Eligible Services in CHAMP | Permanent Housing ICMS

LA COUNTY Homeless Services & Housing

Eligible Services are the standardized service options available in CHAMP for documenting Permanent Housing ICMS support provided to participants. Providers shall select the Eligible Service option that best reflects the **primary purpose** of the interaction or activity being documented.

Recording Eligible Services in CHAMP supports documentation, performance management, reporting, billing rate review, and other ICMS program implementation activities.

Program Participation Management

Administrative tasks that support system-wide information sharing, reporting, billing, and accountability.

- Intake
- Universal Consent
- CHAMP Profile Update
- PH Update
- Incident Report
- Exit Request
- Opt-Ins
- Notice of Privacy Practices
- PHA Sharing Addendum

Assessment and Care Planning

Conducting assessments and developing/updating participant-centered care plans based on needs, strengths, and goals.

- HMIS Assessment
- 5x5
- Housing Acuity Index
- Psychosocial Assessment
- LA HAT
- Create SMART goal
- Assign New Action Step
- Update Goal Status
- Update Action Step Status

Housing Navigation Support

Supporting housing search, application, and move-in processes for participants.

- Document Support (Housing/Subsidy)
- Submit Subsidy Application
- Resolve Housing-Related Debt
- Housing Search
- Coordinate Move-In
- Housing Deposits Coordination
- Rent Reasonableness Certification

Permanent Housing Retention Assistance

Providing ongoing support to maintain housing stability and promote long-term wellbeing.

- Health and Safety Visit
- Tenancy Education
- Lease Compliance Support
- Reasonable Accommodation Support
- Engage Property Manager
- Re-Certify Voucher
- Moving On Application
- Decluttering Support
- Resolve Arrears
- Submit FHSP GAR Request
- Mediate Dispute
- Crisis Intervention

Accompaniment - Health Care

Attending healthcare visits alongside participants.

- Prepare Participant for Appointment
- Attend Participant Appointment
- Debrief with Participant After Appointment

ISP Care Coordination

Linking to and coordinating services with PSH Integrated Services Program (ISP) providers.

- Submit CENS Referral
- Submit HSSP Referral
- Submit FSP Referral
- Coordination / Follow-Up with ISP Provider

Case Conference

Collaborating with internal and external care team members to coordinate services and address complex participant needs.

- Internal Case Conference
- Multidisciplinary Team Coordination
- Case Conference with Housing Providers
- Case Conference with Healthcare Providers

Transportation

Supporting participant access to services, housing, and appointments through transportation-related assistance.

- Housing Search Tranportation
- Coordinate Rides or Transit Access
- Healthcare Transportation

Health and Life Skills Promotion

Supporting participant education, coaching, and skill-building related to health, daily living, and self-sufficiency.

- Life Skills Coaching
- Health Education
- Medication Adherence Support
- Budgeting and Daily Living Skills

Community Resources/Supports Linkage

Assisting participants in connecting to community-based resources and services that support health, income, & overall wellbeing.

- Basic Needs Assistance
- CBEST Referral
- Medi-Cal / Medicare Application
- GR/CalFresh
- Unemployment Income Connection
- VA Coordination
- BenefitsCal
- Social Security Benefits Assistance
- Document Support (Benefits/Services)
- Connect to Caregiving
- Connect to Primary Care
- Connect to Mental Health Care
- Connect to Specialty Medical Care
- Connect to Substance Use Care
- PH² Referral
- Pharmacy & Grocery
- Link to Community of Faith
- Volunteer Opportunities
- School Registration
- Job Search

Family/Friend Coordination

Engaging & coordinating with family members or other individuals identified by the participant to support care & housing stability.

- Coordination with Family
- Communication with Identified Support Persons
- Family Reunification
- Care Planning with Family Involvement
- Support for Family Engagement in Care Planning
- Coordination During Crises

Safety Planning

Supporting participants in identifying risks, enhancing personal safety, and developing strategies to reduce harm, including in situations involving domestic or intimate partner violence.

- Identify Safe Contacts/Locations/Emergency Strategies
- Develop Safety Plan
- Provide Info About DV Resources
- Refer to DV Shelter
- Coordinate VAWA Relocation

ICMS TOC Visit

Supporting participants during transitions of care (TOC) following hospitalization.

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

Services Documentation Tips

- Occupied ICMS slots are generally expected to have at least **two (2) Eligible Services recorded during each service month** to satisfy minimum documentation requirements.
- Services and case notes should **support active SMART Goals and Action Steps** as much as possible.
- Many activities could reasonably fit more than one service option. **Select the service that best represents the primary purpose of the interaction**.
- Record **where the service occurred—not where the documentation was completed**. Multiple in-person services on the same date count as one in-person encounter.
- **Unsuccessful Outreach ≠ Eligible Service**. "Initial Outreach – Unsuccessful" and "Unsuccessful Outreach Attempt" document outreach efforts but do not count toward minimum monthly Eligible Service requirements.
- Track participant service delivery through the **Participant Level Summary and Services Log in the ICMS Snapshot**.
- Services **must accurately reflect work** performed—not be selected simply to satisfy reporting or billing requirements.

For complete documentation requirements, refer to the ICMS Implementation Handbook

Comments, Questions, or Feedback about this guide? Let us know