HUD-VASH

Case Management System

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- Full description of procedures and services codified in VHA Handbook.
- Identifies priorities for services among the chronically homeless.
- Addresses oversight, service, and support responsibilities at each level of the organization.
- Detailed description of referral and assessment process, program design, case management services, program monitoring and evaluation.
- Establishes staffing guidelines and training requirements.

1. HCHV Outreach staff
   - May make direct referrals from community to HUD-VASH.
   - Community education can generate referrals to VA from community providers (i.e. shelters, food kitchens, welfare offices, etc.)
2. VA Homeless Programs
   - Homeless Residential Treatment
   - Grant & Per Diem

Assessment

1. Confirm eligibility
2. Assess for suitability
   - If not housing ready, possible acceptance pending treatment in residential and/or inpatient setting
   - If not appropriate, alternative treatment plan developed
3. Determine need for other services to ensure adequate income, skills and support to maintain housing status once placed.
4. Multidisciplinary team to make determination on acceptance.

Entry Into HUD-VASH

- Once accepted, an individualized treatment plan is developed by the case manager and the veteran.
- Treatment plan reflects of the goals of the veteran. Potential strengths and barriers to maintaining housing placement are addressed.
- Establish process to monitor treatment plan including: use of alcohol and drug screening, frequency of medical and mental health appointments, assistance with employment and income needs, resolution of legal and financial issues.

- Alert PHA of referral.
- As needed, assist veteran in completing and assembling required documentation.
- Following PHA guidelines, assist veteran in locating suitable housing.
- Request PHA inspection and approval of selected unit.
- Assist veteran and landlord to complete lease.
- Prepare for the move as needed providing guidance on turning on utilities, obtaining furnishings and supplies, and transportation to complete the move.

- Establish a therapeutic relationship.
- Provide support for long-term recovery by working towards treatment plan goals.
- Reassess needs and goals based on changing conditions. Inability to maintain sobriety does not generally lead to discharge from case management if veteran can maintain housing.
- Foster community integration and independence.
- Maintain veteran in housing.

Delivery of Services

- Coordinate VA and community interventions, acting as a liaison with critical partners (the landlord and other service providers).
- Make regular home visits to assess veteran's ability to maintain themselves in a safe environment that promotes sobriety, physical, and mental well being.
- Schedule individual and group meetings. Individual sessions will focus on treatment plan and current needs. Group meetings should foster peer support.
- Provide linkages for child care, medical coverage for family members (ex. Medicaid), family therapy, legal and income assistance programs.

Discharge from Services

- Agreement between case manager and veteran that goals have been met.
- Permanent loss of rental subsidy.
- Move into more intensive level of care.
- Client refusal of services.
- Loss of contact.
  - *Every effort will be made to re-engage veterans who are struggling or ultimately discharged from housing.*