County of Sacramento Department of Health Services Behavioral Health Services Policy and Procedure	Policy Issuer (Unit/Program)	Mental Health Services
	Policy Number	04-22
	Effective Date	
	Revision Date	02-10-25
Title: **Homeless Management Information System and the Coordinated Access System**	Functional Area: **Programs**	
Approved By: *Signed version available upon request.* Monica Rocha-Wyatt, LMFT Health Program Manager Sheri Green, LMFT Division Manager		

Background/Context:

The Sacramento region uses the Homeless Management Information System (HMIS) to track client data and manage referrals to housing and services for individuals and families at-risk of or experiencing homelessness. Access to shelter and housing through the homeless Continuum of Care (CoC) of requires clients to be enrolled in HMIS and referred through the Coordinated Access System (CAS). CAS prioritizes individuals with the highest vulnerability and service needs for available housing resources. To be included in the community's overall homeless needs and outcomes, Sacramento County Behavioral Health Services (BHS) requires that all consenting BHS clients enrolled in specialty mental health services who are also experiencing homelessness be enrolled by their BHS provider into HMIS.

Definitions:

A. Affordable Housing: Housing where rent/mortgage payments, including utilities, do not exceed 30% of gross income, according to the Department of Housing and Urban Development (HUD) guidelines.

B. Continuum of Care (CoC): The CoC is a community-driven initiative mandated by HUD to coordinate local efforts to prevent and address homelessness. The CoC brings together partners such as service providers, county and city departments, community-based organizations, and people with lived experience to create a collaborative approach to providing housing and services for individuals and families experiencing homelessness.

C. Case Conferencing Tool: An HMIS based tool which is used by services providers to collect demographic and biopsychosocial information. The tool is

utilized by members of the CoC to discuss and coordinate housing efforts and plans for those experiencing homelessness.

D. Coordinated Access System (CAS): A system designed to match people experiencing homelessness with housing and service options. People with the highest vulnerability are prioritized for housing resources, as quickly as possible. To be considered for housing slots through CAS, individuals must connect with a CoC provider and have a completed Housing Conversation Tool in HMIS.

E. Homeless Management Information System (HMIS): HMIS is a data tool that captures client-level information. Sacramento Steps Forward (SSF) is the lead agency for HMIS and CoC for Sacramento County. The goals of HMIS are to track the demographics of homelessness in Sacramento County and the movement of individuals experiencing homelessness. In addition to HMIS, behavioral health providers enter clients' homeless and housing statuses in SmartCare. Homeless status should match in both Smart Care and HMIS.

F. Homeless – Based on the definitions used by HUD and used for HMIS:

1. **Category 1** – Literally Homeless, living unsheltered outside, in a vehicle or other place not meant for human habitation or in homeless shelters.
2. **Category 2** – Imminent Risk of Homelessness (i.e., losing housing within 14 days without other housing identified or secured).
3. **Category 3** – Homeless under other Federal statutes. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition.
4. **Category 4** – Any individual who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing.

   For the purposes of this Policy and Procedure, "Domestic Violence" includes dating violence, sexual assault, stalking, human trafficking, and other dangerous or life-threatening conditions that relate to violence against the individual or family member that either takes place in their primary nighttime residence or the person is afraid to return to their primary nighttime residence.
5. **Chronic Homelessness** - Any individual who: (i) Is currently homeless; and (ii) Has been living in a place not meant for human habitation, a safe haven, or an emergency shelter continuously for at least 12 months, or on at least 4 occasions in the last 3 years, where combined occasions equal to at least 12 months, with each break in homelessness separating the occasions includes at least 7 nights of not living as described above; and (iii) Has a disability of a long and continued nature.

G. Housing Conversation Tool (HCT): A trauma-informed tool service providers complete to assess vulnerability used to prioritize individuals for housing

opportunities available through CAS. The HCT must be updated annually or when client housing or homeless circumstances change.

H. **Level of Intensity Screening Tool (LIST):** LIST is a clinical screening tool used to assess the level of care needs for mental health services, including eligibility for a Full-Service Partnership (FSP) program. Completion of the LIST is mandatory for all Adult FSP programs and the Transitional Aged Youth (TAY) FSP and is a prerequisite for linkage to one of these FSPs for clients to access BHS Permanent Supportive Housing. This tool ensures consistency in data collection by evaluating clients across various distinct functional domains.

I. **Rapid Re-Housing (RRH):** Short-term (up to three months) and medium-term (4-24 months) interventions, providing rental assistance and housing focused case management to stabilize individuals or families in permanent housing. Length of assistance is based upon need and evaluated on a month-to-month basis. Key elements of these services include assisting clients in searching for housing in the private rental market, negotiating with landlords, offering move in support, and providing short-term rental assistance.

J. **Permanent Supportive Housing (PSH):** Long-term permanent, affordable rental housing with the community-based supportive services to help people who are homeless. Clients enrolled in behavioral health services can access PSH through CAS, through our FSP continuum depending on eligibility or other privately funded PSH programming.

K. **Prevention Assistance & Re-Housing Services:** Flexible financial and service supports to prevent or resolve homelessness, including rental assistance, security deposits, and utility hook-ups.

Purpose:

To establish a consistent process for Sacramento County Mental Health Plan (MHP) providers to enroll clients experiencing homelessness into CAS, maximizing access to housing supports such as shelter, RRH, PSH, and affordable housing. Providers must ensure all consenting clients experiencing literal homelessness are included in HMIS and CAS to leverage community resources.

Details:

A. Program Philosophy and Design

Providers will integrate housing supports into treatment plans to address the impacts of homelessness on mental health and recovery. This includes offering flexible funding and leveraging community resources through CAS to resolve homelessness for Medi-Cal beneficiaries.

B. Program Target Population and Eligibility

1. Target Population: Individuals and families at-risk of or experiencing literal homelessness.

2. Eligibility: Clients identified as homeless through screening are eligible, unless they decline.

C. Basic Requirements

1. Staffing & Training:

Providers must maintain trained staff in HMIS, CAS tools, and data standards.

2. Client Data Entry

a. Record housing status and updates in both SmartCare and HMIS.

b. Ensure enrollment in HMIS for clients experiencing literal homelessness.

3. Assessments & Documentation:

a. Crisis Assessment Survey: For shelter referrals.

b. Housing Conversation Tool (HCT): For CAS prioritization.

c. Maintain required client documentation, including releases and case conferencing notes.

4. Service Entry:

a. Record at least one service every 90 days in HMIS.

b. Enter all housing-related activities (e.g., case management, rent assistance, housing readiness).

5. CAS Referrals:

a. Complete referrals promptly for eligible clients.

b. Use CAS resources when internal supports cannot resolve homelessness.

6. Participation in CoC Activities:

a. Attend CoC case conferencing and meetings.

b. Review data quality and share outcomes.

7. Exit Planning:

a. Record exit destinations in HMIS per standards.

Related Policies and Attachments:

- MH 04-19 Level of Intensity Screening Tool (LIST)
- MH 04-11 Prevention Assistance & Re-Housing Services

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