CONTRACT AMENDMENT SMHC

DSHS CONTRACT NUMBER: 1169-36664

Amendment No. 09

This Contract Amendment is between the State of Washington Department of Social and Health Services (DSHS) and the Contractor identified below.	Program Contract Number Contractor Contract Number

CONTRACTOR NAME Greater Columbia Behavioral Health		CONTRACTOR doing business as (DBA) Greater Columbia RSN	
CONTRACTOR ADDRESS 101 N. Edison Street Kennewick, WA 99336-1958		WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) 601-552-389	DSHS INDEX NUMBER 1128
CONTRACTOR CONTACT Ken Roughton	CONTRACTOR TELEPHONE (509) 735-8681	CONTRACTOR FAX (509) 783-4165	CONTRACTOR E-MAIL ADDRESS kenr@gcbh.org

DSHS ADMINISTRATION Behavioral Health and Service Integration	DSHS DIVISION Division of Behavioral Health and Recovery	DSHS CONTRACT CODE 1685LS-69
DSHS CONTACT NAME AND TITLE Thomas Gray Mental Health Program Administrator	DSHS CONTACT ADDRESS 4500 10th Avenue SE Lacey, WA 98503	
DSHS CONTACT TELEPHONE (360) 725-1314	DSHS CONTACT FAX	DSHS CONTACT E-MAIL ADDRESS graytr@dshs.wa.gov
IS THE CONTRACTOR A SUBRECIPIENT FOR PURPOSES OF THIS CONTRACT? No		CFDA NUMBERS
AMENDMENT START DATE 07/01/2014	**CONTRACT END DATE** 12/31/2015	
PRIOR MAXIMUM CONTRACT AMOUNT $40,977,315.00	AMOUNT OF INCREASE OR DECREASE $-664,064.00	TOTAL MAXIMUM CONTRACT AMOUNT $40,313,251.00

REASON FOR AMENDMENT;
CHANGE OR CORRECT CONTRACT TERMS OR SOW, SEE PAGE TWO

ATTACHMENTS. When the box below is marked with an X, the following Exhibits are attached and are incorporated into this Contract Amendment by reference:

☒ Additional Exhibits (specify): Exhibits C, F and G

This Contract Amendment, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties as changes to the original Contract. No other understandings or representations, oral or otherwise, regarding the subject matter of this Contract Amendment shall be deemed to exist or bind the parties. All other terms and conditions of the original Contract remain in full force and effect. The parties signing below warrant that they have read and understand this Contract Amendment, and have authority to enter into this Contract Amendment.

CONTRACTOR SIGNATURE Small	PRINTED NAME AND TITLE Shon Small, Chair GCBH Board of Directors	DATE SIGNED 7.22.14
DSHS SIGNATURE Michael Rice	PRINTED NAME AND TITLE Michael Rice, DBHR Contracts Supv DBHR Contracts	DATE SIGNED 7-22-14

This Contract between the State of Washington Department of Social and Health Services (DSHS) and the Contractor is hereby amended as follows:

1. Amend the Total Maximum Agreement Amount, by a decrease of $664,064, for a revised Total Maximum Contract Amount of $40,333,251.

2. Amend the Agreement by replacing Exhibit C, Funding **(attached).**

3. Amend the Agreement by adding a new Exhibit F, RSN Transfer Agreement **(attached).**

4. (GRAYS HARBOR, GREATER COLUMBIA, AND NORTH SOUND ONLY) Amend the Agreement by adding a new Exhibit G, Housing And Recovery Through Peer Services (HARPS) **(attached).**

5. (NORTH SOUND ONLY) Amend the Agreement's Section 5 Payment and Fiscal Management, subsection 5.3.2, by deleting it in its entirety.

6. (KING COUNTY ONLY) Amend the Agreement's Section 5 Payment and Fiscal Management, by adding a new subsection 5.3.4, to read as follows:

   5.3.4 Funds provided to King County RSN according to Exhibit C shall be used solely to maintain services as it works to transition services to settings eligible for federal participation for individuals covered under the Medicaid program.

7. (GRAYS HARBOR, GREATER COLUMBIA, AND NORTH SOUND ONLY) Amend the Agreement's Section 5 Payment and Fiscal Management, by adding a new subsection 5.3.5, to read as follows:

   5.3.5 Funds provided to Grays Harbor, Greater Columbia, and North Sound RSNs for Housing And Recovery Through Peer Services (HARPS) will include a one-time payment as listed in Exhibit C, Funding, and two payments for housing subsidies as listed in Exhibit C, Funding.

   5.3.5.1 Additional funds for housing subsidies will be based on performance and monthly reporting. Monthly reports are due by the 15th of the following month. The first report is due August 15, for services provided July 1-31.

8. Amend the Agreement's Section 5 Payment and Fiscal Management, by adding new subsections 5.9.1.1 - 5.9.1.3, to read as follows:

   5.9.1.1 The Contractor may not enter into any agreement or make other arrangements for use of state hospital beds outside of the agreed-upon allocation in Exhibit D.

   5.9.1.2 Any changes to the allocation shall require an amendment to the Agreement, and will become effective the 1st day of the quarter following the effective date of this Amendment.

   5.9.1.3 State hospital reimbursement payments will be based only on the allocation of beds contained in Exhibit D, and any subsequent Amendments.

9. Amend the Agreement's Section 12, Services, by revising subsection 12.3.1.6, to read as follows:

   12.3.1.6 Provide Training for Peer Counselors when the training meets the following requirements:
   - The Contractor will submit Peer Counselor Training Applications to DBHR no later than 30 days prior to attendance at the training.

- Each participant is over age 18 and meets the WAC 388-865-0150 definition of Consumer, unless DBHR approval for exception has been obtained in writing prior to attendance at the training. Only participants with a DBHR approved Peer Counselor Training Application may sit for the Peer Counselor Exam.
- Training is structured in compliance with the RSN Guidelines for Peer Counseling Training according to guidelines provided by DBHR. The guidelines define RSN, DBHR, and applicant/participant responsibilities.

10. Amend the Agreement's Section 14, Tribal Relationships, by adding a new subsection 14.4, to read as follows:

14.4 Tribal Coordination for Crisis, Voluntary Inpatient and Involuntary Commitment Evaluation Services

The Contractor shall submit to the DBHR Tribal Liaison a plan for providing crisis, ITA evaluation, voluntary inpatient authorization and discharge planning services on Tribal Lands within the RSN, on or before January 31, 2015.

The plan shall be developed in conjunction with the affected Tribal entities within the RSN region and must be co-signed by the appropriate Tribal representative for each affected Tribe.

The plan shall identify a procedure and timeframe for evaluating the plan's efficacy and a procedure and timeframe for modifying the plan to the satisfaction of all parties at least once per year.

- If the RSN and Tribal entity are not able develop a plan or the tribe does not respond to the request, DBHR will work with both the Tribes and RSN to reach an understanding.
- These meetings will be conducted in a manner which comports with the DSHS government-to-government relationship with Washington Tribes.
- Those Tribes whose Tribal lands lie within multiple RSNs, may develop joint plans with those RSNs. If an RSN has multiple Tribal lands within their service region one plan may be developed for all Tribes if all parties agree.

14.4.1 The plan must include a procedure for crisis responders and DHMPs (non-Tribal) to access Tribal lands to provide requested services, including crisis response, and ITA evaluations.

14.4.1.1 Any notifications and authority needed to provide services including a plan for evening, holiday and weekend access to Tribal lands if different than business hours.

14.4.1.2 A process for notification of Tribal authorities when crisis services are provided on Tribal land, especially on weekends, holidays and after business hours. This must identify the essential elements included in this notification, who is notified and timeframe for the notification.

14.4.1.3 A description of how crisis responders will coordinate with Tribal Mental Health providers and/or others identified in the plan for, including a description of how service coordination and debriefing with Tribal mental health providers will occur after a crisis service has occurred.

14.4.1.3.1 This must include the process for determining when a DMHP is requested and a timeframe for consulting with Tribal mental health providers regarding the determination to detain or not for involuntary commitment.

14.4.2 ITA Evaluation Services

14.4.2.1 The plan shall include procedures for coordination and implementation of ITA evaluations on Tribal lands, including whether or not DMHPs may conduct ITA evaluations on Tribal lands.

14.4.2.2 If ITA evaluations cannot be conducted on Tribal land, the plan shall specify how and by whom individuals will be transported to non-Tribal lands for ITA evaluations and detentions.

14.4.2.3 If DMHP evaluations cannot be conducted on Tribal Land, the plan shall specify how and by whom individuals will be transported off of Tribal Land to the licensed Evaluation and Treatment facility.

14.4.2.4 The plan shall specify where individuals will be held and under what authority, If no E&T beds are available.

14.4.3 Voluntary Hospital Authorization

14.4.3.1 The plan will include specifics as to how the RSN would like Tribal Mental Health providers to request voluntary psychiatric hospitalization authorizations for Medicaid-eligible Consumers.

14.4.3.2 The RSN shall provide to the Tribes information on how to request for voluntary authorization, appeals and expedited appeals. The plans shall reiterate that only a psychiatrist or a doctoral level psychologist may issue a denial and that denials may only be issued by the RSN and not the crisis provider.

14.4.4 Inpatient Discharge Planning

The plan shall address a process for identifying the Tribal mental health provider as the liaison for inpatient coordination of care when the Consumer is an identified Tribal member and has not expressed a preference regarding involvement by the Tribe in their care. This includes all liaison activities required in section 12.2.10.

11. Amend the Agreement's Section 17.6 Confidentiality, by adding new subsection 17.6.3, to read as follows:

17.6.3 Verify the identity or authenticate all of the system's human users before allowing them to use its capabilities to prevent access to inappropriate or confidential data or services.

17.6.3.1 Authorize users and client applications to prevent access to inappropriate or confidential data or services

17.6.3.2 Protect application data from unauthorized use when at rest.

17.3.3.3 Keep any sensitive data or communications private from unauthorized individuals and programs.

All other terms and conditions of this Contract remain in full force and effect.

Revised July 2014 - EXHIBIT C - Funding

		Greater Columbia RSN State Only Contract July 2014 to June 2015		
	Jan 2014 Amendment Monthly Payments July 2014 to June 2015	July 2014 Revised Monthly Payments July 2014 to June 2015	Monthly Difference	12 Month Difference
State Only*	$672,203	$577,661	($94,542)	($1,134,504)
ECS	$-	$-	$-	$-
PACT	$28,958	$28,958	$-	$-
PALS	$-	$-	$-	$-
Jail Services	$25,350	$25,350	$-	$-
Diversion	$-	$-	$-	$-
ITA	$-	$-	$-	$-
Total	$726,511	$631,969	($94,542)	($1,134,504)

One-time Payment	
Housing services	**$190,440**

Quarterly Payments - Additional housing services	
July-September 2014	$150,000
October-December 2014	$150,000
Total	$300,000

*State only funding includes Community Inpatient, Direct Care Wage, Double Staff and a decrease in State only funding with a corresponding increase in Federal Block Grant within the calculation.

Exhibit F – RSN Transfer Protocol

1. **Purpose.** The purpose of this RSN Transfer Protocol is to establish an agreed-upon process by which individuals can be transferred from one RSN to another to ensure:

   b. A seamless transition for the individual with no more than minimal interruption of services:

   c. The individual receives care that better meets his or her needs.

   d. The individual has the opportunity to be closer to family and/or other important natural supports.

   e. The individual has access to Medicaid covered services.

2. **Definitions.**

   a. "Multiple" means, for the purpose of defining risk factors, multiple three or more.

   b. "Referring RSN" means the RSN in whose region the individual resided and/or from whom they received services prior to state hospital admission.

   c. "Receiving RSN" means the RSN into whose region the Referring RSN is pursuing the transfer.

   d. "Risk factors" include the following:

      (1) Transfer is being requested due to availability of specialized non-Medicaid resource.

      (2) High inpatient utilization – 2 or more inpatient admissions in the previous 12 months, an inpatient stay in a community hospital for 90 days or more in the previous 12 months, or discharge from a state hospital in the previous 12 months.

      (3) History of felony assaults, ORCSP eligibility, or multiple assaultive incidents during inpatient care (that may not have resulted in criminal charges but resulted in injuries).

      (4) Significant placement barriers - behavioral issues resulting in multiple placement failures, level 3 sex offender, arson history, dementia (the RSN would need to be involved even though HCS might be arranging placement), and co-morbid serious medical issues.

   e. "Specialized Non-Medicaid services" includes, for purposes of this protocol, IMD admissions, residential placement, and state hospital census.

3. **RSNs acknowledge and agree that:**

   a. Medicaid enrollees are entitled to Medicaid covered services in the community where they live.

   b. Individuals who participate in mental health services have the right to freely move to the community of their choosing.

   c. There are circumstances when an RSN (referring RSN) wishes to place an individual in another RSN's region (receiving RSN) to better meet the needs of that individual, or moving to another RSN's region would allow the individual to be closer to family and/or other important natural supports.

   d. Some individuals require specialized, non-Medicaid services to meet their needs.

e. Due to the scarcity of specialized, non-Medicaid services, these may not be immediately available upon the request of the transferring individual.

f. The receiving RSN assumes immediate financial risk for crisis services and Medicaid covered services at the time of transfer.

g. The referring RSN will continue the financial responsibility for "specialized non-Medicaid services" provided to the individual for the duration of time as determined by the number of risk factors identified at the time of transfer.

Number of Risk Factors	Duration
One risk factor	6 months
Two risk factors	9 months
Three or more risk factors	12 months

h. After completion of the risk factor time frame, the receiving RSN will assume all financial responsibility for the individual.

i. The referring RSN will retain the individual on their state hospital census until the individual is discharged. The referring RSN will accept on their census any individual placed in the receiving RSN who returns to the state hospital during the period of financial responsibility as defined above.

j. This protocol is intended to ensure a seamless transition for individuals with no more than minimal interruption of services.

4. Uniform Transfer Agreement-Community Inter-RSN Transfer Protocol

a. If a Medicaid enrollee re-locates to a region outside of their current RSN they are entitled to an intake assessment in the new region and are then provided all medically necessary mental health services required in the PIHP contract, based on the RSN's level of care guidelines and clinical assessment.

b. Each RSN will establish a procedure to obtain information and records for continuity of care for enrollees transferring between RSNs.

c. All Medicaid enrollees requesting a transfer will be offered an intake assessment and all medically necessary mental health services under the PIHP. The availability of Specialized Non-Medicaid Services cannot be the basis for determining if the enrollee is offered an intake for services in the desired community of their choice.

d. There are circumstances when moving between RSNs is necessary to better meet the needs of the individual, or moving to another RSN would allow the individual to be closer to family and/or other natural supports.

e. The receiving RSN will provide assistance to the enrollee to update the enrollee's residence information for Medicaid Benefits.

f. When an enrollee is re-locating and may benefit from specialized non-Medicaid services beyond medically necessary services required in the PIHP, the RSNs agree to the following protocol:

(1) The placement is to be facilitated by the joint efforts of both RSNs.

(2) The referring RSN will provide all necessary clinical information along with the completed Inter-

RSN transfer form.

(3) The receiving RSN will acknowledge the request within 3 working days.

(4) The receiving RSN will follow established procedures for prioritizing the referred enrollee and must offer an intake assessment to the enrollee for services Medicaid-covered services even if the specialized non-Medicaid services are not immediately available.

(5) The placement may not be completed without written approval on the inter-RSN transfer form from both RSN administrators, and their designees.

(6) The receiving RSN shall make a placement determination within 2 weeks of receiving all necessary information/documentation from the referring RSN. The enrollee and the referring RSN will receive information regarding the placement policy of the receiving RSN for the specialized non-Medicaid service.

(7) Placement will only occur when the specialized non-Medicaid service becomes available. If the specialized non-Medicaid service is not available at the time of the intended transfer, the receiving RSN will notify the referring RSN and continue to provide timely updates until such time the specialized non-Medicaid service is available. The referring RSN will keep the individual and others involved in the individual's care informed about the status of the transfer.

(8) Payment responsibility for individuals transferring between RSNs will be described in this protocol and specified on the inter-RSN transfer form.

5. Uniform Transfer Agreement - Eastern and Western State Hospital Inter-RSN Transfer Protocol

a. This section describes the inter-RSN transfer process for individuals preparing for discharge from a state hospital, and who require specialized non-Medicaid resources.

b. Generally, individuals are discharged back to the RSN in whose region they resided prior to their hospitalization (designated by the state hospitals as the "RSN of responsibility").

c. For all individuals in a state hospital (regardless of risk factors) who intend to discharge to another RSN, an Inter-RSN transfer request is required and will be initiated by the RSN of responsibility (hereinafter referred to as the referring RSN).

d. The financial benefits section at the state hospital will provide assistance to the enrollee to update the enrollee's residence information for Medicaid Benefits.

e. The placement is to be facilitated through the joint efforts of the state hospital social work staff and the RSN liaisons of both the Referring RSN and Receiving RSN.

f. A *Request for Inter-RSN Transfer* form and relevant treatment and discharge information is to be supplied by the Referring RSN to the Receiving RSN via the liaisons.

g. The Referring RSN will remain the primary contact for the state hospital social worker and the individual until the placement is completed.

h. The Receiving RSN will supply the state hospital social worker with options for community placement at discharge.

i. Other responsible agencies must be involved and approve the transfer plan and placement in the

Receiving RSN when that agency's resources are obligated as part of the plan (e.g., DSHS Home and Community Services or Developmental Disabilities Administration).

j. Should there be disagreement about the discharge and outpatient treatment plan, a conference will occur. Participants will include the individual, state hospital social worker or representative of the state hospital treatment team, liaisons, the mental health care provider from the referring RSN, and other responsible agencies.

k. Once the discharge plan has been agreed upon, the *Request for Inter-RSN transfer* will be completed within two weeks. The Receiving RSN has two weeks to complete and return the form to the Referring RSN. This process binds both the Referring and Receiving RSNs to the payment obligations as detailed above.

Exhibit G – Housing And Recovery Through Peer Services (HARPS)

See Attached

Exhibit G – Housing And Recovery Through Peer Services (HARPS)

1. Background.

a. The Adult Behavioral Health System - Making the Case for Change report (DBHR 2013) identified the intersection between behavioral health problems and homelessness.

(1) Homelessness is traumatic, cyclical, and puts people at risk for Mental Health and Substance Use Disorders. Homelessness also interferes with one's ability to receive services, including services for behavioral health conditions, and jeopardizes the chances for successful recovery.

(2) Compared to DSHS clients overall, homeless children and adults were significantly more likely to have a Mental Health Disorder (50% increase for children/youth; 23% increase for adults) and three times as likely to have a Substance Use Disorder (Ford Shah, Black, and Felver, 2012a).

(3) DSHS Research and Data Analysis (RDA) (Report #1490) identified that 4,720 of the 9,909 individuals exit chemical dependency residential facilities are homeless in a 12-month period following exit (48%) 516 of 1792 individuals exiting state mental health hospitals (note -this does not include E&Ts or local hospitals) are homeless within a 12-month period following exit (29%).

b. In the winter of 2012, DBHR was chosen by the Substance Abuse Mental Health Services Administration (SAMHSA) for a Chronic Homeless Policy Academy. The policy academy provides assistance to four states with high rates of chronic homelessness: California; Washington; Louisiana; and Georgia. Each state receives support and coaching from a faculty team, led by federal staff, with access to technical assistance and planning tools. The policy academy (also known as Housing 3000) became a subcommittee of the Interagency Council on Homelessness and developed a strategic plan to reduce chronic homelessness in Washington State. One of the strategies of the plan includes developing pilot projects for individuals exiting state hospitals and residential chemical dependency treatment agencies.

c. In 2013 the Legislature adopted two bills, Second Substitute Senate Bill 5732 and Engrossed Substitute House Bill 1519, which require the state to establish outcome expectations and performance measures in its purchasing of medical, behavioral, long-term care, and social support services. In 2014, the Legislature adopted 2SSB 6312 directing DSHS to integrate chemical dependency purchasing primarily with managed care contracts administered by RSNs, exempting the Criminal Justice Treatment Account, by April 1, 2016. Within funds appropriated by the legislature for this purpose, behavioral health organizations shall develop the means to serve the needs of people with mental disorders residing within the boundaries of their regional service area. Elements of the program may include:

(1) Crisis diversion services;

(2) Evaluation and treatment and community hospital beds;

(3) Residential treatment;

(4) Programs for intensive community treatment;

(5) Outpatient services;

(6) Peer support services;

(7) Community support services;

(8) Resource management services; and

(9) Supported housing and supported employment services.

d. In the supplemental budget for this bill, three supportive housing pilot projects were funded to assist individual's transition from institutional settings into permanent supportive housing, provide the basis for supportive housing services, and provide integration opportunities between substance abuse treatment services and RSNs. Each Team consists of:

(1) 1 FTE MA Professional - $66,000*

(2) 2 FTE Certified Peer Counselors - $36,000* each

(3) 20% Benefits

(4) 15% Administration

(5) Total Team Costs: $190,440

*costs based on Behavioral Health Data Book 2013 Median Salaries by type - Area 1

2. **Principles of Evidence-based Permanent Supportive Housing.** Permanent Supportive Housing (PSH) is decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord-tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences. PSH makes housing affordable to someone on SSI, (either through rental assistance or housing development). It provides sufficient wraparound supports to allow people with significant support needs to remain in the housing they have chosen. Dimensions of PSH EBP include:

a. Choice in housing and living arrangements

b. Functional separation of housing and services

c. Decent, safe, and affordable housing

d. Community integration and rights of tenancy

e. Access to housing and privacy

f. Flexible, voluntary, and recovery-focused services

g. Even though HARPS will not require high fidelity PSH EBP, we encourage sites to become familiar with the dimensions of PSH EBP. A link to the SAMHSA PSH toolkit can be found at http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.

3. HARPS Priority Populations:

a. Individuals who are Co-Occurring (Mental Health & Substance Abuse) who meet Access to Care Standards, or

b. Individuals who experience mental health issues and who meet Access to Care Standards, or

c. Individuals who experience substance abuse issues and who do not meet Access to Care Standards

Who are released from:

a. Psychiatric Inpatient settings, or

b. Substance Abuse Treatment Inpatient settings

Who are Homeless/At Risk of homelessness

a. Broad definition of homeless (couch surfing included)

4. Peer Services.

a. The HARPs program will build from the Permanent Options for Recovery-Centered Housing (PORCH) project. PORCH is designed to transform service delivery by promoting sustainable access to evidence based Permanent Supportive Housing. PORCH provides consumers with meaningful choice and control of housing and support services, utilizes Peer Housing Specialists, reduces homelessness and supports the recovery and resiliency of individuals with serious mental illness. http://publications.rda.dshs.wa.gov/1492/

b. SAMPLE Job Description: Peer Support Specialist II

(1) Principal Duties and Responsibilities

Provide peer counseling and support with an emphasis on enhancing access to and retention in permanent supported housing. Draw on common experiences as a peer, to validate clients' experiences and to provide guidance and encouragement to clients to take responsibility and actively participate in their own recovery. Serve as a mentor to clients to promote hope and empowerment. Provide education and advocacy around understanding culture-wide stigma and discrimination against people with mental illness and develop strategies to eliminate stigma and support client participation in consumer self-help programs and consumer advocacy organizations that promote recovery. Teach symptom-management techniques and promote personal growth and development by assisting clients to cope with internal and

external stresses. Coordinate services with other Mental Health and allied providers.

(2) Housing

Assist clients to find and maintain a safe and affordable place to live, apartment hunting, finding a roommate, landlord negotiations, cleaning, furnishing and decorating, and procuring necessities (telephone, furniture, utility hook-up). Identify the type and location of housing with an exploration of access to natural supports and the avoidance of triggers (such as a neighborhood where drug dealing is prolific if the peer has a history of substance abuse). Provide practical help and supports, mentoring, advocacy, coordination, side-by-side individualized support, problem solving, direct assistance and supervision to help clients obtain the necessities of daily living including medical and dental health care; legal and advocacy services; financial support such as entitlements (SSI, SSDI, veterans' benefits); housing subsidies (HUD Section 8); money- management services (e.g., payee services); and transportation.

(3) Employment

Assist with referrals to job training and DVR. Perform mentoring, problem solving, encouragement and support on and off the job site. Provide work-related supportive services, such as assistance securing necessary clothing and grooming supplies, wake-up calls, and transportation.

(4) Activities of Daily Living Services

Provide ongoing assessment, problem solving, side-by-side services, skill teaching, support (prompts, assignments, encouragement), and environmental adaptations to assist clients with activities of daily living Assist and support clients to organize and perform household activities, including house cleaning and laundry. Assist and support clients with personal hygiene and grooming tasks. Provide nutrition education and assistance with meal planning, grocery shopping, and food preparation. Ensure that clients have adequate financial support (help to gain employment and apply for entitlements). Teach money-management skills (budgeting and paying bills) and assist clients in accessing financial services (e.g., professional financial counseling, emergency loan services). Help clients to access reliable transportation (obtain a driver's license and car and car insurance, arrange for cabs, use public transportation, find rides). Assist and support clients to have and effectively use a personal primary care physician, dentist, and other medical specialists as required.

(5) Social and Interpersonal Relationships and Leisure Time

Provide side-by-side support, coaching and encouragement to help clients socialize (going with a client to community activities, including activities offered by consumer-run peer support organizations). Assist clients to plan and carry out leisure time activities on evenings, weekends, and holidays. Organize and lead individual and group social and recreational activities to help clients structure their time, increase social experiences, and provide opportunities to practice social skills.

(6) Education, Experience, and Knowledge Required

Certified Peer Counselor or complete certification within six months of employment. Good oral and written communication skills. Must have a strong commitment to the right and the ability of each person with a severe mental illness to live in normal community residences; work in market jobs; and have access to helpful, adequate, competent, and continuous supports and services. It is essential the peer specialist have skills and competence to establish supportive trusting relationships with persons with severe and persistent mental illnesses and respect for clients' rights and personal preferences in treatment is essential.

5. HARPS Housing Bridge Subsidy Guidelines.

a. The budget for the HARPS pilot project estimates up to 1000 individuals total across the three sites exiting residential treatment facilities, state hospitals, E&T's, local psychiatric hospitals could receive up to 3 months of housing 'bridge' subsidy. The 'bridge' subsidy may include application fees, security deposits, utilities assistance, and rent.

b. Of these 1,000 individuals approximately 200 will receive supported housing services from pilot sites teams each year. This assumes that three teams will support an active caseload of 50 individuals at any one time and assumes turnover of 35% per year.

c. Transitional housing/Bridge subsidy ($500/per person/3 months). Allowable expenses for HARPS Housing Bridge Subsidy:

(1) Monthly rent and utilities, and any combination of first and last months' rent for up to 3 months. Rent may only be paid one month at a time, although rental arrears, pro-rated rent, and last month's may be included with the first month's payment.

(2) Rental and/or utility arrears for up to three months. Rental and/or utility arrears may be paid if the payment enables the household to remain in the housing unit for which the arrears are being paid or move to another unit.

(3) Security deposits and utility deposits for a household moving into a new unit.

(4) HARPS rent assistance may be used for move-in costs including but not limited to deposits and first months' rent associated with housing, including project- or tenant-based housing.

(5) Application fees, background and credit check fees for rental housing.

(6) Lot rent for RV or manufactured home.

(7) Costs of parking spaces when connected to a unit.

(8) Landlord incentives (provided there are written policies and/or procedures

explaining what constitutes landlord incentives, how they are determined, and who has approval and review responsibilities).

(9) Reasonable storage costs.

(10) Reasonable moving costs such as truck rental and hiring a moving company.

(11) Hotel/Motel expenses for up to 30 days if unsheltered households are actively engaged in housing search and no other shelter option is available.

(12) Temporary absences. If a household must be temporarily away from his or her unit, but is expected to return (e.g., participant violates conditions of their DOC supervision and is placed in confinement for 30 days or re-hospitalized), HARPS may pay for the households rent for up to 60 days. While a household is temporarily absent, he or she may continue to receive HARPS services.

d. HARPS Reporting. A monthly report format will be provided by DBHR and will be submitted to DBHR HARPS Program Manager or DBHR SH/SE Behavioral Health Program Administrator by the 15th of the following month.

e. Data Reporting: Encounters will be tracked for individuals receiving supportive housing services by the team. DBHR will work with each RSN to develop the codes or modify existing codes. Service Descriptions include:

(1) Housing Stability. Includes activities for the arrangement, coordination, monitoring, and delivery of services related to meeting the housing needs of individuals exiting inpatient settings and helping them obtain housing stability. Services and activities may include developing, securing, and coordinating services including:

(a) SSI/SSDI through SSI/SSDI Outreach, Access, and Recovery (SOAR)

(b) Affordable Care Act activities that are specifically linked to the households stability plan;

(c) Activities related to accessing Work Source employment services;

(d) Monitoring and evaluating household progress;

(e) Assuring that households' rights are protected; and

(f) Developing an individualized housing and service plan, including a path to permanent housing stability subsequent to assistance.

f. Housing search and placement. Includes services or activities designed to assist households in locating, obtaining, and retaining suitable housing. Services or activities may include: tenant counseling, assisting households to understand leases, securing utilities, making moving arrangements, representative payee services concerning rent and utilities, and mediation and outreach to property owners related to locating or retaining housing.

HARPS Participant Log

First Housing Placement															Discharge from HARPS project	
Last Name	First Name	Client ID	Date of Birth	First Contact	Location of first Contact	Date Housed	Housing Obtained By HARPS/Other (please specify)	Housing Type	Subsidy Amount	Purpose of Subsidy	Housing Change 1 Reason for change - Evicted/Voluntary move/Lease End	Date of Housing Change 1	6 months housing retention goal date	Achieved 6 mo. housing retention Yes/No	Date	Reason