reach them after 30+ days of exhausting all outreach options, then submit an ICMS Exit Request.
- New project-based lease-up exit requests may be subject to shorter exit timelines.

ICMS Snapshot

Use this tool to prioritize efforts, coordinate care, and monitor documentation progress.

- Active Participant Roster
- Client Level Summary
- Hospitalization Log
- Action Step Log
- Services Log
- Exit Log

ℹ Access the ICMS Snapshot Data Glossary in the PSH Info Center

Please register for 1:1 Screen Share if you have questions.

Questions, Comments, or Feedback on this Sheet? Let us know!

Use the Care Plan to develop at least one SMART Goal in collaboration with the participant within 30 days of intake. Record New/Pending/Complete Action Steps to guide and track progress towards achieving SMART Goal(s). Check out some sample Care Plan content.

When writing a Case Note, record a Service for each Action Step completed by the Case Manager.

When recording Services, remember:
High billing rate requires a minimum of 2 in-person encounters per month;
Low billing rate requires a minimum of 1 in-person encounter per month.

Service Options & Definitions

Common Case Mgr. Action Steps

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

Action Steps

SMART Goal* Obtain Permanent Housing in Next 90 Days

Case Notes should include details that clarify the context of the participant's situation and Services received.

Please record the steps that need to be completed to attain the goal detailed above.

Set 1 or more New/Pending Action Steps every 90 days
What you're working on to complete next

Complete 1 or more Action Steps every 90 days
Progress you've made so far

	Action Step Title*	Set Date*	Target Date*	Assigned To*	Status	Completion Date
☑	Obtain Social Security Card	03/10/2025	04/10/2025	Participant Name	New/Pending	
☑	Transport Participant to DMV	03/13/2025	03/13/2025	Case Manager	Complete	03/13/2025

Services

Record Case Note?* ◉ Yes ○ No ☑ Check if you wish to record services associated with this note

Use the fields below to record the services provided in association with the note above.

	Service Date*	Service*	Enrollment	Place of Service	Units of Measure	Unit Value	Units
☑	03/13/2025	Housing Navigation Support	03/03/2025 - Perm..	Non Clinic Comm	Count	$0.00	1.00
☑	03/10/2025	Care Plan Development/Upd..	03/03/2025 - Perm..	Interim Housing	Count	$0.00	1.00

When did you provide the Service?

Which Service did you provide?

Always select Permanent Housing Enrollment.

Where did you provide this Service?

Never edit these data fields. Leave as is.

You can record more than one Service in a Case Note, but please only record one Service per line.

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