Housing and Behavioral Health:

A Guidebook for California Counties

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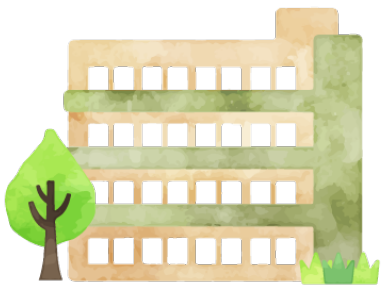


INTRODUCTION TO THIS GUIDE

Housing and the Behavioral Health System: A Shared Framework for Counties

This guidebook has been developed to introduce housing pathways within the behavioral health system and to provide practical resources that strengthen collaboration between county housing and behavioral health departments.

CalMHSA worked closely with key California subject matter experts and the Department of Health Care Services (DHCS) to ensure the guide is a practical tool for staff, providers, and stakeholders working to address housing challenges within the behavioral health system. It is intended to provide clarity, consistency, and alignment with statewide initiatives, regulations, and best practices, with three main goals in mind:

- **Clarify Housing Pathways** – to outline approaches that connect individuals with behavioral health needs to safe, stable, and supportive housing.
- **Foster Collaboration** – to provide tools that enhance cross-department coordination between housing and behavioral health systems at the county level.
- **Support Implementation of the Behavioral Health Services Act (BHSA)** – to ensure that counties have guidance tailored to the evolving policy landscape and expectations under the BHSA.

By integrating housing and behavioral health services, California counties can more effectively promote recovery, independence, and long-term stability for individuals and families. CalMHSA has adapted this guidebook with the aim of providing both a shared framework and practical resources to help counties succeed in this important work.

Acknowledgment

This guidebook is the result of collaboration between multiple partners and CalMHSA with funding by the Department of Health Care Services. The original content was authored by three respected resources in the fields of housing and behavioral health: Barbara L. Mitchell, MSW, non-profit management consultant; Abt Global Services; and Homebase. Their contributions provide the foundation for the guidance presented here.

CalMHSA extends its gratitude to California counties, behavioral health leaders, housing agencies, and community partners whose ongoing work and feedback continue to shape effective housing pathways. Their dedication ensures that this guidebook is not only a reflection of best practices, but also a practical tool for real-world implementation.

Together, these combined efforts demonstrate a shared commitment to expanding access to housing as a cornerstone of behavioral health recovery and community wellness.

Housing Basics: A Guide for County Behavioral Health

Stable housing is more than a basic need—it is the foundation for wellness, recovery, and long-term stability. For individuals experiencing homelessness, especially those navigating behavioral health challenges, access to safe and supportive housing can be life changing.

Behavioral health staff play a vital role in bridging systems that too often operate in isolation. By learning the basics of housing programs, understanding how to engage with the local homelessness response system, and fostering strong partnerships with Continuums of Care (CoCs), you help open critical pathways to housing for people who may otherwise be left out.

This guide is designed to support your efforts and help you feel confident and connected. Whether you're taking your first steps in engaging with the housing system or expanding your work with local partners, and as you continue to uplift those you support, ask questions, build relationships, and work across systems, your contributions will matter deeply in the shared effort to ensure everyone has a place to call home.

The Role of Behavioral Health in Housing

Stable housing is one of the most important social determinants of health. Without a safe place to live, individuals face greater barriers to recovery from mental illness, substance use, and chronic physical health conditions. Housing is more than shelter—it's a foundation for care, stability, and dignity.

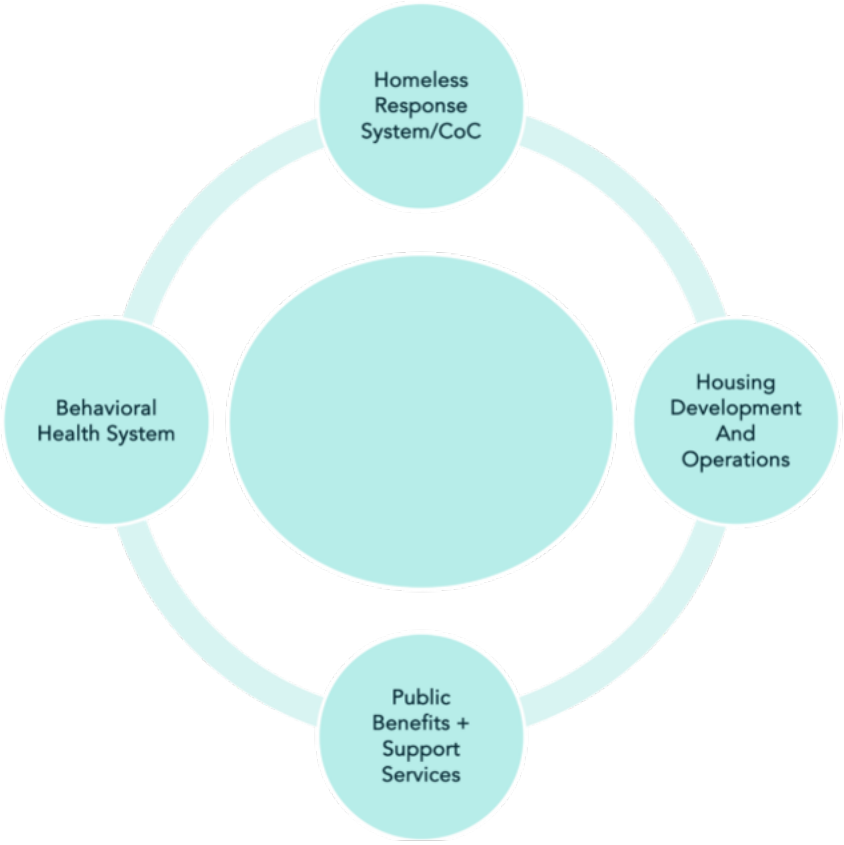
Collaborating with the housing and homelessness response system helps behavioral health providers better support recovery and stability. By working together, providers can connect clients to safe, stable housing and related resources that address the social and environmental factors impacting their health and well-being. In turn, the housing and homelessness system benefits from behavioral health expertise that can help people maintain housing and reduce the risk of returns to homelessness.

Finding housing for clients with behavioral health needs is often confusing and frustrating. Behavioral health staff must navigate a patchwork of systems, funding rules, and documentation requirements. These complex systems, while each serving important functions, can create navigation challenges that delay placements and require additional coordination to connect people to stable housing that supports recovery.

Behavioral health agencies are vital partners in the homelessness response. Their involvement strengthens the housing system's ability to serve people with complex needs. Behavioral health agencies:

- Help clients access services that prevent or end homelessness.
- Provide essential services that help clients stay housed (rental assistance, case management, medication support, etc.)
- Provide stability for mental health through supportive services and resources
- Partner with communities, housing providers, and in some cases, Medi-Cal managed care plans to design programs for people with diverse needs

To effectively connect clients to housing, behavioral health staff need to understand and engage with four key system participants. These include the homeless response system (which includes the Continuum of Care (CoC)), housing development and operations, public benefits and support services, and the behavioral health system — **all of which control critical pieces of the housing access puzzle.**



Understanding Homelessness and Housing Systems

Behavioral health agencies should understand that much like primary and behavioral health care systems and services, the homelessness response and housing "system" is quite fragmented and involves multiple agencies that often operate in silos. In your county or community, homeless services, including specialized housing programs like permanent supportive housing for people experiencing homelessness, are organized into Continuums of Care. Federal housing programs like public housing and Housing Choice vouchers (the most widely available rental assistance program) are administered by public housing authorities (PHAs). Another set of county or municipal housing agencies administer capital programs that help finance the construction of affordable housing. These separate actors—the Continuum of Care, public housing authorities, and county or municipal housing development agencies—may be more or less coordinated depending upon your community. It is important to know and understand each of these actors and agencies to maximize access to housing for people with behavioral health needs.

Who Facilitates Access To Housing?

Helping people secure housing often involves multiple partners working together. The homeless response system that is coordinated through the CoC manages access to most housing resources, generally through the Coordinated Entry System (CES). Behavioral health providers connect people to essential services and help navigate housing resources. Public housing agencies and housing developers create and manage affordable units. Public benefits programs, such as SSI, CalFresh, and Medi-Cal, provide the income and support that help people remain housed. Each plays a role in ensuring people with behavioral health needs can access and maintain stable housing.

Behavioral Health System

The behavioral health system helps facilitate access to housing. In California, the system includes:

- **County Behavioral Health Departments:** Serving seriously mentally ill clients and persons with substance use disorders who need support services as well as housing (e.g., Behavioral Health Bridge Housing, No Place Like Home, MHSA-funded housing programs).
- **Substance Use Treatment Providers:** May have access to housing subsidies (e.g., SUD housing pilots, CalAIM funding streams).
- **BHSA Program Leads:** Oversee housing intervention requirements under the BHSA and the new facilities funded through Prop. 1, as well as the previously funded interim, bridge, and permanent housing connected to behavioral health care.
- **Medi-Cal Managed Care Plans:** Provide Medi-Cal services to address mild to moderate behavioral health (BH) issues and help unhoused members apply for, secure, and sustain housing. The "housing trio" is part of the 14 Community Supports under CalAIM and includes Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services. Beginning on January 1, 2026, MCPs are required to cover Transitional Rent for members meeting specified BH and other eligibility criteria.

Public Benefits and Support

Beyond housing-specific agencies, several service systems offer housing assistance as part of their broader missions. These programs can be critical access points for targeted populations, helping connect people to housing resources as well as other services.

- **Social Services Agencies (e.g., CalWORKs, General Assistance):** May have housing assistance for eligible families or individuals
- **Veterans Affairs (VA):** Administers housing access through medical centers, county VA officers, and funding streams (e.g., GDP, SSVF)
- **Adult and Aging Services / APS:** Often serve vulnerable older adults at risk of or experiencing homelessness with access to housing programs
- **CalAIM Housing and Community Supports:** Through Medi-Cal managed care plans (MCP), provide enhanced care management services and the housing trio to Medi-Cal beneficiaries with behavioral health needs or who are experiencing homelessness. Beginning January 1, 2026, MCPs will be required to cover a six-month transitional rent benefit for members meeting the behavioral health population of focus and who have a housing support plan in place.

Ways to Engage with Public Benefits and Support

Connecting individuals to public benefits and support programs is essential for securing and maintaining stable housing. By building strong referral networks with eligibility workers, collaborating with Managed Care Plan leads, and partnering with legal aid advocates, providers can help streamline access to critical benefits and address barriers that might otherwise delay or prevent housing stability by:

- **Building referral relationships with eligibility workers** at local social services agencies to streamline applications for Medi-Cal, SSI, CalWORKs, or GA.
- **Collaborating with CalAIM Community Supports leads** at Medi-Cal MCPs to identify mutual clients and align housing support services.
- Building relationships with **legal aid** and public benefits advocates to help clients overcome documentation or benefits access issues.

Homeless Response System/Continuum of Care

In the broader community, access to housing is facilitated by a network of partners, each of whom play a distinct role in helping people move from homelessness to stability. From system-level coordination to direct client engagement, these groups work together to connect people with the housing and support they need. Together, these partners form a Homeless Response System. Common partners include:

- **Continuum of Care (CoC):** A local or regional planning body that coordinates the community's response to homelessness through a broad group of stakeholders, with a designated Lead Agency responsible for managing housing programs, overseeing HMIS, and administering HUD and other funding sources
- **Coordinated Entry System (CES) Operators**: Governed by the CoC, they match clients to available housing resources based on vulnerability and need.
- **Homeless Outreach Teams**: Identify and engage unsheltered individuals, often the first connection to housing services.
- **Emergency Shelter and Transitional Housing Providers**: Offer immediate shelter and connect clients to permanent housing.
- **Permanent Housing Providers:** Offer Rapid Rehousing (time-limited assistance) and Permanent Supportive Housing (non-time-limited assistance).

Continuum of Care (CoC)

Every community receiving federal homelessness funding has a CoC. These are the organizations responsible for coordinating housing and services across cities and counties.

A CoC is a local or regional planning body that coordinates housing and services for people experiencing homelessness. Each California county (or group of counties) has a CoC. You can find your local CoC here. California CoCs are responsible for:

- Managing the Coordinated Entry System (CES)
- Applying for HUD funding and overseeing local housing programs
- Managing all funding applications relevant to serving those experiencing homelessness
- Tracking number of people experiencing homelessness through the Point in Time (PIT) count
- Prioritizing access to housing resources
- Convening housing and service providers to collaborate on systemwide goals
- Maintaining the Homeless Management Information System (HMIS)

Coordinated Entry System

CoCs use a system called Coordinated Entry (CES) to streamline access to housing programs and ensure those with the highest needs are prioritized. The CES assesses and prioritizes people who are at risk of or experiencing homelessness and refers them to housing resources. Essentially, the CES is the primary point of entry to the homeless system of care. Key features include:

- Standardized assessments to understand client needs
- Prioritization based on vulnerability and housing barriers
- Matching people to available housing programs (e.g., Permanent Supportive Housing, Rapid Re-Housing, etc.)

The Behavioral Health Services Act (BHSA) requires entry into HMIS for services and housing provided to clients under the Housing Interventions category of BHSA, but county BH is not required to work through the CES to place clients.

Ways to Engage with the Homeless Response System/CoC

Active participation in the homeless response system helps behavioral health providers connect clients to housing more efficiently and strengthen community partnerships. By joining collaborative forums, building direct relationships, and staying up to date on housing initiatives, providers can position themselves — and their clients — to take advantage of emerging opportunities.

Some opportunities for behavioral health teams to become more involved with the CoC include:

- Joining your local **CoC meetings or workgroups** to remain informed about housing opportunities
- Invite your CoC staff to your Integrated Plan development meetings
- Identify your HMIS lead within the CoC and begin discussions on the addition of the BHSA project build into HMIS
- **Building direct relationships** with coordinated entry operators and housing navigators to coordinate referrals
- **Co-locating staff** or joining case conferences with homeless services providers to share client updates and reduce duplication
- **Participating in "housing pipeline" groups** hosted by homeless coalitions or CoC lead agencies. These meetings provide updates on housing projects in development and create opportunities to identify potential partnerships with the behavioral health system. While these types of groups may not exist in every community, some CoCs have committees dedicated to housing development. Once connected with your local CoC, ask whether there are committees that discuss the housing pipeline or new project opportunities

This worksheet helps county behavioral health providers learn how to work with their local CoC and the CES. Use it to gather key information, identify partners, and prepare for collaboration with CoCs and the CES.

Housing Development and Operations

In addition to homeless service providers, housing access depends on key partners who supply and manage the physical units and funding that make stable housing possible. These organizations shape availability, affordability, and the pathways clients can use to secure long-term homes.

- **Public Housing Authorities (PHAs):** Administer Section 8/HCV, Emergency Housing Vouchers (EHVs), HUD-VASH and other subsidies. Note: EHV funding expires in 2026.
- **Affordable Housing Developers and Operators:** Build and manage permanent supportive housing or other affordable units
- **Property Managers and Landlords:** Gatekeepers for units — relationships and landlord incentives can improve access
- Local City or County Housing Departments: Oversee funding streams (e.g., HOME, CDBG, state/local bonds) and typically fund tenant-based rental assistance through contractors rather than providing it directly. Some cities and counties also own or control inclusionary housing units that can provide affordable options.

Ways to Engage with Housing Development and Operations

Engaging with housing providers and local housing departments strengthens the ability to connect clients to safe, affordable homes and prevents housing loss. Building partnerships with property managers, staying informed about available units and subsidies, and linking clients to landlord incentives and tenancy supports can improve placement success and promote long-term housing stability.

This worksheet helps county behavioral health providers learn how to work with their local Public Housing Authority (PHA). Use it to gather key information, identify partners, and prepare for collaboration with PHAs.

Basic Housing Models to Know

Understanding the different housing programs can help you determine which options may best support the people you serve. Each program type offers different levels of support and duration. HUD categorizes housing as follows and these categories are used within HMIS:

- **Emergency Shelter: Entry/Exit:** Any housing assistance and service delivery for people experiencing homelessness that is temporary that doesn't include tenancy rights for the clients.
- **Emergency Shelter:** Night-by-Night: Nightly shelter stays or hotel/motel vouchers.
- Permanent Housing (PH) – Rapid Rehousing (RRH): Rental assistance and/or services with tenancy rights.
- **Rapid Re-Housing (RRH) Subtypes:** RRH: Services Only OR RRH: Housing with or without services
- **Supportive Services Only (SSO):** Any service delivery that is connected to or explicitly provides housing but is housing that would otherwise create a "break" in homelessness or chronic homelessness per CoC guidance for assessment and prioritization for PSH. Includes auxiliary funding for assisted living. This project type should only be used when project activities do not fit into one of the previously mentioned project types.

Each model plays a role in the broader housing system. Behavioral health clients may be eligible for multiple types, depending on their needs and circumstances.

Behavioral Health Services Act Allowable Settings

The Behavioral Health Services Act (BHSA) specifies the allowable settings that can be funded and differentiates between time-limited interim settings and non-time-limited permanent settings.[1]

Non-Time-Limited Permanent Settings	Time Limited Interim Settings
· Supportive housing · Apartments, including master-lease apartments · Single and multi-family homes · Housing in mobile home communities · Single room occupancy units · Accessory Dwelling Units, including Junior Accessory Dwelling Units · Tiny homes · Shared housing · Recovery/Sober Living housing, including recovery-oriented housing · Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care) · License-exempt room and board · Other settings identified under the Transitional Rent benefit*	· Hotel and motel stays · Non-congregate interim housing models · Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls) (does not include behavioral health residential treatment settings) · Recuperative care · Short-Term Post-Hospitalization housing · Tiny homes, emergency sleeping cabins, emergency stabilization units · Peer respite · Other settings identified under the Transitional Rent benefit* **As of 9/5/25, no other settings are included under the Transitional Rent benefit than what is listed above.*

1 Allowable Settings, Section 7.C.9.3, Behavioral Health Services Act County Policy Manual, DHCS, Version 1.3.0 – June, 2025

Types of BHSA Housing Options

Different housing types are often better suited for different populations, recognizing that no single model works for everyone. The BHSA supports a range of housing options that address both immediate housing needs and long-term stability. These housing types are designed to meet individuals where they are, offering varying levels of structure, support, and independence. By offering flexible housing pathways, the BHSA promotes recovery, independence, and overall wellness while ensuring that each person has access to the right level of care at the right time.

Market Rate / Affordable Housing

These units provide safe, stable housing for individuals and families who may not require intensive onsite services but still face affordability as the primary barrier to housing. Market-rate housing is typically out of reach for people experiencing homelessness without subsidies, while affordable units become viable options when deed restrictions or rental subsidies (project-based or tenant-based) are available.

This housing model works best when paired with case management or light supportive services to ensure stability for tenants with behavioral health needs.

Best served populations:

- **Independent adults with behavioral health needs** – Individuals who are engaged in outpatient care or otherwise stable but need affordable housing to avoid homelessness.
- **Families with limited income** – Parents or caregivers who may benefit from community-based behavioral health services but do not need intensive daily support.
- **Individuals at risk of homelessness** – People whose main barrier is affordability, rather than requiring a high level of onsite service coordination.
- **Tenants with rental assistance** – Individuals or families able to use project-based or tenant-based vouchers to make market-rate or affordable units financially accessible.

Units are available as market-rate or affordable housing, depending on eligibility.

Some examples include:

Accessory Dwelling Units (ADU): Smaller, independent residential dwelling units located on the same lot as a stand-alone primary residence.[2]

Best served populations:

- Single adults exiting homelessness – Particularly those who can live independently with light to moderate case management support.
- Transition-aged youth (TAY) – Young adults leaving foster care or facing homelessness who benefit from small, supportive, and community-integrated housing.
- Older adults/seniors – Individuals with behavioral health needs or fixed incomes who require affordable, independent units in residential areas.
- Small households with minimal service needs – People whose primary barrier is affordability, not intensive onsite supports.
- Considerations: Accessory Dwelling Units (ADUs) are not inherently affordable unless deed restricted. They typically consist of one or two units built on the site of a single-family home, though some have been added to larger projects. When tenants require on-site supportive

2 California Department of Housing and Community Development. Accessory Dwelling Unit Handbook. January 2025. Accessed April, 2025.

services, space for those services may be limited. If ADUs are located near family housing, it is important to assess whether tenants can comfortably live in such close proximity to the main property. One strategy is to prioritize developing ADUs on sites that already provide affordable housing.

Shared Housing offers tenants their own private bedrooms and bathrooms, with common areas like kitchens and living rooms. This model helps maximize the number of people served and can provide built-in peer support through shared living. Agencies have found that outcomes are stronger when tenants are not required to share bathrooms, making this the preferred approach. In most models, the maximum number of unrelated tenants per household is six. Bedrooms are individually leased (or may be leased to two persons), and tenants share the common areas of the house, such as the kitchen, living room, dining area, and bathrooms. Utilities are generally included in the rent if the property is owned or master-leased by a non-profit agency, or the tenants may be required to share utility costs. As well as the maintenance of the household by dividing duties such as cleaning or trash removal.

Best served populations:

- Adults who can live independently but benefit from peer interaction and community.
- Individuals transitioning out of homelessness who may not yet be ready for complete independence.
- Tenants with limited rental assistance where shared housing helps stretch resources.
- Young adults or older adults seeking community and reduced isolation.

Shared Housing for Families

For related family members, shared housing is structured similarly where multiple families live within a single property, but each household has its own private space—typically one or more bedrooms and a dedicated bathroom. Kitchens, living rooms, laundry areas, and outdoor spaces are shared among families, creating a communal environment while maintaining privacy for each household.

Best served populations:

- Families exiting homelessness who need affordable housing but can share common areas.
- Parents with children who would benefit from peer support from other families in similar situations.
- Families with limited rental assistance, where shared housing helps maximize resources.
- Households seeking a bridge option before moving into fully independent permanent housing.

Considerations: Most shared housing models do not have shared bedrooms. Shared housing may be more affordable if there are shared bedrooms; however, shared bedrooms for persons who are unrelated may make the housing less desirable due to lack of privacy, make it harder to maintain full occupancy, and may require more oversight and supervision from the property owner/ manager or a support services provider. Any type of shared housing, even without shared bedrooms, generally requires more staff oversight as tenants may have more conflicts over shared space, cleaning, guests, and other household management.

According to the DHCS Community Supports Policy Guide (Vol. 2), "Shared housing is an effective way to make housing more affordable, to maximize available housing stock and to decrease isolation for people not used to living alone. Typically, each household has its own lease or sublease, and shares expenses like utilities. Rent is split by the number of bedrooms."[3]

3 DHCS-Community-Supports-Policy-Guide-Volume-2.pdf

Generally Affordable Housing Types Allowable Under BHSA Housing

Supportive Housing: This model combines deeply affordable housing with wraparound supportive services and is designed to serve people with the most significant barriers to housing—those experiencing chronic homelessness with co-occurring serious mental health and/or substance use disorders. Case management and services are provided on a long-term basis, with support scaled to the tenant's needs. This is considered permanent housing, without a limit on length of stay, occupied by the target population and connected to services designed to help residents maintain housing stability, improve health, and maximize independence, including participation in community life and, when possible, employment. Usually, supportive housing has rental subsidies which make it more affordable, although some properties may require tenants to provide tenant-based vouchers.

Best served populations:

- Individuals experiencing chronic homelessness with serious mental illness and/or substance use disorders.
- People with high service needs who require intensive, ongoing case management.
- Tenants cycling between homelessness, hospitals, and/or the criminal justice system.
- Those for whom stable housing is the foundation for recovery and wellness.

Considerations: Supportive housing offers the highest level of stability for individuals experiencing homelessness with serious mental illness, substance use disorders, or other high service needs. Because housing is paired with onsite or closely linked services, tenants receive ongoing support to maintain housing and address health, recovery, and wellness goals.

However, supportive housing typically requires significant funding for both operations and services, making it more costly to sustain compared to other housing models. In addition, supportive housing may concentrate tenants with high needs in one location, which can require intensive property management, higher staffing levels, and strong collaboration between housing providers and behavioral health teams. While this model is highly effective for long-term stability, it may not be the right fit for individuals who could succeed in more independent or less service-intensive settings.

Transitional Housing: Sometimes also called bridge housing, this shorter-term housing option provides immediate shelter and stability while tenants work toward securing permanent housing. Services are focused on stabilization, connection to treatment, and preparation for long-term housing solutions. Stays are typically time-limited, but support is designed to reduce barriers and ensure successful transition.

These buildings or units are usually configured as rental housing developments but are operated under programs that require an end date to the assistance to make the unit available to another program recipient at a set future date, at least six months after the start of assistance.

Best served populations:

- Individuals exiting homelessness who need temporary housing while awaiting a permanent unit or voucher.
- People leaving institutions (e.g., hospitals, treatment programs, or jail) who need an interim place to stabilize.
- Tenants new to services that require a structured environment before moving to independent housing.
- Individuals in crisis that need safe, short-term housing with connections to care.

Considerations: There are generally no tenant-based federal housing vouchers for transitional housing. The county behavioral health system may need to provide rental subsidies, either through

project or tenant-based vouchers. Transitional housing is also time-limited, which can be challenging if permanent housing options are scarce. When exits to permanent housing are delayed, stays may extend beyond the intended timeframe, reducing turnover and limiting the number of people served. In addition, transitional housing projects require ongoing funding for operations and services, which can be a challenge to sustain. For some tenants, the temporary nature of the model may feel destabilizing compared to immediate access to permanent housing.

License Exempt Room and Board are defined as any house, institution, hotel, or other similar place that supplies room and/or board only, if no care and/or supervision is provided or made available. These homes provide shared living environments where tenants rent a room and receive basic services such as meals and utilities, but the housing does not operate as a licensed residential care facility. Oversight and services are generally lighter than in licensed programs, with an emphasis on providing affordable housing paired with a safe, stable environment. However, this does not preclude care and/or supervision provided for brief and irregular periods of time for reasons such as temporary illnesses or emergencies, if such is determined to be minor and temporary and does not require 24-[4]

Best served populations:

- **Adults with behavioral health needs who do not require 24/7 care** – Individuals who are largely independent but benefit from a structured setting with meals and some support.
- **People exiting homelessness with limited income** – Especially those unable to afford independent housing but not needing intensive clinical oversight.
- **Older adults or adults with disabilities** – Tenants who need assistance with daily meals or basic supports but do not qualify for, or wish to live in, licensed care facilities.
- **Individuals in recovery or stabilization** – People who may benefit from a semi-structured environment while working toward independent or permanent supportive housing.

Considerations: License-exempt room and board homes can provide an affordable, semi-structured housing option for individuals who may not need or qualify for licensed residential care and often fill a gap for people exiting homelessness who need more structure than independent housing but less oversight than a treatment facility.

This option is not suitable for anyone needing "care and supervision," but may be an option for someone who needs food service provided with housing. It is unsuitable for tenants who need central storage and assistance with medication management. Some license-exempt room and board sites may use shared bathrooms. It is rare to find these types of settings with enforceable leases, and tenant protections may be minimal.

Because these homes are not licensed, the level of oversight, quality, and services can vary greatly. Tenants may have limited privacy and autonomy, especially if meals and household routines are highly structured. Conflicts can arise in shared living environments, and some homes may lack formal connections to behavioral health providers, requiring outside coordination for care. Sustainability of operations can also be a concern, as room and board homes often rely on tenant income (such as SSI/SSDI) without significant subsidy streams.

Housing Options Specifically for Older Adults and/or for Persons Needing Care

Independent Living

Independent living is a housing model where individuals or families maintain their own private unit and live autonomously, without onsite staff or structured daily supports. In this context, the focus is on providing safe, affordable housing while allowing tenants to make their own choices about services and supports.

4 California Code of Regulations -22 CCR § 87107

For people experiencing homelessness with behavioral health needs, independent living often relies on rental subsidies (such as Housing Choice Vouchers) to make units affordable. Support is typically provided through community-based case management, outpatient behavioral health services, or peer support, which tenants may engage in voluntarily.

This model is designed to promote self-sufficiency, stability, and community integration. It acknowledges that with the right housing and access to flexible services, many individuals with serious mental health or substance use disorders can successfully live independently.

Best served populations:

- Individuals or families whose primary barrier is affordability, not daily supervision.
- Adults in recovery who benefit from outpatient or community-based services.
- People ready to transition from supportive housing, transitional housing, or institutional care to a more autonomous setting.
- Families with children who need long-term housing stability but not intensive onsite services.

Considerations: Independent living provides the highest level of autonomy, privacy, and choice for individuals and families, allowing them to fully manage their household, routines, supporting recovery and long-term stability. When paired with rental subsidies and voluntary community-based services, it can be one of the most cost-effective and empowering housing models.

However, independent living may not be appropriate for individuals who need frequent onsite support, close supervision, or assistance with daily living activities. Without engagement in services, some tenants may struggle with responsibilities, including lease compliance or maintaining stability, particularly if behavioral health symptoms or substance use are not well managed. Access can also be limited by the availability of affordable units and rental subsidies, which are often scarce.

Assisted Living (Adult Residential Care Facilities, Residential Care Facilities for the Elderly, and Licensed Board and Care Facilities)

Assisted living and licensed care facilities provide housing with built-in supports such as meals, medication management, supervision, and help with activities of daily living (ADLs). These environments are structured, staffed, and regulated to ensure safety and stability for residents who cannot live fully independently. Although these facilities don't have leases, adult residential facilities and residential care facilities for the elderly — also known as board and care facilities — may be long- or short-term housing with care and supervision. According to the California Code of Regulations, "Such facilities provide 24/7 care to people who require it due to cognitive impairment or inability to perform activities of daily living (ADLs), along with room and board. These settings may be appropriate for some people experiencing homelessness who have serious behavioral health conditions, require assistance with ADLs, or have severe cognitive impairment."5 All residential care facilities and board and care facilities require licenses from the California Department of Social Services Community Care Licensing Division.

Best served populations:

- **Older adults (seniors) experiencing homelessness** who have behavioral health needs and require support with daily living tasks.
- **Adults with serious mental illness (SMI)** who benefit from a structured environment, supervision, and medication management.
- **Individuals with co-occurring behavioral health and physical health conditions** that limit their ability to live independently.
- **People transitioning from institutional care** (psychiatric hospitals, skilled nursing facilities, or jail) who are not yet able to manage in independent or semi-independent housing.

- **Adults with developmental disabilities or cognitive impairments** who need 24/7 supervision or ongoing support in a residential setting.

Considerations: Assisted living and licensed care facilities provide a highly structured and supportive environment for individuals who cannot live independently due to behavioral health conditions, age-related needs, or co-occurring physical health issues. With staff available around the clock, residents receive help with meals, medication management, and activities of daily living (ADLs). This level of care ensures safety, stability, and continuity of support for some of the most vulnerable populations.

However, these settings are more restrictive than independent or supportive housing and limit personal autonomy. They can also be costly, requiring sustainable funding streams such as SSI/SSDI, Medi-Cal, or county behavioral health contracts. Availability is often limited, particularly for facilities willing to serve people with serious mental illness or co-occurring substance use disorders. In addition, some residents may view assisted living as institutional rather than community-based, making them less attractive. Finally, under the 1999 U.S. Supreme Court Olmstead vs. L.C. decision, states must provide services for persons with disabilities in the most integrated community setting appropriate to their needs, in the least restrictive settings possible.[5]

For a complete list of residential settings, see DHCS' Behavioral Health Settings, Services, and Funding Sources Infographic.

Landlord Engagement

Lasting solutions to homelessness require collaboration across communities. Engaging landlords of privately owned homes and apartments is critical to expanding housing options for people experiencing homelessness. While not every community has a Flex Pool Operator responsible for securing a portfolio of units, dedicated staff or a formal landlord engagement program, building trust and offering support can increase landlords' willingness to rent to tenants with barriers such as criminal records or past evictions.

Strategies to effectively engage landlords can include:

1. Building Relationships and Trust
   - Dedicated landlord liaison: Identify a single point of contact who can respond quickly to landlord concerns
   - Regular communication: Keep landlords updated on tenant progress and available supports
   - Recognition efforts: Publicly acknowledge and celebrate landlord partners through events, newsletters, or certificates
2. Providing Financial Incentives
   - Risk mitigation funds: Offer reimbursement for unpaid rent, property damage, or legal costs
   - Sign-on bonuses or holding fees: Compensate landlords for leasing units to program participants or holding units during tenant placement
   - Guaranteed rent: Partner with agencies that ensure timely payment, reducing financial uncertainty
3. Offering Ongoing Support Services
   - Case management: Provide tenants with ongoing support to help them succeed in housing
   - 24/7 response line: Ensure landlords can reach someone quickly if issues arise

5 California Olmstead Plan Update on its Implementation, November 2012, California Health and Human Services Agency

- Mediation services: Help resolve conflicts between landlords and tenants before they escalate

4. Building Relationships and Trust
   - Dedicated landlord liaison: Identify a single point of contact who can respond quickly to landlord concerns
   - Regular communication: Keep landlords updated on tenant progress and available supports
   - Recognition efforts: Publicly acknowledge and celebrate landlord partners through events, newsletters, or certificates
5. Highlighting Community Benefits
   - Promote success stories: Share examples of landlords who have had positive experiences
   - Frame as partnership: Emphasize how landlords are part of the solution to homelessness
   - Community impact messaging: Show how participating contributes to stronger, healthier neighborhoods

The BHSA Housing Intervention category of expenditures allows funds to be spent on "other housing supports" that include Landlord Outreach and Mitigation, Participant Assistance, and Housing Transition Navigation Services and Housing Tenancy and Sustaining Services as long as the services cannot be covered as a Medi-Cal Community Support through the individual's Medi-Cal MCP. Please see the Flexible Housing Subsidy Pools discussion in the Types of Housing Resources and Funding Sources section. Flex pools are an important tool for braiding different housing funding sources and particularly helpful for implementing landlord engagement services.

Community Examples of Landlord Engagement Activities

Example 1 – Regional Partnership Approach

Some housing providers and systems maintain large-scale landlord engagement programs that focus on building strong partnerships with property owners to increase housing access for people experiencing homelessness. These programs often reduce risk for landlords by offering financial incentives, covering deposits and potential damages, and ensuring timely rental payments. Tenants benefit from ongoing case management, mediation, and access to support teams, while landlords gain peace of mind knowing there is a reliable partner to help address issues quickly. With dedicated housing specialists, these models can create a steady pipeline of available units by building trust and long-term relationships with landlords.

Example 2 – Countywide Collaborative Approach

At the county level, landlord engagement programs may be coordinated by local nonprofits, government agencies, or coalitions to expand rental opportunities for households with housing vouchers. These programs typically provide property owners with financial incentives such as move-in bonuses or damage mitigation funds, paired with streamlined payment systems and responsive customer service. Tenants receive housing stabilization support, while landlords have a direct point of contact for problem-solving. This type of collaborative approach has demonstrated success in rapidly housing large numbers of people while maintaining high rates of stability and retention.

The following resources may be helpful:

Effective Property Management Engagement Strategies: Addressing the Housing needs of Individuals with Serious Mental Illness, Substance Use Disorders, and Co-Occurring Disorders

These brief highlights ways to showcase service providers' strengths and resources to property managers, create a clear agency pitch, connect with existing rental housing networks or build new ones when needed, and establish formal partnerships between providers and property management.

Housing Alliance of Pennsylvania Landlord Engagement Toolkit
Practical resource for homelessness systems. Offers sample engagement plans, marketing tools, incentive menus, and templates for outreach and focus groups. Designed for system-level coordination.

By using these approaches, communities can make it easier for landlords to say yes helping more people find a safe, stable place to call home.

Example 3—Dedicated Landlord Engagement

One of the benefits of Flex Pools is dedicated landlord engagement provided by a Flex Pool Operator. Flex Pool Operators are responsible for securing an inventory of units, eliminating the need for participants to compete with the entire private housing market. Flex Pools offer financial incentives and streamlined payment systems to support landlord engagement, and they also may creatively deploy rental subsidies opening the door to strategies such as master leasing, shared housing, and non-traditional housing options.

The following resources may be helpful:

Effective Property Management Engagement Strategies: Addressing the Housing needs of Individuals with Serious Mental Illness, Substance Use Disorders, and Co-Occurring Disorders
These brief highlights ways to showcase service providers' strengths and resources to property managers, create a clear agency pitch, connect with existing rental housing networks or build new ones when needed, and establish formal partnerships between providers and property management.

Housing Alliance of Pennsylvania Landlord Engagement Toolkit
Practical resource for homelessness systems. Offers sample engagement plans, marketing tools, incentive menus, and templates for outreach and focus groups. Designed for system-level coordination.

By using these approaches, communities can make it easier for landlords to say yes helping more people find a safe, stable place to call home.

Changewell Project: Landlord Engagement Guide
Step-by-step guide to creating a landlord engagement program. Offers a variety of strategies for landlord recruitment and for helping participants transition to new housing.

Flexible Housing Subsidy Pools

Flexible Housing Subsidy Pools ("Flex Pools") are a program model for centrally administering rental assistance and coordinating related housing supports that can help County BH and MCPs maximize coverage for eligible services. Flex Pools help people who are experiencing or at risk of homelessness enter and maintain stable long-term housing. Core functions of a Flex Pool include:

- Coordinating and braiding funding streams (including new funding available under Transitional Rent, BHSA Housing Interventions);
- Facilitating compliance and required reporting;
- Acting as a single fiscal intermediary between funders and landlords;
- Identifying, securing, and supporting a portfolio or units; and
- Coordinating with providers of housing supportive services.

County BH may serve as the lead entity of their local flex pool or they may choose to fund and refer eligible individuals to a flex pool led by a MCP, CoC, or other government entity. Lead entities develop the administrative and operating plan for the flex pool and aggregate and administer the multiple funding sources required to achieve the flex pool core functions.

Behavioral Health Services Act Housing – Why Partnerships Matter

Partnering with affordable housing developers will help county behavioral health systems to obtain more housing opportunities for clients with serious behavioral health issues. Many developers need and want opportunities to house and serve behavioral health clients if the behavioral health system provides the resources and supportive services necessary to help the tenants be successful.

Resources that behavioral health systems can offer include housing support services, behavioral health services, and rental subsidies, either through tenant-based rental subsidies or project-based rental subsidies. Behavioral health systems and Medi-Cal Managed Care Plans can also offer support to clients moving into housing, such as funding for deposits, furnishings, and initial household supplies.

For partnerships to work, behavioral health systems need to consider the needs of both the tenants and the housing owner or developer/ operator. Some developers are admittedly able to provide financing and construction and even ongoing property maintenance but certainly not support for behavioral health clients, so they have developed partnerships with those who can.

Another important perspective is the value of partnerships for housing developers who are seeking competitive capital grants and loans to fund affordable housing projects in California. Affordable housing proposals — including those for senior housing — generally need to include a portion of units designated for formerly homeless individuals in order to remain competitive for government grants and tax credits. Funding programs often prioritize projects that incorporate these set-asides in their scoring criteria, and some offer additional incentives to encourage developers to include units for people exiting homelessness. So, they work with partner agencies to help identify tenants and support the ongoing stability of the units.

Helpful Links & Resources:

- Webinar: Pathways to Housing 101: Navigating Access for Clients with Behavioral Health Needs
- Webinar: Diving Deeper: Emerging Strategies for Behavioral Health Housing Engagement
- California CoC Contacts
- HUD Exchange: CoC Program Basics
  CalAIM Housing Services Overview
- Homeless Response 101 for Healthcare Providers and Stakeholders
- Collaborating with Health System Partners: Why, Who, and How?
- Homebase Webinars on Health Care-Homeless Response System Collaboration
- DHCS Housing for Health
- Flexible Housing Subsidy Pools Technical Assistance Resource

Definitions & Guidelines

Understanding the Definitions of Homelessness

Definitions of "experiencing homelessness," "at-risk of homelessness," and "chronically homeless" differ by funding sources. It is important to understand the differences for each program to know how eligibility may differ.

Many of California's state programs rely on the federal definitions that apply to HUD programs authorized by the McKinney-Vento Homeless Assistance Act, with modifications in some areas for some programs. The McKinney-Vento Act is the authorizing legislation governing the HUD Continuum of Care Program that funds numerous permanent supportive housing and transitional housing projects for homeless persons in California.

Even within California's programs, there are differences in definitions for different programs. For example, the Prop. 1 bond funding, which is directed to the Homekey+ Program administered by the California Department of Housing and Community Development (HCD), uses one set of definitions. Other programs funded through California HCD or through California Housing Finance Agency (CHFA) have their own definitions of homelessness, and occupancy in those programs is dictated by those regulations. Further, other California departments, such as the California Department of Health Care Services (DHCS), use a different set of definitions. DHCS administers Medi-Cal, which covers a suite of services for Medi-Cal Members experiencing or at risk of homelessness called Community Supports, as well as the Behavioral Health Services Act funding which covers a broad range of housing interventions.

Some of those programs no longer provide new funding, but the prior funding dictates the occupancy rules. Examples include but are not limited to the Mental Health Services Act Housing Program administered by CHFA, the No Place Like Home Program administered by DHCS and HCD, and the Behavioral Health Bridge Housing Program administered by DHCS.

When planning programs, it is important to consider not only how clients will qualify for services, but also how they can qualify for housing assistance. For example, a client who qualifies for housing assistance under the BHSA and qualifies under the definition of "at-risk of homelessness" would not be eligible for permanent supportive housing in a federal program operated under the local HUD Continuum of Care McKinney-Vento funding (HUD CoC), as "at-risk of homelessness" doesn't qualify for eligibility.

It is important that staff who are working with homeless clients for services under the BHSA Housing category of services accurately document every possible qualification for clients, even if not necessary for the BHSA Housing Services to ensure that the client can access federally funded housing (HUD CoC) that may have more restrictive criteria. Since 50 percent of BHSA Housing funds must be used for persons who are "chronically homeless," it is important to note the significant differences between the federal definition and the BHSA definition.

Specific language for definitions can be found through the following sources:

- Behavioral Health Services Act (DHCS): Behavioral Health Services Act County Policy Manual V1.3.0
- Community Supports (DHCS): DHCS-Community-Supports-Policy-Guide-Volume-2.pdf
- Homekey + (California Housing and Community Development), bond portion of Proposition 1: hk-plus-nofa-2024-amendment-2025.pdf
- Federal McKinney-Vento Homeless Assistance Act (federal funding through U.S. Department of Housing and Urban Development's (HUD's) Continuum of Care Program), and in the Consolidated Submissions for Community Planning and Development (CPD) programs. This is also referred to as Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): CoC Program.

Some specific requirements for documentation of homeless status vary by funding source. The HUD McKinney definitions for Continuum of Care-funded programs and housing are the most restrictive. Regulations and sample record keeping requirements can be found at:

- HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf
- CoC and ESG Homeless Eligibility - Four Categories in the Homeless Definition - HUD Exchange
- CFR :24 CFR 578.3 -- Definitions.
- https://www.ecfr.gov/current/title-24/section-578.3

Definition Comparison Charts

Experiencing Homelessness (also referred to as "homeless")

- Primary Differences: The federal McKinney (HUD CoC) definition is more restrictive for people who are exiting institutions and more restrictive for people facing eviction.

Funding Sources, Regulatory Entity	Location of Stay	Temporarily Housed	Exiting Institutional Settings	Losing Primary Residence	Youth	Domestic Violence
California Behavioral Health Services Act (BHSA) through Department of Health Care Services (DHCS)	Nighttime residence, meaning: a. A primary nighttime residence that is not designed for or ordinarily used as a regular sleeping accommodation for human beings (e.g., a car, park, abandoned building, bus or train station, airport, or camping ground)	Living in a supervised shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels)	An individual who is exiting an institution and was considered homeless immediately prior to entering the institution **or becomes homeless during the institutional stay, regardless of the length of stay** NOTE: BHSA allows a person to be considered homeless when exiting an institution regardless of length of stay and regardless if they were homeless before entering.	An individual or family who will lose their primary nighttime residence, within **30 days** of the date of application for homeless assistance; no subsequent residence has been identified; and they lack the means to obtain other permanent housing NOTE: BHSA allows 30 days, HUD CoC requires person(s) to be within 14 days of eviction	Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who are defined as homeless under various federal programs, have not had a lease or stable housing within the last 60 days, have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and can be expected to continue in such status for an extended period of time because of chronic disabilities or other factors (list is extensive)	Any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member
Medi-Cal Community Supports through Department of Health Care Services (DHCS)	Same as BHSA	Same as BHSA	**Same as BHSA**	Same as BHSA	Same as BHSA	Same as BHSA
California Housing and Community Development (HCD) bond funding, Prop. 1, Homekey+ **AND** **Federal McKinney Vento Homeless Assistance Act, HUD Continuum of Care programs (HUD CoC)**	Same as BHSA	Same as BHSA	An individual who is exiting an institution and was considered homeless **immediately prior to entering the institution and has been there less than 90 days**	An individual or family whose residence will be lost within **14 days** of the date of application for homeless assistance; no subsequent residence has been identified; and they lack the means to obtain other permanent housing.	Same as BHSA	Same as BHSA

At-Risk of Homelessness

- BHSA: Must meet Requirement 2, as well as one requirement from A-F
- Medi-Cal Community Supports: Must meet Requirement 2, as well as one requirement from A-F
- HCD Homekey+: Must meet income limitations (Requirement 1) and Requirement 2, and one requirement of A-F
- Federal McKinney funded programs, under the Continuum of Care: The federal at-risk of homelessness definition does not apply, as only persons who are homeless or chronically homeless qualify for housing or services.

Funding Sources, Regulatory Entity	**Requirement 1** Income Limitations	**Requirement 2** 2 For people currently housed Must have insufficient resources to prevent homelessness and meet one qualification in A-G	**(A) Housing Instability**	**(B) Economic Hardship**	**(C) Overcrowded Housing**	**(D) Lives in Motel**	**(E) Exiting Institution**	**(F) Lives in Housing Associated with Instability**	**(G) Losing current housing situation**
California Behavioral Health Services Act (BHSA) through Department of Health Care Services (DHCS)	No limitation	Does not have sufficient resources to prevent them from moving to an emergency shelter or another place where they would be “homeless”	Moved two or more times in last 60 days	Lives in home of another due to hardship	Lives in SRO with more than 2 people or in larger housing with more than 1.5 people to a room	Motel not paid for by govt or charity	Broadly defined, mental health facility, health care facility, jail, foster care	Must be identified in the “consolidated plan”	Notified in writing that right to occupy their current housing or living situation will terminate within 30 days
Medi-Cal Community Supports through Department of Health Care Services (DHCS)	Same as BHSA	Same as BHSA	Same as BHSA	Same as BHSA	Same as BHSA	Same as BHSA	Same as BHSA	Same as BHSA	Same as BHSA
California Housing and Community Development (HCD) bond funding, Prop. 1, Homekey+	**Requirement 1** Annual income below 30% of median family income for the area determined by HUD. Must also meet the insufficient resources requirement and one requirement in A- G	**Requirement 2** Does not have sufficient resources to prevent them from moving to an emergency shelter or another place where they would be “homeless”	(A) Moved two or more times in last 60 days	(B) Lives in home of another due to hardship	(C) Lives in SRO with more than 2 people or in larger housing with more than 1.5 people to a room	(D) Motel not paid for by govt or charity	(E) Broadly defined, mental health facility, health care facility, jail, foster care	(F) Must be identified in the “consolidated plan”	(G) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days of the date of application for assistance;

Chronic Homelessness (or Chronically Homeless)

- Note: The definition of chronic homelessness is exactly the same for Community Development (HCD) bond funding, Prop. 1, Homekey+, and for federally funded McKinney programs, but is different for California Behavioral Health Services Act (BHSA) funding through DHCS. Medi-Cal Community Supports does not define chronically homeless.
- Veterans: Some veterans' programs allow a veteran to retain their "chronic homelessness" status even if they are housed in transitional housing.
- Federally funded McKinney Act programs automatically nullify an individual's chronic homelessness status if they move to transitional housing. It is unclear if under the BHSA or Homekey + if this will still be the case.

Funding Sources, Regulatory Entity	Disability	Living Location	Length of Homelessness	Length of Homelessness, Not Continuous	Institutional Stays	Institutional Stays, Homeless Before Stay	Transitional Housing
California Behavioral Health Services Act (BHSA) through Department of Health Care Services (DHCS)	A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2), including a family whose composition has fluctuated while the head of household has been homeless	Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter	12 months. Has been homeless as defined in 7.C.4.1.1 Experiencing Homelessness and At Risk of Homelessness (Note:the individual could have been "at-risk of homelessness" for 12 months as long as they are currently in a place not meant for human habitation or a shelter.)	Homelessness on any number of occasions in the last 3 years, as long as the combined occasions equal at least 12 months (BHSA less restrictive than HUD CoC)	An individual who is exiting an institution and met all of the criteria in paragraph (1) immediately prior to entering the institution regardless of the length of stay Note: BHSA will count stays in institution regardless of length of stay towards 12 months of homelessness.	Must have met homeless criteria before entering institution, homeless or "at-risk of homelessness" criteria. Note: BHSA criteria for homelessness covers "at risk of homelessness" which is broader than HUD CoC definition.	Time spent in transitional housing before current situation of living on streets, shelter or other place not meant for human habitation may count towards 12 months of homelessness if the individual was forced to move.
HUD Continuum of Care (HUD CoC)	A homeless individual with a disability as defined in section 401, subdivision (9) of the McKinney-Vento Assistance Act (42 U.S.C. section 11360)	Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter	12 consecutive months or 12 cumulative months over 4 separate occasions in the last 3 years; separate occasions must have a 7-day break	12 months or 12 cumulative months over 4 separate occasions in the last 3-years; separate occasions must have a 7-days break	Institutional stays of less than 90 days when individual was homeless prior to entry do not constitute a break in homelessness and are counted towards the 12 months of homelessness.	Must have been homeless before the stay in the institution. An individual in an institution more than 90 days doesn't qualify as homeless upon release.	Individual or family who resides in transitional housing no longer qualifies as chronically homeless

Note: The definitions of chronic homelessness are the same for Homekey+ and for HUD CoC
McKinney definitions for Continuum of Care-funded programs and housing are the most restrictive. Regulations and sample record keeping requirements can be found at:

- HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf
- CoC and ESG Homeless Eligibility - Four Categories in the Homeless Definition - HUD Exchange
- CFR :24 CFR 578.3 -- Definitions.
- https://www.ecfr.gov/current/title-24/section-578.3

These links to the separate sections of Version 1.3.0 (June 2025) of Chapter 7.C, Housing Interventions, of the BHSA County Policy Manual, are designed to be used as a shortcut for finding specific sections quickly.

Links to Key Sections of BHSA County Policy Manual

C.1 Housing Interventions Funding
C.2 Introduction and Background
C.3 Program Priorities
C.4 Eligible and Priority Populations
C.4.1 Eligible Populations for Housing Interventions

Individuals must meet the BHSA eligibility requirements identified in the policy manual and meet the definition of:
At-Risk of Homelessness; or
Experiencing Homelessness; or
Chronically Homeless, with a focus on those in encampments

C.4.1.1 Experiencing Homelessness and At Risk of Homelessness
C.4.1.2 Chronically Homeless
C.4.1.3 People in Encampments
C.4.2 Priority Populations
C.4.3 Individuals Transitioning from MHSA to BHSA
C.5 Program Requirements
C.6 Transfers and Exemptions
C.6.1 Transfers
C.6.2 Exemptions
C.7 Relationship to Medi-Cal Funded Housing Services
C.7.1 Prohibition on Housing Interventions Coverage of Managed Care Plan-Covered Services
C.7.2 Expectations for Coordination with MCPs
C.8 Flexible Housing Subsidy Pools
C.9 Allowable Expenditures and Related Requirements
C.9.1 Rental Subsidies
C.9.1.1 Rental Assistance Requirements
C.9.1.2 Project-Based Housing Assistance
C.9.1.3 Master Leasing
C.9.2 Operating Subsidies
C.9.3 Allowable Settings
C.9.3.1 Permanent Supportive Housing
C.9.3.2 Shared Housing
C.9.3.3 Recovery Housing
C.9.3.4. Assisted Living (Adult Residential Care Facilities, Residential Care Facilities for the Elderly, and Licensed Board and Care Facilities)
C.9.3.5 Recuperative Care
C.9.3.6 Short-Term Post-Hospitalization Housing
C.9.4 Other Housing Supports
C.9.4.1 Landlord Outreach and Mitigation Funds
C.9.4.2 Participant Assistance Funds
C.9.4.3 Housing Transition Navigation Services and Housing Tenancy Sustaining Services
C.9.4.4 Outreach and Engagement
C.9.5 Other Housing Interventions Requirements and Policies
C.9.5.1 Housing First
C.9.5.2 Family Housing

Behavioral Health Services Act: Integrated Plan Goals and Measures

The BHSA Integrated Plan requires Behavioral Health Plans to report on six priority statewide goals and to choose an additional statewide goal from eight other goals. Each goal has primary and supplemental measures that BHPs are required to report on to reflect their community's status relative to each goal. Reducing homelessness is one of the priority goals.

BHPs are required to use their performance on the seven goals to inform the Community Planning Process and to address in their Integrated Plan interventions they will take to improve any areas of low performance relative to the statewide rates.

CalMHSA developed the BHT Data Explainer Series to assist BHPs in interpreting their data in the required goals and measures, including related to the goal of reducing homelessness. CalMHSA also prepared data dashboards for each goal to enable BHPs to review their data and compare it to other BHPs and statewide averages. To view recorded webinars and slides, and for links to data dashboards for each goal, visit the CalMHSA website.

Housing Inventory Count

What is the Housing Inventory Count?

The Housing Inventory Count (HIC) is a point-in-time inventory of provider programs within a Continuum of Care (CoC) that provide beds and units dedicated to people experiencing homelessness. It is categorized by six program types:

- Emergency Shelter
- Transitional Housing
- Rapid Re-housing
- Safe Haven
- Permanent Supportive Housing (PSH)
- Other Permanent Housing

Like the Point in Time (PIT) count of homeless individuals, the HIC reports provide a snapshot of a CoC's housing inventory and are produced annually during the last 10 days in January. The HIC reports are available at the national and state level, as well as for each CoC. They tally the number of beds and units available on the night designated for the count by program type, and include beds dedicated to serve persons who are homeless as well as persons in permanent supportive housing. The reports also include data on PSH beds dedicated to serve those who are chronically homeless; veterans and their families; and homeless youth age 24 and younger.

Why is it important?

The Integrated Plan[6] (IP) requires county behavioral health departments to answer a series of questions in the Housing Intervention section, with the goal of identifying the largest gaps in available housing for individuals experiencing homelessness and at risk of homelessness with a behavioral health condition who are BHSA-eligible; it also refers counties to the HIC reports to inform their responses. The HIC reports may be the best housing inventory available and are a valuable resource for county behavioral health to include in their Community Planning Process as well as completing the IP.

The HIC reports on only six program types, whereas the IP lists 22 (the IP also includes services). The HIC reports also list the names of all the programs in each of the six categories. The specific names may allow counties to gather more specific information that enables them to understand the variety of available housing and how to categorize it in the IP.

6 See page 75 of the Integrated Plan.

For example, below are two screenshots of pages 1 and 2 of the Fresno City and County/Madera County CoC HIC 2024 report. Page 1 shows the totals for the categories of housing (there are no safe havens listed for this CoC). Page 2 is the partial listing of the emergency shelters in this CoC. Additional pages of the HIC continue the listing of emergency shelters and the other categories of housing. On the far right are three columns showing the number of beds for chronically homeless, veterans and their families, and youth.

CoC Number: CA-514

CoC Name: Fresno City & County/Madera County CoC

Summary of all available beds reported by Continuum of Care:

								Subset of Total Bed Inventory		
	Family Units[1]	Family Beds[1]	Adult-Only Beds	Child-Only Beds	Total Yr-Round Beds	Seasonal	Overflow / Voucher	Chronic Beds[2]	Veteran Beds[3]	Youth Beds[3]
Emergency, Safe Haven and Transitional Housing	**144**	**356**	**1,360**	**0**	**1,716**	**0**	**0**	**n/a**	**99**	**22**
Emergency Shelter	115	297	1,234	0	1,531	0	0	n/a	39	10
Transitional Housing	29	59	126	0	185	n/a	n/a	n/a	60	12
Permanent Housing	**362**	**599**	**1,487**	**0**	**2,086**	**n/a**	**n/a**	**n/a**	**770**	**67**
Permanent Supportive Housing*	87	257	1,176	0	1,433	n/a	n/a	1,099	668	0
Rapid Re-Housing	273	325	274	0	599	n/a	n/a	n/a	61	67
Other Permanent Housing**	2	17	37	0	54	n/a	n/a	n/a	41	0
Grand Total	**506**	**955**	**2,847**	**0**	**3,802**	**0**	**0**	**1,099**	**869**	**89**

Available CoC beds reported by Program Type:

Emergency Shelter

									Subset of Total Bed Inventory		
Provider Name	Facility Name	Family Units[1]	Family Beds[1]	Adult-Only Beds	Child-Only Beds	Seasonal	Overflow / Voucher	Total Beds	Chronic Beds[2]	Veteran Beds[3]	Youth Beds[3]
Community Action Partnership Of Mader	Kaiser - Emergency Shelter	5	5	5	0	0	0	10	n/a	0	0
Community Action Partnership Of Mader	ES CAPMC HHAP 3 - Emerg	5	5	10	0	0	0	15	n/a	0	0
Community Action Partnership Of Mader	ES - Martha Diaz Shelter	3	9	0	0	0	0	9	n/a	0	0
Community Action Partnership Of Mader	ES CAPMC HHAP 3 - Youth	0	0	10	0	0	0	10	n/a	0	10
County of Madera Department of Social S	ES - CalWorks Motel Paymen	12	29	0	0	0	0	29	n/a	0	0
County of Madera Department of Social S	ES- Madera HDAP Hotel Pay	0	0	17	0	0	0	17	n/a	0	0
ES - Village of Hope Emergency Shelter	ES- Village of Hope Emergen	0	0	65	0	0	0	65	n/a	0	0
ES - Village of Hope Emergency Shelter	ES Hope Pointe Emergency S	0	0	65	0	0	0	65	n/a	0	0
ES- HOPE Shelter	ES- HOPE Shelter	0	0	9	0	0	0	9	n/a	0	0
ES- MRM - Triage Center	ES- MRM - Triage Center	0	0	8	0	0	0	8	n/a	0	0
ES- POV Family Hope Shelter	ES- POV Family Hope Shelte	8	32	0	0	0	0	32	n/a	0	0
Fresno Mission	ES- The Family Center	21	84	0	0	0	0	84	n/a	0	0
Fresno Mission	ES- Community Care	2	8	30	0	0	0	38	n/a	0	0
Madera Rescue Mission	ES-MRM Men's Emergency S	2	4	69	0	0	0	73	n/a	0	0
Madera Rescue Mission	ES- MRM Mens BH	0	0	24	0	0	0	24	n/a	0	0
Madera Rescue Mission	ES- MRM Womens BH	0	0	11	0	0	0	11	n/a	0	0
Madera Rescue Mission	ES - MRM Women's Emerge	2	4	28	0	0	0	32	n/a	0	0
Marjaree Mason Center	ES - MMC Safe House	40	83	0	0	0	0	83	n/a	0	0
Poverello House	ES - Naomi's House Triage C	0	0	34	0	0	0	34	n/a	0	0
RH Community Builders	ES- Ambassador Triage Cente	0	0	62	0	0	0	62	n/a	0	0
RH Community Builders	ES - The Lodge	0	0	30	0	0	0	30	n/a	0	0
RH Community Builders	ES- Sierra Sunrise	0	0	60	0	0	0	60	n/a	0	0
RH Community Builders	ES- Villa Inn Bridge Center	0	0	52	0	0	0	52	n/a	0	0
RH Community Builders	ES- Travel Inn Triage Center	0	0	151	0	0	0	151	n/a	0	0
TURN- BHS (Behavioral Health Services)	ES - Fresno HOME Triage	9	28	22	0	0	0	50	n/a	0	0
Turning Point - Turning Point of Central	ES - Journey Home	0	0	76	0	0	0	76	n/a	0	0
Turning Point - Turning Point of Central	ES- Victory Village (Homeke	0	0	75	0	0	0	75	n/a	0	0
Turning Point - Turning Point of Central	ES - The Welcome Center	0	0	30	0	0	0	30	n/a	0	0

Recovery Housing and Housing First

The Housing First model prioritizes access to housing without conditions that require individuals to meet prerequisites—such as sobriety, participating in mental health or substance use treatment programs, demonstrating employment readiness, or adhering to behavioral requirements. Housing First proposes that housing is the foundation from which individuals can find stability and pursue recovery. This section discusses the intersection of recovery housing and housing first principles.

What is recovery housing?

Recovery Housing is an allowable use of BHSA Housing Intervention funds and is defined in the BHSA County Policy Manual as:

"Recovery housing is a housing intervention that is recognized by both Substance Abuse and Mental Health Services Administration (SAMHSA) and HUD as an important housing option for individuals with substance use disorders. Recovery housing, also referred to as sober living or recovery residences, offers shared housing in a milieu that is supportive of recovery and that builds a sense of community and mutual support. Recovery housing, including recovery-oriented housing, can provide valuable support for those in outpatient treatment, leaving residential treatment, or others seeking to live in an alcohol and drug-free environment that supports recovery and wellness." [7]

HUD'S Recovery Housing Policy Brief notes, "Notwithstanding its emphasis on a Housing First approach, HUD also recognizes the importance of providing individual choice to support various paths towards recovery. Some people pursuing recovery from addiction express a preference for an abstinence-focused residential or housing program where they can live among and be supported by a community of peers who are also focused on pursuing recovery from addiction–environments that are provided by Recovery Housing programs. However, supporting individual choice must also mean that a community is ensuring that housing options are available for people at all stages of recovery, including people who continue to use drugs or alcohol. HUD is emphasizing that unless court ordered, CoC program funded projects should not require any homeless person to enter Recovery Housing or be offered or provided this type of program as the only housing option, but rather should offer them choices ..."[8]

What are the important features when considering use of recovery housing ?

1. Can include but is not limited to abstinence-based recovery
2. Offers substance-use specific services and supports *Participation must be voluntary* except for persons under a court order
3. Should not be the only model available; harm reduction models of housing should also be developed.
4. Can be peer-run or run by an entity
5. Shared housing or individual apartments
6. Permanent or transitional housing
7. All other components of Housing First are still applicable.
8. Tenants in permanent housing must have leases and may also be required to have leases in some transitional housing settings.

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7 C.9.3.3 Recovery Housing, Behavioral Health Services Act County Policy Manual-V.1.2.0 (Page 177-178), 2025. Behavioral Health Services Act County Policy Manual-V.1.2.0-20250407.pdf (SECURED) https://policy-manual.mes.dhcs.ca.gov/__attachments/152862862/Behavioral Health Services Act County Policy Manual-V.1.2.0-20250407.pdf?inst-v=8f0effa4-60a1-49fe-9808-b7adbe423063

8 Recovery Housing Policy Brief (Page 2-3), 2015, U.S. Department of Housing and Urban Development (HUD), Recovery Housing Policy Brief - HUD Exchange, https://narronline.org/wp-content/uploads/2024/05/HUD-Recovery-Housing-Policy-Brief.pdf

9. Licensed *treatment facilities are not recovery housing*.

Does California permit recovery housing as part of Housing First?

Yes, but guidance on the use of state funds to construct recovery housing is in flux. Several state legislative initiatives clarify the use of state housing program funds for construction of recovery housing, but some programs clearly allow use of funds for operations or rent subsidies.

> "Housing First proposes that housing is the foundation from which individuals can find stability and pursue recovery."

Recovery housing is specifically allowed as a model in the following programs:

1. Recovery housing is an allowable use of funds under the Housing Interventions component of the BHSA (for eligible populations.)[9]
2. The California Behavioral Health Bridge Housing Program funds transitional housing in various settings. Recovery housing and Sober Living are allowable settings.[10]

What is Housing First?[11]

Under California law, Housing First refers to the evidence-based model that uses housing as a tool, rather than a reward, for recovery and that centers on providing or connecting persons who are homeless to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and that do not make housing contingent on participation in services.

This provision applies very broadly to all state programs; "any programs a California state agency or department funds, implements, or administers for the purpose of providing emergency shelter, interim housing, housing, or housing-based services to people experiencing homelessness or at risk of homelessness, with the exception of federally funded programs with requirements inconsistent with this chapter."[12]

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9 C.9.3 Allowable Settings. Recovery Housing, Behavioral Health Services Act County Policy Manual-V.1.2.0 (Page 174), 2025. Behavioral Health Services Act County Policy Manual-V.1.2.0-20250407.pdf (SECURED) https://policy-manual.mes.dhcs.ca.gov/__attachments/152862862/Behavioral Health Services Act County Policy Manual-V.1.2.0-20250407.pdf?inst-v=8f0effa4-60a1-49fe-9808-b7adbe423063

10 Are people required to participate in services to receive BHBH Program-funded housing? Frequently Asked Questions, Behavioral Health Bridge. https://bridgehousing. buildingcalhhs.com/faq/are-people-required-to-participate-in-services-to-receive-bhbh-program-funded-housing/ Link

11 California Code, WIC 8255. CHAPTER 6.5., Welfare and Institutions Code – WIC, Housing First and Coordinating Council [8255 - 8257.2], 2025. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=8255.

12 Ibid.

Core Components of California Law on Housing First

In California, the Core Components of Housing First include:

1. Tenant screening and selection practices that promote accepting applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services
2. Applicants are not rejected on the basis of poor credit or financial history, poor or lack of rental history, criminal convictions unrelated to tenancy, or behaviors that indicate a lack of "housing readiness."
3. Acceptance of referrals directly from shelters, street outreach, drop-in centers, and other parts of crisis response systems frequented by vulnerable people experiencing homelessness
4. Supportive services that emphasize engagement and problem solving over therapeutic goals and service plans that are highly tenant-driven without predetermined goals
5. Participation in services or program compliance is not a condition of permanent housing tenancy.
6. Tenants have a lease and all the rights and responsibilities of tenancy, as outlined in California's Civil, Health and Safety, and Government codes.
7. The use of alcohol or drugs in and of itself, without other lease violations, is not a reason for eviction.
8. In communities with coordinated assessment and entry systems, incentives for funding promote tenant selection plans for supportive housing that prioritize eligible tenants based on criteria other than "first-come-first-served," including, but not limited to, the duration or chronicity of homelessness, vulnerability to early mortality, or high utilization of crisis services. Prioritization may include triage tools, developed through local data, to identify high-cost, high-need homeless residents.
9. Case managers and service coordinators who are trained in and actively employ evidence-based practices for client engagement, including, but not limited to, motivational interviewing and client-centered counseling
10. Services are informed by a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of tenants' lives, where tenants are engaged in nonjudgmental communication regarding drug and alcohol use, and where tenants are offered education regarding how to avoid risky behaviors and engage in safer practices, as well as connected to evidence-based treatment if the tenant so chooses.
11. The project and specific apartment may include special physical features that accommodate disabilities, reduce harm, and promote health and community and independence among tenants.[13]

Does Housing First apply to the California Housing and Community Development Homekey+ program funded under Prop. 1?

Yes, "like other programs administered by the State of California that serve people experiencing homelessness, Homekey+ requires the use of Housing First, which is an evidenced-based model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry or continued tenancy, such as sobriety, treatment or service participation requirements.[14]

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13 California Code, WIC 8255. CHAPTER 6.5. Welfare and Institutions Code – WIC, Housing First and Coordinating Council [8255 - 8257.2], (b) 1-11, 2025. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=8255.

14 Memorandum for Potential Applicants. Homekey+ Program Amended 2024 Notice of Funding Availability (Page 2 paragraph 1), Jennifer Seeger, Deputy Director Division of State Financial Assistance, 2025, hk-plus-nofa-2024-amendment-2025.pdf

Does Housing First apply to the Behavioral Health Services Act housing funding?

Yes, but there are some limited exceptions. Some of the allowable BHSA housing settings would not be able to fully implement Housing First principles if a participant is placed into housing that has federal funding, if the federal and state provisions conflict, the federal provisions supersede the California law on Housing First.

Federally funded housing may have "drug free" housing requirements that are in conflict with Housing First provisions of California law.[15]

Who is charged with implementing Housing First in California?

The California Interagency Council on Homelessness (Cal ICH) has the statutory obligations to, "Implement Housing First by ensuring all state programs identified in statute incorporate Housing First Core Components."[16]

The Cal ICH Action Plan for Preventing and Ending Homelessness in California, 2025-2027, published in December 2024, defines this obligation.[17]

Is Housing First mandated under federal law?

No. While HUD promotes and often requires elements of Housing First in certain frameworks they have not universally mandated that all HUD-funded homeless assistance providers use the model in every instance for programs funded under the Continuum of Care. Under prior Administrations, HUD has encouraged communities and grantees to use a Housing First approach in its programs through scoring incentives in the annual CoC funding competition. Through other scoring incentives, HUD has emphasized the provision of voluntary supportive services through partnerships with health and behavioral health care providers. Under the current Administration, HUD has currently suspended incentives for Housing First in HUD funded projects.

In addition, on July 24, 2025, an Executive Order was released entitled, "Ending Crime and Disorder on America's Streets." [18] This order directs the Secretary of Health and Human Services to end funding for "harm reduction" programs. In Sec. 5., "Increasing Accountability and Safety in America's Homelessness Programs", it also states, "(a) The Secretary of Health and Human Services and the Secretary of Housing and Urban Development shall take appropriate actions to increase accountability in their provision of, and grants awarded for, homelessness assistance and transitional living programs. These actions shall include, to the extent permitted by law, ending support for "housing first" policies that deprioritize accountability and fail to promote treatment, recovery, and self-sufficiency; increasing competition among grantees through broadening the applicant pool; and holding grantees to higher standards of effectiveness in reducing homelessness and increasing public safety.

- (b) The Secretary of Housing and Urban Development shall, as appropriate, take steps to require recipients of Federal housing and homelessness assistance to increase requirements that persons participating in the recipients' programs who suffer from substance use disorder or serious mental illness use substance abuse treatment or mental health services as a condition of participation."

The interpretation of this provision, and the implications for California public policy mandating Housing

15 Title 24 Subtitle B Chapter VIII Subpart E § 882.518 Denial of admission and termination of assistance for criminals and alcohol abusers. Code of Federal Regulations,1978. eCFR :: 24 CFR Part 882 -- Section 8 Moderate Rehabilitation Programs

16 Chapter 6.5. Housing First and Coordinating Council. Division 8 Section 8256 (a). Miscellaneous, Welfare and Institutions Code – WIC, 2025. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=8255.

17 Action Plan to Prevent and End Homelessness in California 2025-2027. California Interagency Council on Homelessness, 2024. https://www.bcsh.ca.gov/calich/documents/action_plan.pdf

18 Section 5a and 5b. Ending Crime and Disorder on America's Streets – The White House, Executive Order, 2025. https://www.whitehouse.gov/presidential-actions/2025/07/ending-crime-and-disorder-on-americas-streets/

First as the policy for California has not yet been determined. Since the EO requirements appear to conflict with the California mandates for Housing First, particularly in the area of mandating treatment as a condition of housing, housing programs that use both State and Federal funding will need to seek guidance on the applicability of the Executive Order to their operations.

> "Some of the allowable BHSA housing settings would not be able to fully implement Housing First principles if a participant is placed into housing that has federal funding, if the federal and state provisions conflict, the federal provisions supersede the California law on Housing First.

Housing First and Recovery Housing, Cal ICH Guidance

January 2025 – DRAFT Document[19]

The draft document discusses how to implement recovery housing and comply with California laws and requirements on Housing First. It defines recovery housing under California law as "sober living facilities and programs that provide housing in a recovery-focused and peer-supported community for people recovering from substance use issues."

This can include, but is not limited to, abstinence-based recovery. Additionally, participation in recovery housing settings is voluntary, unless that participation is pursuant to a court order or is a condition of release for individuals under the jurisdiction of a county probation department or the California Department of Corrections and Rehabilitation (CDCR).

Recovery housing is defined similarly by the U.S. Department of Housing and Urban Development (HUD) as "a housing model that uses substance use-specific services, peer support, and physical design features to support individuals and families on a particular path to recovery from addiction, typically emphasizing abstinence. Recovery housing might not be in conflict with Housing First, a system-wide approach that removes barriers whenever possible and that addresses the housing needs of people at all stages of recovery, so long as entry into the program is based on the choice of the program participant."

Core components of Housing First must still be implemented, except for "recovery housing programs administered by CDCR (Returning Home Well Program, the Specialized Treatment for Optimized Programming Program, and the Long-Term Offender Reentry Recovery Program)."

Key points:

1. Unless a participant is court-mandated to live in a sober living facility, then the choice to live in recovery housing must be the choice of the individual.
2. Recovery housing should not be the only option offered to persons who are homeless and seeking housing.
3. Housing program also must not evict or remove a participant from housing or shelter settings solely for use of alcohol or drugs, without other program violations.
4. Recovery housing has a range of program/housing models, from entirely peer- run sober living, to professionally staffed with clinical services.
5. Tenants who continue to use substances and wish to exit from recovery housing, and no longer want abstinence-focused housing or who are being evicted due to violations of lease, must be offered other options that include housing that uses a harm reduction approach for substance use disorders.

19 Defining Recovery Housing. Housing First and Recovery Housing Cal ICH Guidance, California Interagency Council on Homelessness, 2025, https://www.bcsh.ca.gov/calich/meetings/materials/recovery_housing_guidance.pdf

6. Staff should be trained in evidence-based practices such as motivational interviewing, harm reduction, and trauma-informed care.
7. Recovery housing programs should ensure that they promote equity and can serve underrepresented communities competently.
8. Recovery housing should not impose barriers for clients to use prescribed medications for substance use disorders or mental health conditions.

Additional Resources On Housing First

1. Implementing Recovery Housing in Alignment with California Housing First Requirements: Cal ICH Guidance, July, 2025 https://www.gov.ca.gov/wp-content/uploads/2025/10/FINAL-Recovery-Housing-Guidance.pdf
2. Cal Interagency Council on Homelessness Guide to California's Housing First Law: Cal ICH published its original guidance on recovery housing. This guide provides answers to frequently asked questions about the implementation of Housing First in state-funded programs. https://bcsh.ca.gov/calich/documents/housingfirstguidance_20241003.pdf
3. Homekey Round 3, Housing First Guidance: Includes requirements with a background and overview which provides a chart on th principals in action, checklist for requirements, and numerous resources for understanding Housing First. https://www.hcd.ca.gov/sites/default/files/docs/grants-and-funding/homekey/housing-first-guidance.pdf
4. Implementing Housing First in Permanent Supportive Housing: A Fact Sheet from USICH with assistance from the Substance Abuse and Mental Health Services Administration. Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf
5. Housing First, A Review of the Evidence: Is a Spring/ Summer Issue from 2023 published by the U.S. Department of Housing and Urban Development that provides an overview of Housing First approaches with insights on research and studies. https://archives.huduser.gov/portal/periodicals/em/spring-summer-23/highlight2.html
6. Protecting the Use of Housing First: Policy information on Protecting the Use of Housing First from the National Alliance to End Homelessness. https://endhomelessness.org/resources/policy-information/protecting-the-use-of-housing-first/

Types of Housing Resources & Funding Sources

Types of Housing Resources and Funding Sources

Access to housing is essential to ending homelessness, and behavioral health staff have a unique role to play in connecting people with the housing supports they need. Housing, homelessness, and other supports are often complex. Housing funding sources are often siloed, with terminology, eligibility restrictions, and application procedures that are not aligned with other systems of care.

This resource is designed for behavioral health professionals who want to understand how housing is funded outside of the BHSA, what supports are available, and how to align their work with local homelessness response systems. It includes examples, guidance documents, and links to key training resources. It's important to note that funding streams and access to programs vary by community and change over time; the best guides are your local homelessness Continuums of Care (CoCs) and local agencies who administer housing funding.

Overview of Homeless Housing Program Terminology

Understanding a few core housing terms is key to effectively navigate partnerships and funding.

State and federal housing programs will often clarify under "eligible activities" what the funds may be used for. This can be helpful to know when learning about new funding opportunities that may support behavioral health clients.

Among the main terms used by housing providers are those that distinguish how funding may be implemented: capital vs. operating costs, units vs. subsidies, tenant-based vs. project-based, and time-limited vs. non-time-limited assistance.

Capital vs. Operating Costs

Capital costs:

- Funding for capital costs cover one-time investments in acquisition, construction, and rehabilitation.
- These funds can help with buying properties, building new units, and major renovations to make a building suitable for housing.
- Some programs that provide funding for capital costs include programs like Homekey+, HOME-ARP, Multifamily Finance Super NOFA.

Operating costs:

- Funding for operating costs cover ongoing expenses like maintenance (that doesn't rise to the level of renovation), utilities, insurance, security, and even things like furniture.
- Operating costs are funded through various state programs and capitalized operating subsidies.

Units vs. Subsidies

Units: When housing providers talk about funding for more "units," they are referring to the physical housing itself. Funding for units means creating physical housing inventory through acquisition, building, or conversion to increase the actual supply of housing units available.

- Communities create units through capital expenditures or through finding individual units available to rent through private-market landlords.

Subsidies: Subsides are supports for rent; they are what make existing housing affordable by providing people with rent vouchers or rental assistance subsidies. They can help people afford existing housing in the marketplace. Some examples are Housing Choice Vouchers (also known as Section 8), and time-limited rental assistance.

- **Master leasing:** When it's allowed by a funding source, master leasing allows organizations to lease entire properties, or a subset of units in a property, and then sublease to program participants. This approach has been very promising in increasing housing unit availability and housing stability for tenants, especially those with significant barriers to renting with private landlords (for example, past evictions, criminal background, etc.). Partnering with community-based housing services organizations is a successful strategy for master leasing.

Rental Assistance

Rental assistance is simply a subsidy that pays all or part of the rent for an eligible program participant. There are multiple programs, administered by multiple agencies and partners, that may fund rental assistance, each with their own eligibility rules, target populations, and allowable expenses. Although the rent is subsidized, federal vouchers require the renter to pay a portion of the rent, typically a defined percentage of their income. The BHSA, however, does not require the renter/client to pay a portion of the rent. A few terms can help to provide clarity on the basic types of assistance:

- **Tenant-based assistance:** With tenant-based rental assistance, the subsidy or voucher attaches to the individual or the family. This means the assistance can be portable and used in a housing unit of their choosing in the marketplace, including a private landlord or other housing location.
- **Project-based assistance:** A project- or site-based voucher means that the voucher is not portable. Rather, it attaches to a specific unit or property. These vouchers are typically used in a housing development built or operating with other government funding (as in capital expenditures).
- **Scattered-site assistance:** This term often accompanies "tenant-based rental assistance." It means the rental assistance may be used in various locations, dependent on where the client has found a place to live. This is a housing model where apartments or homes are spread out across different neighborhoods in the community, rather than being concentrated in a single building or complex.
- **Time-limited rental assistance:** Time-limited rental assistance refers to the duration of the subsidy and may be used to refer to interim or short-term housing, or it can be applied to programs in which the rental assistance is temporary. The goal is to transition to permanent housing (sometimes also called rapid rehousing). The duration of time-limited rental assistance varies by funding source and by program policies.
- **Non-time-limited rental assistance:** This is the term generally applied to a permanent subsidy, like Permanent Supportive Housing, or PSH.
- **Housing vouchers:** This term is typically used to describe the rental assistance programs administered by Public Housing Authorities (PHAs), whose programs are also known as Section 8. These programs are typically permanent vouchers with distinct eligibility and application processes.
- **Transitional rent:** Transitional rent is a new Community Supports benefit provided by Medi-Cal Managed Care Plans (MCPs) and will launch Jan. 1, 2026. Transitional rent will provide up to six months of rental assistance in interim and permanent settings to MCP members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria. In addition, transitional rent requires the member to have a housing support plan in place that identifies a permanent housing solution.

Types of Housing Resources and Funding Sources

California's housing efforts are powered by multiple, distinct funding streams — each with its own eligibility rules, allowable uses, and lead agencies. Key funding sources for housing interventions are typically federal or state government agencies. Behavioral health programs may combine some of

these resources together (known as "braided funding") for integrated housing support and to access multiple streams managed outside the behavioral health system. Understanding how each funding stream operates enables providers to leverage the right combination of programs for their clients, removing barriers and opening more pathways to housing, both permanent and interim.

Continuum of Care (CoC) Managed Funding

The U.S. Department of Housing and Urban Development's (HUD) primary homelessness funding stream is through the CoC organization. The CoC's role is to organize and deliver housing and supportive services to people experiencing homelessness and help individuals and families move toward stable, permanent housing and self-sufficiency. CoCs are designated by HUD and serve as regional planning bodies made up of service providers, government agencies, and community members. They decide how to allocate state and federal funding streams for homeless services, set priorities, and coordinate housing and services to best meet the needs of people experiencing homelessness in their area. CoCs are tasked with engaging and coordinating with housing and other systems of care and managing the community's Homeless Management Information System (HMIS), providing an important gateway for behavioral health to engage with community providers.

The CoC establishes and oversees a coordinated entry system (CES) to ensure there is an intake and assessment process, an equitable prioritization process, and efficient referrals. The CES is the centralized system that refers clients to CoC-funded housing resources and is determined individually by each CoC.

- **CoC Funding:** The CoC applies for and distributes funding from HUD for permanent supportive housing (PSH), rapid re-housing (RRH), transitional housing, and the CES.

Learn More About: CoC Program Funding and Resources

To make the most of HUD funding and resource opportunities, behavioral health providers and community partners can engage directly with CoCs to understand funding streams, referral processes, and ways to align services with housing resources. The following strategies provide some ideas on how to connect with your CoC and leverage coordinated entry systems to better serve clients with behavioral health needs.

- Engage with the CoC and community planning activities to learn more about housing and community funding opportunities.
- Participate in CES housing placement meetings (often called case conferencing by CoC partners) to ensure clients with behavioral health needs are referred and prioritized to be placed in appropriate programs.
- Explore opportunities for braided funding by integrating behavioral health case management with CoC-funded housing services to promote long-term tenancy stability.
- Partner with your local CoC to understand how clients can be assessed and referred through its CES. Participate in defining the prioritization process to include behavioral health acuity as a measurement.

For more information about CoCs, including how to find your local CoC, refer to the [CoC Connection Guide Link].

Key Tip:
CoC-funded housing often has strict eligibility requirements (e.g., chronic homelessness for PSH), so early coordination with CoC case managers and providers, and accurate documentation of homelessness and disability status, are essential.

Learn More About: State Funding Resources

State funding programs offer important opportunities to support housing stability and behavioral health services. By understanding how these resources work, providers can better connect clients to the assistance they need. Behavioral health staff are especially well-positioned to help clients navigate these systems and maximize available supports. Staff can:

- Refer and connect clients to housing programs funded through the Behavioral Health Services Act (BHSA), No Place Like Home (NPLH), Homekey, or Homeless Housing, Assistance and Prevention Program (HHAP).
- Partner with Medi-Cal MCPs to coordinate CalAIM community supports for clients needing tenancy services.
- After a client has exhausted their benefits under Medi-Cal, use BHSA and HHAP resources for outreach, housing navigation, and service supports while relying on Medi-Cal or federal programs for clinical and tenancy services.

Share client needs and outcomes with county planners and the CoC to ensure program designs reflect behavioral health priorities.

Key Tips:

- Build strong relationships with your CoC and housing developers. These partnerships will be essential to linking your clients with housing.
- Funding sources work best when used together. Since no single program can meet every need, the aim is to blend and coordinate resources to fully support clients.
- Stay current on training opportunities. The Housing Pathways Training and Maximizing Housing Intervention Funding Training provides practical tools for navigating funding streams and housing resources.
- Track documentation carefully. Eligibility, homelessness history, and behavioral health needs will be required to connect clients to most housing programs.

Important Funding Sources

The following chart provides behavioral health staff with a quick reference to the main funding sources that support homelessness services and housing. It is intended to simplify complex information by offering a snapshot of what each funding stream can be used for, who it serves, and how it can be accessed (including whether the funding opportunity is currently open). The chart serves a two-fold purpose: 1) to highlight funding opportunities that may be available for application, and 2) to identify programs already funded and available for client placement, even if the application deadline has closed. This helps staff identify available resources, understand how different funding streams fit together, and make informed decisions when supporting clients.

Each funding source comes with its own eligibility criteria, which are further shaped by local program design decisions. Your knowledge of the client's circumstances will be the key link in determining whether they qualify for a given program and how the funding could support their housing or service needs.

Funding Program	Updated Status (as of September 2025)	Eligible Uses
Behavioral Health Infrastructure Bond Act ((BHIBA, AB 531) Passed in March 2024 as "Proposition 1," consists of two bills: the Behavioral Health Services Act (SB 326) and the Behavioral Health Infrastructure Bond Act (BHIBA, AB 531). BHIBA provides $6.38 billion in bonds to build behavioral health treatment centers, residential care, and supportive housing for people with mental health and substance use disorders. Up to $4.4 billion of this funding will be distributed by the California Department of Health Care Services (DHCS) through BHCIP competitive grants.	Bond BHCIP Round 2: Unmet Needs Funding Opportunity. Application deadline has passed. Award announcements are anticipated in late spring 2026.	Eligible activities include constructing, rehabilitating, or acquiring mental health and substance use disorder (SUD) facilities, such as community residential beds, crisis settings, urgent care centers, and various outpatient and residential treatment programs. Projects must also serve rural/remote areas, involve regional collaborations, and align with state priorities for expanding access to care.
Behavioral Health Bridge Housing: Funding provided to county behavioral health agencies and Tribal entities to operate bridge housing settings to address the immediate housing needs of people experiencing homelessness who have serious behavioral health conditions, including serious mental illness (SMI) and/or substance use disorder (SUD).	Established in 2022 and will provide funding through June 30, 2027. Three rounds of funding have been awarded. There will not be a fourth round, as originally anticipated. This map provides information for each of the 56 county behavioral health agencies participating in the BHBH Program (Round 1 and Round 3). This map provides information about each of the participating tribal entities participating in the BHBH Program (Rounds 2 and 2B).	Funds provide support through bridge housing settings, including tiny homes, interim housing, rental assistance models, and assisted living settings; and support necessary housing operational costs and costs related to supporting participants' housing stability, retention, and wellness. The bridge housing settings include voluntary supportive services to help program participants obtain and maintain housing, manage symptoms of serious behavioral health conditions, and focus on recovery and wellness.

Funding Program	Updated Status (as of September 2025)	Eligible Uses
Behavioral Health Services Act (BHSA): Provides funding for housing interventions that may include rental subsidies, operating subsidies, shared housing, family housing, non-federal share for Medi-Cal transitional rent, project-based housing assistance, including master leasing, capital development projects, and others.	The BHSA replaces the Mental Health Services Act (MHSA) of 2004. The Behavioral Health Services Act County Policy Manual has been updated with important information and resources regarding the draft and final Integrated Plan, which are due in 2026.	Reforms behavioral health care funding to prioritize services for people with the most significant mental health needs, while adding SUD treatment, expanding housing interventions, and increasing the behavioral health workforce. It also enhances oversight, transparency, and accountability at the state and local levels. Funding categories include: 30 percent for housing interventions for specified populations, with 50 percent of these funds used for individuals who are chronically homeless and a focus on those in encampments. See Chapter 7.C Housing Interventions of the BHSA County Policy Manual. Up to 25 percent of the housing intervention funds may be used for capital development.
Bringing Families Home (BFH): State-funded, locally administered program in which counties and Tribal grantees provide flexible housing-related supports, including housing navigation and rental assistance, to eligible families experiencing, or at risk of, homelessness who are in the child welfare system or who receive child welfare services in accordance with Tribal law or customs.	The BFH program is administered locally. Contact the CDSS Housing and Homelessness Division to learn more.	Financial assistance and housing-related wraparound supportive services, including but not limited to: rental assistance, housing navigation, case management, security deposits, utility payments, moving costs, interim shelter assistance, legal services, and credit repair.
Cal AIM Community Supports: Provides housing-related services such as Housing Transition and Navigation Services, Housing Deposits, Housing Tenancy Sustaining Services, and other services (e.g., Recuperative Care, Short-Term Post-Hospitalization) services that address Medi-Cal managed care plan members' social drivers of health and help them avoid higher, costlier levels of care.	To access, providers and organizations must connect with the DHCS or their local MCP. See which services are offered in your county. Updated Community Supports Policy Guide	Approved community supports include: housing transition navigation services; housing deposits; housing tenancy and sustaining services; respite services (for caregivers); day habilitation programs; nursing facility transition/diversion to assisted living facilities; community transition services/nursing facility transition to a home; personal care and homemaker services; environmental accessibility adaptations; medically tailored meals/medically-supportive food; sobering centers; asthma remediation; short-term post-hospitalization housing; recuperative care (medical respite).
Cal AIM Enhanced Care Management (ECM) Services: Provides a whole-person, interdisciplinary approach to care management that comprehensively addresses the clinical and nonclinical needs of Medi-Cal members with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. (DHCS)	To access, providers and organizations must connect with the DHCS or their local Medi-Cal MCP. Reference the ECM Provider Toolkit to help you navigate this new benefit for your clients.	

Funding Program	Updated Status (as of September 2025)	Eligible Uses
CalWORKs Homeless Assistance (HA): Provides payments for families in the CalWORKs program for temporary shelter for up to 16 days to secure or maintain housing, including a security deposit and last month's rent, or up to two months of rent arrearages. (CDSS)	The Homeless Assistance program is administered through CalWORKs at the county level. Contact your local county welfare office to apply/learn more.	Temporary HA, which helps families pay the costs of temporary shelter for up to 16 days with exceptions, including hotel or motel costs ($85 per day for a family of four or fewer + $15 for each additional family member, up to $145 daily). Permanent HA, which helps families secure housing or prevent eviction. Security deposit and last month's rent or two months arrearages to prevent eviction.
CalWORKs Housing Support Program (HSP): Provides flexible housing-related support, including housing navigation and rental assistance, to families experiencing, or at risk of, homelessness in the CalWORKs program.	The Housing Support Program is administered through CalWORKs at the county level. Contact your local county welfare office to apply and learn more.	Financial assistance and housing-related wraparound supportive services, including but not limited to: rental assistance, housing navigation, case management, security deposits, utility payments, moving costs, interim shelter assistance, legal services, and credit repair.
Conditional Release Program (CONREP): Implements additional residential treatment opportunities to support the safe transition of individuals from the state hospital to community treatment.	The Department of State Hospitals (DSH) administers the CONREP program. DSH can either provide services directly or through a contract with private providers or local governments. Welfare and Institutions Code § 4360; Penal Code § 1615. Typically, DSH contracts with a county to provide a local CONREP program. A county's CONREP program can be administered by the county or by a private or non-profit agency. March 2024 Fact Sheet DSH Diversion Team Office Hours: 10 a.m-noon on the second Friday of each month via Teams. To be added to the invitation list, please email request to: DSHDiversion@dsh.ca.gov	Statewide system of community-based services which treats patients with the following commitment types: Not Guilty by Reason of Insanity, Incompetent to Stand Trial, Mentally Disordered Offenders, and some parolees who have been released to outpatient status. CONREP provides individual therapy, group therapy, random drug screenings, substance abuse screenings, psychological assessments, home visits, court-approved treatment planning, intensive supervision and monitoring, and ongoing evaluation and assessment.
Emergency Solutions Grant (ESG): California ESG funds are federal funds that the U.S. HUD provides to the California Department of Housing and Community Development (HCD), which then allocates the funds to eligible CoC service areas.	Each CoC can recommend up to two eligible organizations (Private Nonprofit Organizations or Units of General-Purpose Local Government) to apply directly to HCD for funding to administer homeless services in that CoC's area. The 2024 ESG NOFA represented a shift to a three-year funding cycle, covering funding years 2024-2026, 2025-2027, and 2026-2028, with one application covering all three cycles. HCD allocates its funding to the state's CoC areas as detailed in the ESG Program Final Guidelines dated December 10, 2024 and in the 2024 ESG NOFA. For specific timelines and application details, contact your local CoC.	ESG funds may only reimburse costs related to the following ESG eligible expenditure program components/activities: street outreach; emergency shelter; homelessness prevention; rapid re-housing; HMIS; and administrative activities.

Funding Program	Updated Status (as of September 2025)	Eligible Uses
Encampment Resolution Funding Program (ERF): Provides grants for local jurisdictions to develop coordinated strategies to resolve encampments and transition people experiencing homelessness in encampments into safe and stable housing.	Currently in Round 3. View awards by city, county and CoC.	Rapid rehousing supports (such as rental subsidies, landlord incentives, and case management), operating subsidies for housing and shelters, street outreach, and coordination of supportive services. Funds can also support system improvements, permanent housing delivery, prevention and diversion efforts, interim housing, and improvements to existing shelters. In addition, applicants may use up to 5% of funds for administrative costs, but site restoration is not an eligible use.
Family Homelessness Challenge Grants: Provides grants for local jurisdictions to support the development and acceleration of innovative programs that expand promising practices and create solutions to address and end family homelessness. (HCD)	Application period closed. Round 2 awards must be spent by July 2026. Current awardees	The grant funds can be used to support a range of housing and homelessness interventions for eligible families, including rapid rehousing, rental and operating subsidies, and street outreach. Funds may also be used for services coordination, prevention and shelter diversion, interim and permanent housing solutions, and improvements to existing shelters. Additionally, resources can support system-level activities that strengthen regional partnerships and homeless services delivery, as well as up to 5% of funds for administrative costs.
Guaranteed Income (GI) Pilot Program: Provides grants to eligible entities that provide a guaranteed income to participants, with funding prioritized for pilot programs that serve individuals who age out of extended foster care at or after 21 years of age, pregnant individuals, or older adults. GI participants must also be low-income residents of California. (CDSS)	Applications to administer the program were due April 2025. For the latest information regarding the State's Guaranteed Income Pilot Program for Older Adults, please sign up for email updates via the CDSS Guaranteed Income for Older Adults Listserv. For questions regarding the Guaranteed Income Pilot Program, please email our team at GIPilot.info@dss.ca.gov.	
HOME Investment Partnerships Program (HOME): Provides funding to create and retain affordable housing for lower-income renters, homebuyers, or homeowners by funding tenant assistance, or single- or multi-family acquisition and/or rehabilitation or new construction. (HCD)	Applications were due on May 22, 2025, except for Native America Entity Applications, whose application will be accepted on a continuous, over-the-counter basis until Sept. 24, 2025, at 5 p.m. PDT, or until the available funds are exhausted, whichever occurs first. Over-the-counter (Native American Entity) applications can be accessed through eCivis Grant Management System - Programs Available for Solicitation page, beginning on Jan. 31, 2025. Subscribe to the HOME emailing list (federal programs) for notifications and announcements.	Housing rehabilitation, new construction, and acquisition and rehabilitation, for multifamily projects; new construction and down payment assistance for single-family projects; first-time homebuyer down payment assistance, owner-occupied rehabilitation and tenant-based rental assistance programs; and predevelopment loans to CHDOs. All activities must benefit low-income renters, homebuyers or homeowners.

Funding Program	Updated Status (as of September 2025)	Eligible Uses
Home Safe: Provides flexible housing-related supports, including housing navigation and rental assistance, to individuals in the Adult Protective Services (APS) intake process, or those who may be served through a Tribe, or Tribal entity or agency, and are experiencing, or at risk of, homelessness for reasons of abuse, neglect, self-neglect, or financial exploitation as determined by APS or Tribal agency.	58 counties operate a Home Safe program, and each program is tailored to meet the needs of the local community. Twenty-three tribal grantees operate a Home Safe program The Home Safe program is administered locally. You may look up your county point of contact for more information or contact the CDSS Housing and Homelessness Division to learn how to connect with your local program.	Housing-related financial assistance: Help with rent arrears, security deposits, and relocation fees. Case Management: Receive intensive housing-related case management. Eviction prevention: Get assistance to prevent homelessness. Landlord mediation: Services to help resolve issues with landlords. Deep cleaning: services to help maintain safe housing.
HOME-ARP Reentry Housing Pilot Project: Provides funding to develop units for re-entry populations and/or those exiting state and federal prisons and local jails.	Application period closed April 2025. Award announcements anticipated Fall, 2025.	The development, acquisition, or rehabilitation of permanent supportive housing for eligible populations, including a capitalized operating reserve, and can cover up to 100% of HOME-ARP unit development and operating costs with a 15-year compliance period. It also funds a wide range of supportive services — such as case management, mental health care, substance use treatment, education, life skills training, and short- or medium-term rental assistance —consistent with McKinney-Vento, homelessness prevention, and housing counseling service definitions.
Homekey Tribal Program: Provides Tribal Entities funding to develop multifamily rental housing developments, including rehabilitation of existing housing, new construction of apartments, townhomes, or single-family rental homes, including manufactured housing, or conversion of non-residential space to residential housing.	Application closed as of November 2024. The deadline to disperse the funds to the awardees was June 30, 2025.	Eligible uses of Homekey Tribal funds include acquiring, rehabilitating, or converting properties into permanent housing; new construction; relocation costs; capitalized operating subsidies; predevelopment activities; and related site improvements. Projects must involve rental housing developments with at least four units, where at least 49% of units serve the target population.
Homekey+: Provides funding to build more permanent supportive homes faster for veterans and residents experiencing homelessness and mental health challenges.	Effective Aug. 7, 2025, HCD reopened the NOFA and accept applications until funds run out. The department will prioritize applications that include veteran units, and after Oct. 7, 2025, it will transfer any unrequested funds from rural, youth, or geographic allocations to the discretionary reserve, continuing to prioritize veteran-serving projects.	Examples of eligible uses include acquisition and rehabilitation of existing sites (e.g., hotels/motels, apartments), commercial properties, master leasing, new construction, and the purchase of affordability covenants.
Homeless and Housing Insecure Pilot Program: Provided colleges, in partnership with local housing service agencies, funding to provide housing navigation and placement services, academic support, and case management services to homeless students or those at risk of becoming homeless.	Operated as a pilot through 2024-2025, HHIP will become a fully scaled program in 2025-2026, and will continue to fund colleges that meet program requirements. Future expansion is dependent on additional legislative funding.	

Funding Program	Updated Status (as of September 2025)	Eligible Uses
Homeless Housing, Assistance and Prevention Program (HHAP): Provides grants for local jurisdictions to support regional coordination and local homelessness response to address challenges and increase permanent housing solutions for individuals and families experiencing homelessness.	Currently in Round 6. Applications were due Aug. 29, 2025. Applications are expected to be reviewed through December 2025.	HHAP 6 funds can support a range of activities including street outreach, new interim housing, safe parking programs, loans to multifamily affordable housing projects, and non-housing solutions that serve or prevent unsheltered homelessness. Grantees must allocate at least 50% of funds to housing solutions but may also use funds for administrative costs (up to 7%) and HMIS (up to 1%), with potential for additional HMIS-related expenses on a case-by-case basis. Costs previously covered under Systems Support may now be categorized under Administrative Costs or Non-housing Solutions.
Housing and Disability Advocacy Program (HDAP): Provides flexible housing-related supports, including housing navigation, rental assistance, and legal services, to individuals likely eligible for disability benefits who are experiencing, or at risk of, homelessness, with a focus on chronic homelessness. (CDSS)	The Housing and Disability Advocacy program is administered locally. Look up your County Point of Contact for more information or contact the CDSS Housing and Homelessness Division to learn more about how to connect with your local program.	Generally, outreach, case management, disability benefits advocacy, and housing assistance. Housing-related financial assistance and wraparound supportive services provided by HDAP include but are not limited to: interim shelter assistance, rental assistance, housing navigation, case management, security deposits, utility payments, moving costs, legal services, and credit repair. Each county administers its own program and may have more limited uses.
Housing for a Healthy California Program (HHC): Creates supportive housing for individuals who are recipients of or eligible for health care provided through the DHCS Medi-Cal program. (HCD)	All awards have been granted. No additional applications published.	Acquisition, new construction or reconstruction and rehabilitation, administrative costs, capitalized operating subsidy reserves (COSR) and rental subsidies for developers.
IST Solutions Infrastructure Program: Expands the availability of residential treatment and interim housing by up to 5,000 beds statewide to support ongoing sustainable diversion and community-based restoration programs for individuals with serious mental illness who have been found incompetent to stand trial. (DSH)	Managed by Advocates for Human Potential. Round 1 closed Dec. 31, 2024. For updates, questions, or comments, contact, follow online form instructions. All funds must be used by June 30, 2028. Includes: Community Based Restoration (CBR) Program (in development)	Funding must be used to provide, prepare, and/or improve a building (or buildings) for delivery of diversion/CBR services, such as the initial down payment to purchase a property, refurbishment costs, and/or the costs of furniture needed for occupancy.
Multifamily Finance Super Notice of Funding Availability (Super NOFA) Streamlines four of HCD's rental housing programs to align eligibility criteria, scoring, and release of funds allowing for a coordinated single application and award process.	Currently in Round 3. Application period closed. LA Disaster NOFO awards are expected to be made in November 2025.	Multifamily Housing Program (MHP): Provides low-interest, long-term deferred payment loans for new construction, rehabilitation, and preservation of permanent and transitional rental housing for lower-income households. Infill Infrastructure Grant (IIG): Promotes infill development by providing financing for infrastructure necessary for the development of affordable and mixed income housing. Veterans Housing and Homelessness Prevention (VHHP): Provides long-term loans for the acquisition, construction, rehabilitation, and preservation of affordable multifamily housing for veterans and their families. Joe Serna, Jr. Farmworker Housing Grant (FWHG): Provides funding for new construction, rehabilitation, and acquisition of owner-occupied and rental units for agricultural workers.

Funding Program	Updated Status (as of September 2025)	Eligible Uses
Transitional Age Youth (TAY) Program: Provides funds to help young adults aged 18-24 secure and maintain housing, with priority given to those formerly in the foster care or probation systems. (HCD)	Eligible applicants are county child welfare services agencies that demonstrate a need to provide housing for young adults aged 18 to 24, inclusive, with priority given to those currently or formerly in the foster care or probation systems. Eligible counties receive an invitation to apply.	Housing navigation and case management, emergency support, homelessness prevention, outreach to those with the greatest needs, and coordination with community resources and the child welfare system. Transitional Housing Plus Housing Supplement Program (THPSUP) funds specifically support maintaining contracted bed capacity and paying providers a set monthly rate per youth.
Transitional Housing Placement Program: Offers transitional housing placements to 18 to 21-year-old non-minor dependents in Extended Foster Care (THP-NMD) and young adults who exited the foster care system on or after age 18, currently between ages 21 and 25, for up to 36 cumulative months (THP-Plus). (CDSS)	Contact your County Child Welfare (or Juvenile Probation) Housing Coordinator or Independent Living Program (ILP) coordinator.	THP-NMD is a supervised, supportive housing program for young adults (ages 18-21) who are in California's Extended Foster Care (EFC) program.
Tribal Homeless Housing, Assistance and Prevention Program (Tribal HHAP): Provides grants for California Federally Recognized Tribes to support unique, culturally responsive interventions to prevent and address homelessness within their communities.	Currently in Round 4. Draft application is published. Final application expected July/August 2025. Applications due Oct. 30, 2025.	Permanent supportive housing, homelessness prevention, interim housing, and non-housing services. Tribes may also contract with Tribal Designated Housing Entities or other partners to administer programs. Up to 7% of funds may be used for administrative costs and 1% for HMIS, though data entry into HMIS is not required.

CalICH Action Plan for Preventing and Ending Homelessness in California 2025 – 2027; Strategic Investment Table pages 33-44. Table edited to reflect updated information and alignment with housing for BH clients.

Funding Coordination Guides and Examples

While the funding landscape in California is complex, several communities have been able to create more integrated and responsive housing solutions. Fortunately, there are tools available to help behavioral health professionals and housing partners make sense of the funding landscape and identify opportunities to better serve their communities.

This Funding Resources page from the California Interagency Council on Homelessness (Cal ICH) provides curated links to state, federal, and national organization's tools and guidance aimed at supporting the strategic use of financial resources detailed in their Putting the Funding Pieces Together Guide.

DHCS' Behavioral Health Settings, Services, and Funding Sources provides an infographic showing housing settings and treatment settings. The infographic also shows the funding sources for residential settings and identifies whether the sources can be used for infrastructure or operational costs, and if the funds are for health care services or housing services.

Flexible Housing Subsidy Pools

As described above, most housing is developed with a variety of funding sources. Flexible Housing Subsidy Pools ("Flex Pools") are a strategy to braid complementary funding sources and resources to provide permanent supportive housing. With a Flex Pool, a centralized administrative entity can efficiently connect individuals to the units that best meet their needs with a collective "housing pool." A Flex Pool is not a rental assistance program in and of itself. Rather, a Flex Pool is a vehicle to organize rental assistance that 1) coordinates and braids funding streams, facilitating compliance and required reporting; 2) acts as a single fiscal intermediary between funders and landlords; 3) identifies, secures, and supports a portfolio of units; and 4) coordinates with providers of housing supportive services.

DHCS is providing technical assistance on the use of Flex Pools to coordinate the administration of the BHSA Housing Interventions, housing-related Community Supports (including transitional rent), and other sources of housing support funding.[20] The Flexible Housing Pools Technical Assistance Resource provides information on Flex Pools, including the results of a landscape scan DHCS conducted to learn about the flex pool-like systems currently operating in California. The examples listed in this resource can help counties better understand how a flex pool-like system works and how it can efficiently and effectively administer rental subsidies within a complex, multi-program funding environment.

The best practices highlighted below demonstrate approaches in different communities that have resulted in successful housing, behavioral health coordination, and placement of clients into permanent housing.

Tight Alignment of County Behavioral Health and its Continuum of Care

One Northern California county behavioral health plan has made housing collaboration a priority, recognizing that behavioral health and housing systems must work hand in hand to effectively serve people experiencing homelessness. To strengthen these connections, the county has embedded its staff throughout the local CoC structure and housing processes. By building relationships and sharing expertise, the county ensures that behavioral health perspectives are integrated into planning, data analysis, and housing placements, using the following strategies:

- Behavioral health department staff join every CoC committee to understand housing systems and build trust with the housing providers and CES operators.

20 Behavioral Health Services Act County Policy Manual V1.3.0, Chpt 7C.8 Flexible Housing Subsidy Pools, Department of Health Care Services

- The department appoints internal staff to serve as liaisons:
- A behavioral health planner sits on CES committee, serves as in-house HMIS expert.
- The behavioral health data team participates on the CoC's data committee and works on data matching and outcomes.
- The behavioral health program coordinators attend all housing placement case conferences across all subpopulations (transitional age youth, families, veterans).

Because many CoC trainings are designed for housing-focused providers and may not immediately resonate with behavioral health staff, the county reviewed these materials and translated key concepts — like coordinated entry, housing prioritization, and case conferencing — into terms that aligned with clinical workflows and behavioral health language. These adapted trainings were then delivered to behavioral health contract providers, helping demystify housing processes and clarify their role in them.

The county also helped to create shared data systems with the CoC. All behavioral health providers enter client data into HMIS (the data management system used by CoCs), ensuring behavioral health clients are visible within Coordinated Entry and to housing providers who may receive a referral for that client. A designated behavioral health planner serves as the internal HMIS expert, supporting data quality, reporting, and training of behavioral health contracted providers who are mandated to enter client data into HMIS. The CoC lead and behavioral health department co-developed a release of information (ROI) that allows for necessary data sharing — enough to support referrals and coordination without exposing protected health information. County counsel was engaged early to ensure processes and tools met privacy and legal standards.

These efforts have strengthened the county's 's ability to bridge behavioral health and housing systems. By actively participating in CoC committees, data planning, and housing placement processes, the county has built trust with housing providers, improved coordination, and ensured that clients with behavioral health needs are more consistently connected to stable housing. The result is a more integrated system that not only expands access but also improves long-term housing stability and recovery outcomes for vulnerable populations.

Establishing Clear Roles Between Behavioral Health and Housing Entities

One Central Valley county's Department of Behavioral Health (DBH) has made housing a priority by supporting a range of options for people experiencing homelessness. This includes funding 13 Permanent Supportive Housing (PSH) sites (funded through NPLH and realignment funds), along with bridge housing programs that provide short-term stability on the path to permanent housing. All projects, including DBH-contracted providers (for project management and supportive services) and DBH staff, are required to enter data into the HMIS. DBH oversees data entry and quality control and works directly with the HMIS lead agency, the Housing Authority.

DBH collaborates with Coordinated Entry, landlord partners, and housing navigators to match people to permanent housing. The department participates in weekly community navigation meetings, which include attendees from outreach teams, shelters, the CoC, housing programs, and supportive services. Attendees discuss housing pathways for people needing housing and/or treatment, and tenancy issues — including how to locate individuals by identifying who had the last contact with them, providing appropriate supports and problem solving.

The DBH is responsible for referring and certifying individuals who meet the eligibility criteria of serious mental illness and homelessness. The CES team matches those with DBH eligibility documentation to available PSH units. DBH Bridge Housing provides interim housing and uses Coordinated Entry to plan a pathway to permanent housing for clients. Clients are initially referred to bridge housing directly

from hospitals, law enforcement, inpatient treatment centers, shelters, TAY inpatient services, FSPs and other DBH programs. Referrals typically involve high-risk individuals who require stabilization services beyond what standard housing or shelter programs provide. While living in bridge housing, clients are enrolled in the CES to secure permanent housing, and 98 percent of those who exit to permanent housing do so through CES programs.

These efforts demonstrate the power of aligning behavioral health and housing systems, resulting in stronger partnerships, more effective service delivery, and lasting housing stability for the individuals and families served.

Close Collaboration Between Behavioral Health, Housing, and Health Departments in a Small County

In response to regional crises (e.g., wildfires), one small county developed an Interdisciplinary Multi-Disciplinary Team (IMDT) model to create collaboration for behavioral health and homeless clients. This model supports a range of high-need groups, from fire survivors to unsheltered community members, and mental health diversion clients. IMDT convenes weekly for three-hour case conferences with representatives from health, human services, homeless services, and behavioral health to collaborate on client needs. Behavioral health staff play an active role in these meetings by identifying housing needs and linking clients to shelter or long-term housing options, while also connecting them to behavioral health services.

Upon enrollment in a high-needs cohort, individuals complete a universal ROI that allows data to be shared seamlessly across departments. This process strengthens collaboration and helps breakdown silos between behavioral health, health services, and homelessness programs. Behavioral health staff use this ROI to coordinate care and support housing navigation in partnership with their homelessness system partners.

The county's Whole Person Care team also plays a key role in engagement and referrals. Outreach teams visit encampments, conduct field assessments, and facilitate warm hand-offs into programs such as bridge housing. In addition, they maintain behavioral health caseloads, ensuring continuity of care as clients transition into shelter or permanent housing. This integrated approach has been pivotal in improving client engagement and expanding housing access for unsheltered individuals with behavioral health needs.

Additionally, the Behavioral Health Bridge Housing program opened in February of 2025 offers six- to 12-month stays for individuals with complex behavioral health needs. It is operated through a partnership between the Department of Health Services and an on-site provider, with co-located county behavioral health staff offering clinical support. On-site housing navigators assist residents with enrolling in CES and developing housing plans.

By uniting health, housing, and behavioral health services, this county has created a collaborative model that not only improves client engagement but also opens real pathways to stability and long-term recovery.

Braided Funding

One southern California county has developed an innovative approach to braided funding, aligning diverse resources to maximize impact and improve outcomes for individuals with complex needs. They have an example of combining funds to support permanent supportive housing operated by a non-profit organization.

This county partners with a nonprofit that has a 115 apartments in master leases. Their funding sources for master leasing and supportive services include HUD CoC contracts combined with funding from the county, a Medi-Cal MCP, and private donations. This enables the nonprofit to master lease apartments, entire buildings, and scattered site units — including furnishing the apartments and paying for utilities, with tenants contributing 30 percent of their income toward rent.

In alignment with HUD contract requirements, their services are focused on individuals and families experiencing chronic homelessness. Many of these tenants have serious mental health issues and/or substance use disorders. All referrals are through the local CES.

The county credits their success to several strategies:

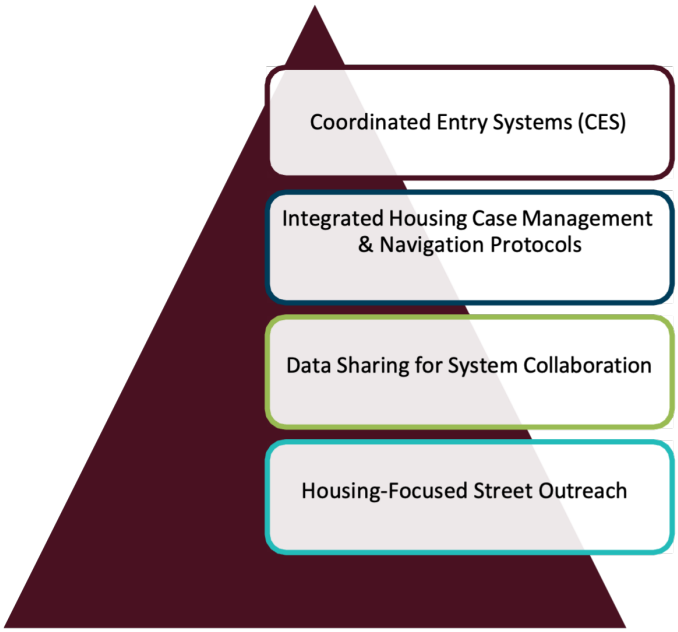
- Development of relationships with property owners and managers: The agency is the master tenant for the unit, sub-leasing to the client. This allows them to master lease individual units or entire buildings through local owners or the Housing Authority.
- Maintenance of units: They negotiate master lease terms that make them responsible for most minor repairs and maintenance — such as clogged plumbing, water leaks, and window repairs — and use their own maintenance staff to perform this work.
- Guarantees for damage repair: The agency uses some of their funding to cover damage beyond normal wear and tear. Because HUD limits the amount of funding that can be used for unit damages, the agency uses other funding sources to cover the cost. Through regular inspections, they are able to identify problems and perform maintenance quickly. This commitment is attractive to property owners.
- Case management: The agency provides case management, using a level of need approach so that tenants receive services at least monthly and up to daily as needed, providing them the required stability to maintain housing.
- Relocation: When tenants want to move, the agency helps by assisting with voucher applications, finding other housing options locally or outside the area, or reconnecting them with family who may be able to provide housing.
- Shared housing: In shared housing arrangements for unrelated tenants, each tenant has their own private bedroom and bathroom. The agency has found this model works best when bathrooms are not shared, so they only lease properties where this setup is possible.
- The agency follows a Housing First model, screening out only tenants with recent convictions for violent acts or those who are registered sex offenders. Tenants are accepted regardless of SUD and are not required to participate in treatment for mental health or other health conditions. However, the use or possession of illegal substances in the housing or on the premises is strictly prohibited.
- The agency offers a housing retention program to tenants experiencing difficulties with lease compliance, providing added support to help them remain housed. When necessary, tenants may be relocated to a different site to better support their success.

Together, these strategies demonstrate the agency's commitment to aligning with HUD requirements while addressing the complex needs of individuals and families experiencing chronic homelessness. By combining housing stability with supportive services, they create pathways for long-term success for both tenants and property partners.

Other Examples and Strategies for Improving Partnerships to Increase Housing Opportunities

Collaboration opportunities – Locate an agency already providing an effective model and join forces to have them designate units specifically targeting the BHSA population eligible for housing. Determine if the tenants qualify to be enrolled in an FSP and identify ways to bring in mental health and substance

use services to the tenants on site or through remote/ virtual care. Additionally, consider providing peer navigators to assist with housing retention for tenants who are BHSA eligible.



Senior housing communities can be an excellent resource for housing behavioral health clients. Because some of the senior housing communities are only subsidized to an affordability level of 50 percent or 60 percent AMI, a county behavioral health system may be able to negotiate with an owner/operator to help subsidize some of the units to a level affordable for persons served under the BHSA. The provider may also be interested in the county behavioral health system's ability to provide or obtain supportive housing and mental health services to assist with tenant retention. Some of the communities have service offices on-site where behavioral health staff or a contracted agency can provide tenant services.

Affordable housing projects can provide a pathway to housing for clients who need intensive on-site support services, either through master leasing or controlling multiple units in one location. Counties and service providers can work with developers to negotiate master leases, preferences, or set-asides of units in projects where rents are still too high for very low-income tenants served under BHSA. By leveraging federal and state funds alongside BHSA resources, these partnerships can fill the gap where project-based subsidies are lacking, ensuring clients with incomes at 30–50 percent of AMI — or those relying on SSI — can still access housing.

To identify opportunities, the county or service providers can look for affordable housing projects in development, or those struggling to lease units targeted toward higher-income households. Tax-credit-funded projects without project-based Section 8 or other subsidies are often ideal, since BHSA funds can provide the additional rental support needed for very low-income tenants to qualify and remain stably housed.

Why Partner With BHSA?

Affordable housing providers benefit from collaboration with the BHSA because tenants gain access to supportive services that help them sustain their housing. Behavioral health staff can connect tenants with programs such as In-Home Supportive Services (IHSS) or Housing Tenancy and Sustaining Services available through Medi-Cal Managed Care Plans. For tenants who do not qualify for these Medi-Cal-funded services, but are eligible for BHSA services, BHSA funding can be used to cover essential housing support . In addition, when affordable housing providers face challenges securing enough project-based housing vouchers to make a project viable, a partnership with the behavioral health system can bridge the gap by bringing in additional funding for housing operations and occupancy stability.

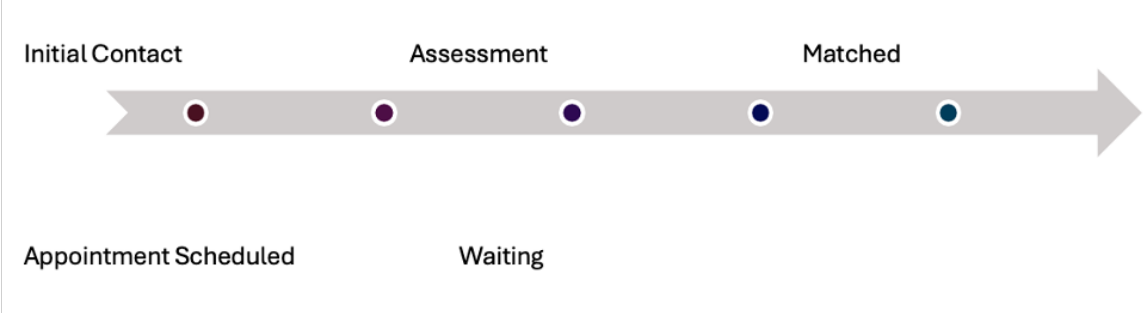
Across counties, these strategies show the power of aligning behavioral health with housing systems. Whether through active participation in CoC committees, funding permanent supportive and bridge housing, or embedding interdisciplinary teams in the community,

Bridging Behavioral Health & Housing Systems

Introduction

Throughout April and June of 2025, Abt conducted 90-minute interviews with County Behavioral Health agencies and Homeless Lead Agencies to gather community- level perspectives on current behavioral health coordination practices, system challenges, and training needs to improve outcomes for individuals living with behavioral health conditions who are also experiencing homelessness.

Themes were synthesized and mapped to underlying systemic issues that hinder service integration and impact outcomes for people with behavioral health and/or substance use disorders who are experiencing homelessness. These findings directly informed the development of targeted training recommendations aimed at strengthening local capacity, improving system coordination, and promoting more person-centered approaches to care.



The four core areas identified are designed to strengthen the integration between housing and behavioral health systems. Bringing together four areas of practice that, when implemented together, form a comprehensive framework for helping individuals with behavioral health issues find housing stability.

These topics introduce a practical framework organized around the four interconnected areas —Coordinated Entry System (CES), Housing Case Management, Housing-Focused Street Outreach, and Data Sharing—that together create a comprehensive approach to supporting behavioral health clients. By aligning these areas, communities can reduce duplication, improve communication, and provide more seamless pathways to stability.

People with behavioral health problems often interact with multiple service providers across different systems, including homeless services and Medi-Cal. Without coordinated systems, clients may be asked to repeat their stories, complete redundant paperwork, or face delays caused by disconnected processes.

By integrating housing, outreach, housing case management, and data-sharing practices, we can ensure services are client-centered and efficient.

behavioral health staff are helping to close gaps, build trust, and create seamless pathways into stable housing. Together, these approaches demonstrate how integrating care and housing services leads to stronger systems, deeper engagement, and lasting stability for people with behavioral health needs.

Assessment Tool: Community Spotlight:
City of Austin

Within the city's CES, they utilize the Austin Prioritization Assessment Tool (APAT). The APAT is a questionnaire used to assess individual's housing and service needs and prioritize those who are least likely to exit homelessness without formal intervention.

Additional Resources

- Webinar: Homeless Outreach: From Street Engagement to Housing Success
- Webinar: System Navigation Starts Here: Optimizing Coordinated Entry
  Webinar: Guiding the Journey to Housing Resources: Strengthening Housing Case Management
- Webinar: Data Sharing for System Collaboration

Fragmentation of the Coordinated Entry System

In every community interviewed, Coordinated Entry (CE) was in place, but the implementation was inconsistent and/or fragmented. Several counties reported that while outreach teams from CoCs could input data into the Homeless Management Information System (HMIS), they often lacked full access to view and act on information from other systems, particularly behavioral health. **CE was often perceived as a housing-focused process rather than an integrated access point for broader supportive services.**

The U.S Department of Housing and Urban Development (HUD) mandates that every Continuum of Care (CoC) operate a Coordinated Entry System (CES) and ensures that all CoC- funded housing projects fill vacancies through the CES process. The CES is the backbone of a community's homelessness response system. It provides a clear and standardized process for assessing individuals experiencing homelessness, prioritizing them based on vulnerability and need, and referring them to the most appropriate housing resources available. The purpose of the CES is to ensure that resources are distributed fairly, transparently, and in alignment with federal requirements. By using assessments and prioritization criteria that are unique to each community, the CES helps communities avoid a "first-come, first-served" model that can disadvantage those in greatest need. While need-based prioritization is ideally informed by clinical assessments and information (e.g., from health and behavioral health care providers), the lack of access to health care and health care information has led many communities to resort to using widely available assessment tools. For example, many communities began using the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). Some counties continue to use the VI-SPDAT, even though it is being phased out. It is important to note that there are currently no federally established standards for assessment tools.

Note: Communities should stay informed about evolving guidance and explore alternative assessment practices that align with accuracy and person-centered approaches.

Behavioral health providers are critical partners in the CES because their clients in need of housing may also have behavioral health needs that affect eligibility, documentation, and service planning. Behavioral health providers could also assist CoCs to improve CES by sharing applicable and allowable primary and behavioral health data and information that could be used to better prioritize access to housing and services. Understanding the CES helps providers navigate the system more effectively on behalf of clients. It also builds the foundation for effective collaboration between housing and behavioral health sectors, ensuring that referrals are not only made but followed through to housing placement.

System Overview

The primary goals of the CES are to ensure that homelessness assistance in each CoC is:

- Allocated as effectively as possible
- Easily accessible by people experiencing homelessness
- Prioritized based on someone's needs and that criteria are clearly documented, publicly available and followed by all providers

Within their CES, CoCs must establish a standardized process for all households presenting to the homeless response system for assistance. The process has four stages: Access, Assessment, Prioritization, and Referral. CoCs are responsible for administering CE in their assigned geographic areas. The CoC establishes physical or virtual access points that cover the entire geographic area and markets the CES to the community.

Access points use varied assessment processes to gather information on households' needs, preferences, strengths, and barriers to housing.

After households are assessed, the CES follows established policies and procedures to prioritize households based on level of vulnerability and need. These policies should be publicly accessible and must be approved by the CoC's governance body.

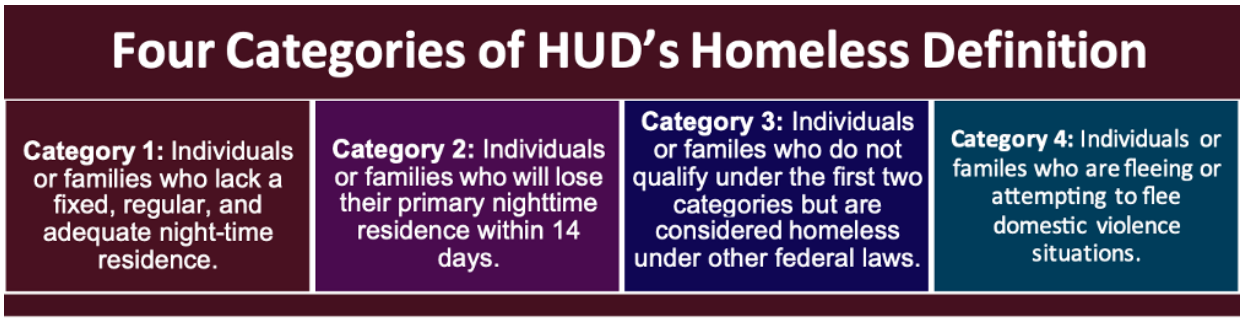
In the CES, the process begins when a person goes to an access point in their community, where they receive an initial or crisis assessment. Many communities conduct assessments in phases to ensure that information is gathered as needed, and as rapport and trust are built with clients.

The initial triage phase is focused on defining the nature of the current crisis and ensuring the client's immediate safety. Phase 2 focuses on addressing housing challenges by using housing navigation and community resources to quickly resolve a person's housing crisis. Phase 3 includes completing a coordinated entry assessment. This occurs when a client's housing crisis cannot be immediately resolved during the initial triage or housing navigation. During Phase 3, the client is enrolled in coordinated entry and may be offered crisis assistance such as emergency shelter or street outreach. At this point, information collected from the client is limited to only the minimum necessary to enroll the client, such as where they are currently residing and their family composition.

Peer Navigation has been an effective model to support this type of improved coordination across often siloed behavioral health and homelessness system. The County of Santa Clara's Behavioral Health Navigator Program is a peer-run program connecting individuals and families to county and community resources.

Behavioral Health Client Intersection

Behavioral health providers need to understand HUD's definition of homelessness as it determines eligibility for federally funded housing programs and ensures clients are properly referred.



Using these definitions helps providers align with housing partners and avoid gaps in service delivery. While many clients may qualify for behavioral health services, they may not meet HUD's definition of homelessness, which directly impacts their access to housing programs. By being familiar with these categories, providers can set realistic expectations, guide clients to appropriate resources, and advocate more effectively during cross-system coordination, such as referrals and case conferencing.

For behavioral health providers, it's important to think about their role in the CES and preparing clients for the process. Providers can support clients by explaining the role and the function of the CES in matching people to housing resources based on vulnerability and eligibility.

Helping clients gather essential documentation, such as identification, disability verification, income information, and documentation of homelessness history, can prevent delays and reduce barriers. Walking clients through the assessment questions beforehand builds comfort and confidence, particularly when discussing sensitive issues like housing history, health, and safety needs. Providers should also clarify that while being connected to behavioral health services does not automatically qualify someone for housing, it can strengthen their case when paired with HUD's definition of homelessness. Encouraging clients to consent to data sharing across systems and offering warm hand-offs during

CES assessments help to address their most critical needs and increase the likelihood of successful housing connections

Collaboration and Coordination

Housing case conferencing is an opportunity for homeless service providers and behavioral health providers to discuss the needs of specific individuals and match them with appropriate housing and service opportunities. To accomplish this, it is important to obtain a release of information and informed consent documents.

Additionally, all partners participating in case conferencing meetings should have an MOU with the Homeless CoC Lead Agency that includes their role and function as they relate to housing case conferencing and coordinated entry.

The housing case conference provides an opportunity to elevate the needs of clients with critical medical and behavioral health needs. Remember, the CES should serve the most vulnerable clients first. A housing case conference provides the opportunity to make the needs of clients visible and to ensure they are accurately represented on the prioritization list.

Resources & Tools:

- APPENDIX C: Coordinated Entry Flow Chart Sample" on page 79
- APPENDIX D: HUD Homeless Definition Categories" on page 80

Strengthening Housing Case Management

Interviews with county behavioral health agencies and CoC lead agencies revealed that although relationships exist between housing and behavioral health agencies, they often rely on informal networks or individual champions. Cross-system coordination is not always institutionalized, and there is a need for clearer roles, shared language, and joint goals. Most communities have case managers within both housing and behavioral health programs, but rarely do these staff coordinate. There is a lack of system navigators who understand both systems and can support individuals through complex processes.

In addition to the housing and behavioral health systems, individuals enrolled in Medi-Cal who are in a managed care plan (MCP) may be eligible for, or are currently receiving, Medi-Cal benefits that include case management. For example, Medi-Cal members may be receiving Enhanced Care Management (ECM), housing navigation, housing tenancy and sustaining services, transitional rent or other housing-related community supports through MCP. MCPs often contract with community providers to deliver these services. These services and providers are important to consider in cross-system strengthening efforts.

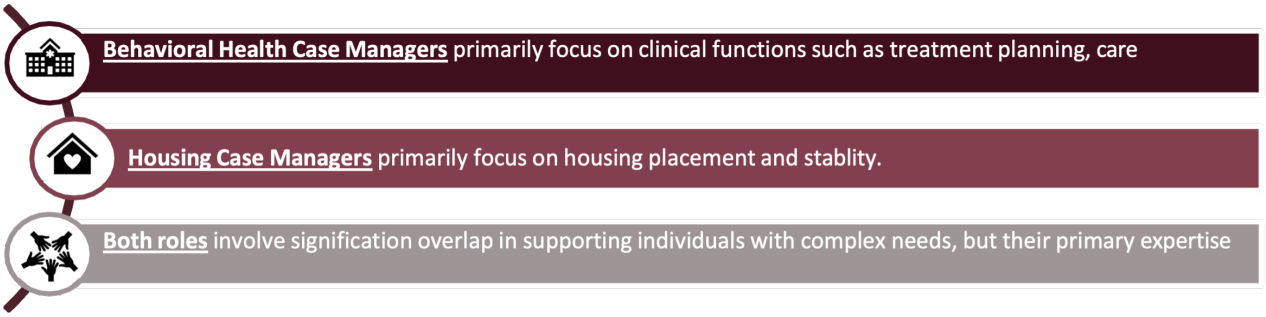
Shared Language

It is important for behavioral health providers and homeless/housing providers to use a shared language because it builds clearer communication, reduces misunderstandings, and ensures that all partners are working from the same definitions and concepts. Shared language helps create alignment around client needs, eligibility requirements, and service goals, which is especially critical when systems have different funding rules, regulations, or program priorities. When providers describe situations, challenges, and successes in consistent terms, it not only improves collaboration but also makes it easier to coordinate care, advocate effectively for clients, and track outcomes across systems. Ultimately, a common language strengthens trust among providers, streamlines service delivery, and prevents clients from being caught between differing interpretations or practices.

Behavioral Health Term	Housing/Homeless Equivalent	Why Shared Language Matters
Client	Tenant	Aligns how we refer to the people we serve, avoiding confusion.
Treatment Plan	Housing Stabilization Plan	Helps both systems understand goals and support as part of a unified plan.
Diagnosis / Symptoms Engagement	Barriers to Housing	Links clinical needs to housing challenges, ensuring both are addressed.
	Enrollment in Program	Clarifies when a person is connected and actively participating in services.
Crisis Intervention Continuity of Care	Emergency Shelter / Interim Housing	Connects immediate safety and stabilization responses across systems.
	Housing Retention / Stability	Emphasizes long-term support that combines health and housing needs.

Role Clarification

Behavioral health providers, Medi-Cal Community Supports, ECM providers, and housing providers should not assume core functions of each other's roles between the two systems. Behavioral Health case managers are clinically focused. Their work centers around things like treatment planning, care coordination, and managing mental health symptoms, etc., while housing case managers lead with a housing-focused approach. Their role is to help clients secure and maintain housing. Understanding these roles helps everyone work better together, make smarter referrals, and provide more comprehensive and coordinated care.



Documentation Alignment

Document ready means having all the necessary documentation—IDs, income verification, birth certificates, Social Security cards, proof of disabling conditions (for federally funded housing programs) etc.—organized, up to date, and easily accessible, preferably uploaded into the community's Homeless Management Information System (HMIS). For behavioral health and homeless providers, helping clients become document ready is critical because many housing opportunities come with tight timelines. Whether it's a unit opening quickly or a deadline for a housing voucher application, delays in documentation can mean missed opportunities. Sometimes providers work hard to find an affordable place for their client to live, but if providers don't assist their clients with all the necessary paperwork, the client can miss the housing resource availability —simply because they weren't able to submit documents in time.

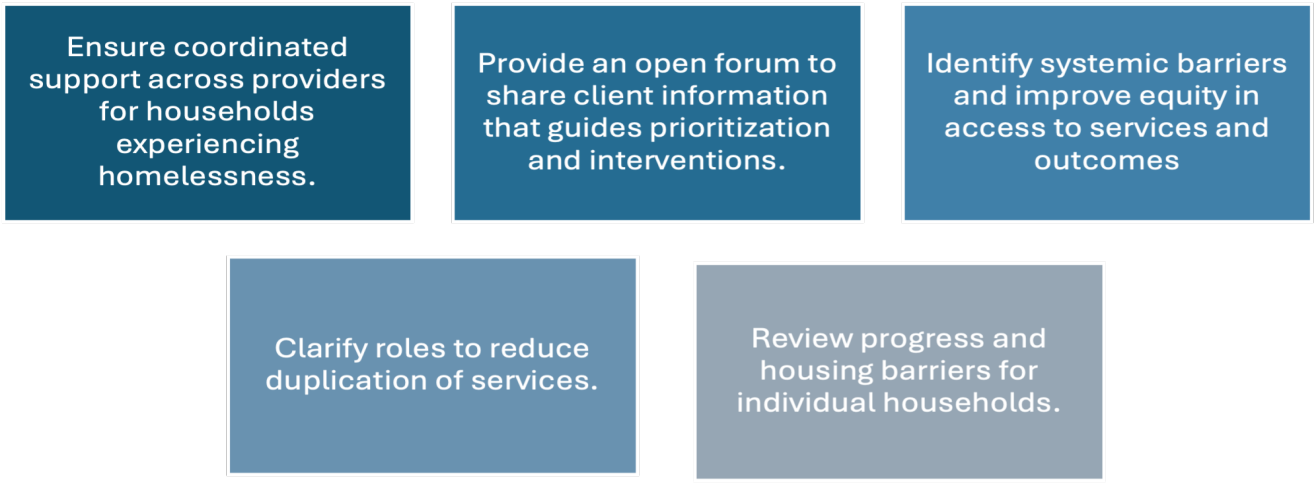
Documentation Needed for Housing

Collaborative Housing Case Conferencing

It is important for behavioral health providers to participate in their local CoC collaborative housing

case conferencing meetings. Housing case management involves working alongside homeless service providers, outreach teams, and housing navigators to address barriers like documentation, income, or landlord engagement. Case conferencing brings these partners together to share information, align strategies, and prioritize clients for available housing resources. When behavioral health providers are engaged in this process, they can integrate critical information about a client's mental health or substance use needs, ensure continuity of care, and advocate for the support necessary to help clients maintain housing. This collaboration reduces duplication, prevents clients from falling through the cracks, and strengthens outcomes by addressing both housing stability and behavioral health needs in a coordinated way.

Collaborative Housing Case Management Goals



Resources and Tools:

- APPENDIX E: Document Ready Checklist on page 81
- APPENDIX F: Shared Roles & Responsibilities on page 82
- APPENDIX G: Housing & Behavioral Health Terminology Guide on page 86

Think About It

Think of a time when you applied for your current apartment or house. Can you image how difficult this process can be if you are missing required documents? Put yourself in the shoes of your clients as they attempt to get "document ready."

Housing-Focused Street Outreach

During Abt's interviews, outreach was universally described as both a strength and a challenge. While outreach teams are often the first point of contact for unsheltered individuals, they operate independently of behavioral health systems, limiting their ability to navigate clients across the Continuum of Care. Outreach is frequently under-resourced, and these teams struggle with engaging individuals experiencing behavioral health crises.

In some communities, outreach workers can refer clients to shelters but not directly to treatment programs. Others mentioned that clients "fall through cracks" when warm handoffs do not happen.

Housing-focused street outreach shifts the emphasis from ongoing engagement without resolution to proactive connection to housing pathways.

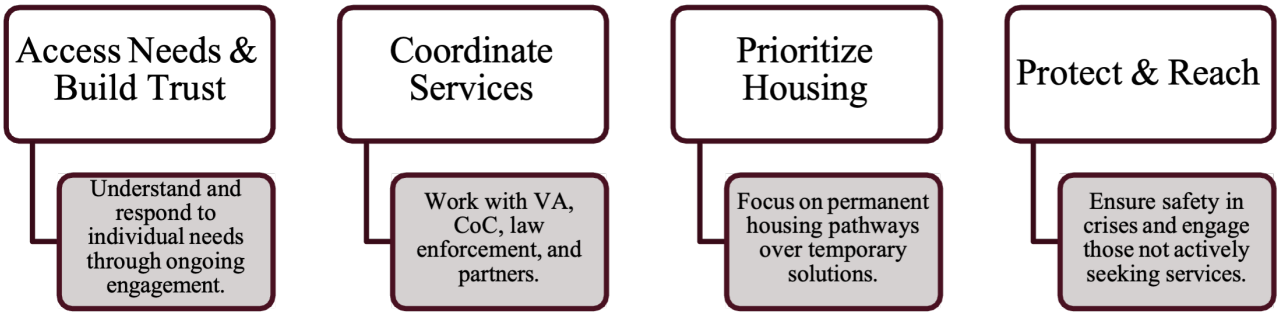
The goal is to make housing the long-term focus of outreach activities while still addressing immediate safety and health needs, including connections with behavioral health services when appropriate. Outreach workers help clients navigate the steps required to enter the CES and become document-ready for housing opportunities.

As a reminder: Homeless outreach does not require people to enter Emergency Shelter (ES) or Transitional Housing (TH) to access housing but offers it as an immediate option.

Traditional outreach sometimes emphasized relationship-building without a clear housing plan. Housing-focused outreach retains relationship-building but uses it as a pathway to housing navigation. This approach has been shown to reduce the length of time individuals remain unsheltered. By embedding housing navigation into every outreach interaction, outreach teams act as the front door to the homeless response system, ensuring that clients enter and move through the process more quickly and successfully.

Core Elements of Housing-Focused Outreach

It's important for behavioral health providers to understand the core elements of housing-focused outreach because this approach ensures that outreach is not just about engagement or crisis response but is intentionally designed to connect people with behavioral health concerns that are experiencing homelessness to permanent housing.



Housing Focused Street Outreach Best Practices

Housing-focused outreach centers on meeting people with behavioral health concerns, where they are—both physically and emotionally—and building a pathway toward stable housing. This work relies on three core elements: **building rapport, crisis intervention,** and **harm reduction.** These principles

guide outreach teams in effectively engaging behavioral health clients experiencing homelessness, particularly those who are unsheltered or highly marginalized.

Community Spotlights

Nevada County, CA HOME Team

The Nevada County HOME Team (Homeless Outreach and Medical Engagement) is a specialized outreach program operated by the county's Health & Human Services Agency that serves highly vulnerable individuals experiencing homelessness by meeting them directly in the community — on the streets, in shelters, and sometimes at points of release from jails or hospitals. The team is multidisciplinary, made up of outreach workers, housing navigators, a peer supporter with lived experience, and a registered nurse. Together, they integrate healthcare, peer support, and housing navigation to build trust, assess health and housing needs, and connect individuals to medical care, behavioral health services, substance use treatment, and long-term housing options.

By collaborating with hospitals, law enforcement, jails, and other community partners, the HOME Team ensures warm hand-offs and works to break cycles of homelessness, incarceration, and provide crisis care. They also support Coordinated Entry by conducting vulnerability assessments in the field, especially for individuals who may not yet be connected to the system and referring them into the housing pipeline. In essence, the HOME Team is a mobile and collaborative outreach unit designed to provide responsive, low-barrier engagement that connects unsheltered individuals to vital services and helps them achieve long-term housing stability coupled with wrap around services.

Sacramento County

The Homeless Engagement and Response Team (HEART) conducts street and encampment outreach using counselors and peer specialists to build trust, assess mental health and housing needs, and link individuals to key services including housing, health care, and substance use treatment.

Riverside (City of Riverside)

The City's Homeless Street Outreach Team comprises outreach professionals who work daily in the field—on the streets, in service venues, etc.—to engage chronically unsheltered individuals and connect them with services. This includes a "street-to-home" pilot where clients are moved directly into housing with aggressive case management, supported by Veteran's Affairs and HUD partnerships

Community Recognition

Communities such as Hennepin County, Minnesota were nationally recognized for their comprehensive, coordinated and Housing Focused Outreach after doing an evaluation of their street outreach program.

Resources:

- APPENDIX H: Outreach to Housing Success Checklist
- APPENDIX I: Warm Handoff Checklist on page 89
- NAEH Housing Focused Street Outreach Framework

Data Sharing for System Collaboration

In interviews with communities, many struggled to share information across systems due to legal concerns, incompatible databases, or a lack of policies. As a result, staff often duplicated efforts, worked without critical background information, and, in turn, re-traumatized clients by having them retell their stories.

Sharing data between housing and behavioral health systems can be challenging due to different privacy regulations, including HIPAA, California state mental health laws, and 42 CFR Part 2 for certain substance use data. Providers need to understand both the opportunities and restrictions these laws create. Knowing what can be shared, with whom, and under what circumstances helps providers collaborate without compromising client privacy. Proper data collection and compliant data-sharing agreements ensure that data is both useful and secure.

Smart, intentional data sharing can make a real difference for people while helping providers work more effectively across behavioral health and homeless service systems. Effective cross-sector collaboration is illustrated through real examples below, along with the privacy rules that govern the work (including 42 CFR Part 2 and HIPAA). Practical strategies are also highlighted to support building a culture where data is not only collected but actively used to improve care, coordination, and outcomes, providing an understanding of what data can be shared in compliance with privacy laws, and will have tools to support the development of systems for referrals and shared care. Although this guide is intended to assist behavioral health and homeless services providers as they serve people with behavioral health challenges, this does not constitute legal advice.

Homeless Management Information System (HMIS) Basics

What is HMIS? Software vs. Data Functions

HMIS is a local software system that tracks client-level information over time, including the characteristics and service needs of people experiencing homelessness.

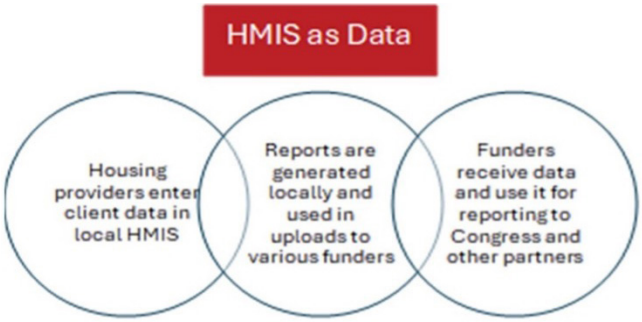
It serves two key purposes:

- It establishes shared standards for data collection and reporting that flow from federal partners to Continuums of Care (CoCs) and software vendors
- It functions as the data system where information is entered locally, analyzed for community use, and submitted for required reports to funders. Those funders, in turn, use the data for accountability, planning, and reporting to Congress and other stakeholders.

For a detailed overview of HMIS, please see the Attributes of Effective Utilization of HMIS.

Relationship Between CoC and HMIS Lead

Management of HMIS is delegated to the HMIS lead by the CoC. CoCs are responsible for designating and ensuring HMIS is administered in compliance with HUD rules/regulations. Strong CoC and HMIS partnerships often result in more use of the data for improving homeless services, strengthening community planning, and resource allocation.



HMIS Privacy and Compliance

Through the oversight of the CoC, HMIS leads publish privacy notices at each agency and website in their community, so clients are informed about the uses and disclosures of their Personally Identifying Information (PII) data. Privacy notices vary from community to community. Clients have the right to refuse to provide data to HMIS – this does not disqualify them from receiving services.[21]

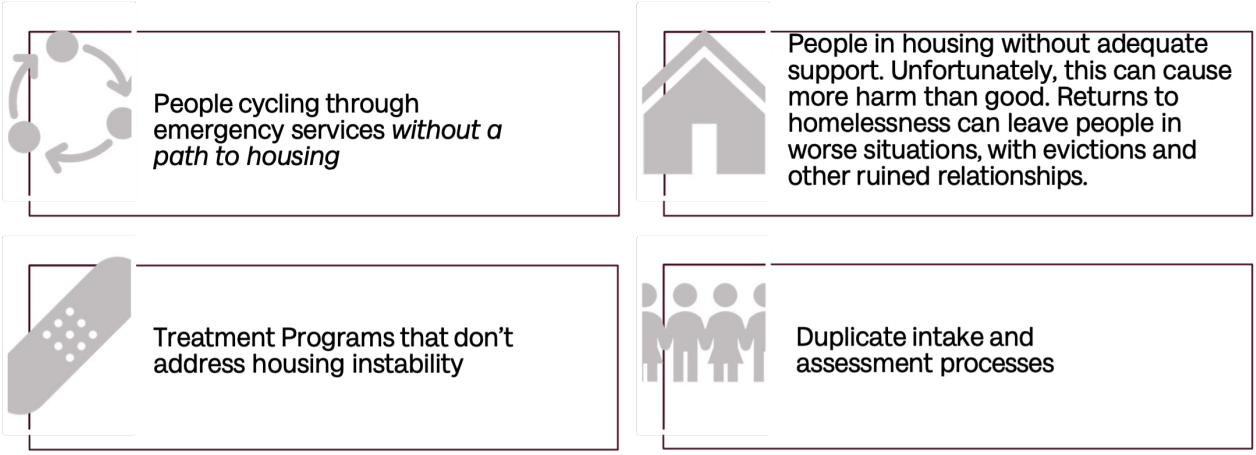
The HMIS privacy notice sets the standards for data sharing. If a disclosure is listed in the privacy notice, it can be shared without the client's consent; however, anything not listed in the privacy notice requires the client's consent.[22]

All in all, with the right consent and/or privacy notice, HMIS information can be shared with behavioral health providers.

HIPAA, California Mental Health Confidentiality Rules (WIC § 5328)

Why Data Sharing Matters

Communities without data sharing protocols in place between the Behavioral Health System and the Homeless Service System tend to see:



The reality is that data sharing often gets blocked, often as a result of misunderstandings about data sharing laws. HIPAA protects privacy, yes — but it also allows for data sharing in specific situations, especially for coordination of care.

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21 https://www.govinfo.gov/content/pkg/FR-2004-07-30/pdf/04-17097.pdf

22 Coordinated Entity Management and Data Guide, available at: https://files.hudexchange.info/resources/documents/coordinated-entry-management-and-data-guide.pdf. HUD Exchange, "Protecting Data in an HMIS Environment: Privacy, Security, and Confidentiality (Slides),"accessed April 17, 2024, available at: https://files.hudexchange.info/course-content/protecting-data-in-an-hmis-environment-privacy-security-and-confidentiality/Protecting-Data-in-an-HMIS-Environment-Privacy-Security-and-Confidentiality-Slides.pdf.

Behavioral health and homeless systems often operate in silos. These different systems work on different data platforms, which are regulated differently and thus make collaboration hard. This separation and siloed work have real consequences; people cycle through crisis services, treatment programs, and miss housing needs, and housing programs overlook the behavioral health system of care.

Leads to increased collaboration and reciprocal care

Data sharing helps break down silos between agencies, creating a "shared table" for decision-making. Providers can see the same information, leading to consistent messaging and coordinated interventions. Reciprocal care means that support flows in both directions. Housing providers can inform health care, and health care can inform housing efforts.

Reduces the need for duplicate data entry

Without data sharing, staff often re-enter the same information into multiple systems, wasting time, risking inconsistencies, and sometimes even asking clients to repeat traumatic events multiple times. Sharing allows data to improve accuracy and efficiency. Less duplication means more time for direct client support rather than administrative work.

Reduces administrative burden for staff in both systems

Administrative tasks can be some of the most time-consuming parts of service delivery. This efficiency frees up resources for high-value activities like outreach, counseling, and follow-up care.

Improves housing and health outcomes when providers collaborate

Clients benefit when providers act as a unified team, seeing the whole picture instead of fragmented pieces. Shared data enables early intervention, for example, identifying a tenant at risk of eviction before a crisis occurs. Research shows that integrated care models lead to more stable housing, reduced hospital visits, and overall better well-being.

The Intersection of HIPAA and HMIS

A HIPAA covered entity is an organization or individual that is required to comply with the Health Insurance Portability and Accountability Act (HIPAA). These entities primarily

include health plans, healthcare clearinghouses, and certain healthcare providers who transmit health information electronically.

Most homeless service providers are not HIPAA-covered entities. HIPAA primarily applies to health care providers, health plans, and health care clearinghouses. Some agencies are primarily behavioral health providers but also provide housing services like outreach and permanent supportive housing. Both HMIS and electronic health records (E.H.R.) contain personal information. In HMIS, it is Personally Identifiable Information (PII); In EHRs, it is Protected Health Information (PHI).

The Minimum Necessary Rule: Whether governed by HIPAA or not, a best practice is to only share the minimum amount of data needed for the purpose at hand. This reduces the risk of unnecessary exposure and builds trust with clients. For example: sharing a client's housing status with a clinic may be essential; sharing their full case history may not be.

HIPAA Uses and Disclosures

HIPAA allows providers to use or disclose PHI without a release of information for the purpose of:

Treatment	Payment	Healthcare Operations	Public Health Activities	Research	Certain Legal Contexts
Coordinating or managing client care.	Billing, eligibility verification, or claims processing.	Quality assessment, training, audits.	Reporting disease, preventing injury.	If permitted under HIPAA's research provisions.	Court orders, law enforcement, mandated reporting.

If the Privacy Rule does not permit or require the use/disclosure, that doesn't mean information cannot be shared, but a release of information is required.

State Law that Supplements HIPAA: Welfare & Institutions Code § 5328

California law (WIC § 5328) treats mental health records as highly confidential. As a rule, written client consent is required before those records are shared with external professionals. There is narrow, enumerated exceptions. While under HIPAA, information can be shared for care coordination without consent, under WIC 5328, that is not an exception. However, some exceptions do not require consent, like emergencies, certain court or public-safety disclosures, or specific county-worker situations. As a best practice, authorizations should clearly describe that mental health information will be shared (for example, "mental health treatment records" or "psychotherapy notes") to avoid confusion and to meet state and program requirements.

- **Emergencies:** WIC contains specific exceptions allowing disclosure during emergency services and in circumstances where there is a serious danger of violence to a foreseeable victim (duty-to-warn type situations).
- **Law enforcement / serious threats:** WIC includes limited law-enforcement exceptions (e.g., to protect an identifiable person from serious danger, or limited disclosures about whether a person is confined when an officer presents certain warrants). These are narrowly drawn.

California's Confidentiality of Medical Information Act (CMIA) provides stricter privacy protection than HIPAA in many cases.

42 CFR Part 2 Substance Use Data Sharing

42 CFR Part 2 is a federal regulation that applies to programs that both hold themselves out by providing substance use disorder (SUD) services and receive federal funding. It specifically protects SUD treatment records, adding extra privacy safeguards beyond general health privacy rules. Unlike HIPAA or HMIS, Part 2 places stricter limits on when information can be shared without a client's permission. This means even disclosures that might be allowed under HIPAA may still require written consent under Part 2. In most cases, written consent from the client is required before SUD treatment records can be disclosed. The consent must be specific, naming the recipient, and stating the purpose of the disclosure. [23]

There are only a few situations where sharing is allowed without written consent:

23 For more information on Part 2, see: Fact Sheet 42 CFR Part 2 Final Rule | HHS.gov

Think of Part 2 as the "extra lock" on the door. It is there to protect individuals seeking SUD treatment from stigma, discrimination, or legal risk. When in doubt, obtain written consent or check with compliance/legal before sharing.

State Law that Supplements 42 CFR Part 2

California's Health & Safety Code § 11845.5, also known as Confidentiality of Alcohol and Drug Abuse Treatment Records, mirrors the privacy protections in the federal 42 CFR Part 2 regulations. But the key difference is, 42 CFR Part 2 only applies to programs receiving federal funding, while California's law applies regardless of federal funding. That means the state rule covers more providers, widening the protection net for clients.

It prohibits disclosing any information that could identify a person as having, or having had, a substance use disorder, or receiving SUD treatment, without the patient's explicit written consent for each specific disclosure. This is not a blanket permission. Each disclosure must have its own consent.

There are two pathways to lawful disclosures:

These rules are designed to protect clients from stigma, discrimination, or legal consequences tied to SUD history. For providers, it's not just a legal requirement — it's a trust-building measure with the people they serve.

How Sharing SUD Information (with consent) Improves Housing Outcomes Regardless of state/federal limitations, data can be shared with the proper consent/ROI. Continuity of Care

When housing teams and treatment providers share relevant SUD information (with the client's consent), everyone maintains a shared understanding. Staying alignment helps avoid mixed messages or conflicting plans. It also reduces service gaps when a client moves from one program to another — for example, from detox to transitional housing — so the support is seamless to the client.

Crisis Prevention & Response

Shared information can provide early warnings about relapse triggers, medication changes, or emerging health risks. This allows the housing team to step in before problems escalate, which can prevent evictions, hospitalizations, or even homelessness recurrence. Rather than functioning as a reactive response, this approach operates as a preventive framework that strengthens stability and supports long-term well-being.

Better Support Planning

When treatment goals and housing case plans are aligned, support feels more holistic and coordinated. Shared information helps wrap services around the client — like making sure appointments, medication schedules, and recovery groups all fit together without conflicts. It turns separate services into a single, cohesive plan that addresses both housing stability and recovery.

Faster Access to Housing

When teams can share SUD-related information (with the client's written consent), it can speed up the housing process. For example, documentation of treatment participation or disability status can be essential for housing programs to meet eligibility requirements. Without this sharing, clients might face delays while agencies locate paperwork or validate information.

Client-Centered Coordination

Sharing information between housing and treatment teams means clients do not have to keep retelling their story to every new provider. This not only reduces frustration but also preserves dignity — clients feel respected and supported rather than processed. Furthermore, coordinated information sharing enhances trust, as clients observe their care teams working collaboratively toward shared objectives.

Stability & Retention

Coordinated support can help clients remain engaged in treatment and connected to recovery resources. The result is stronger, more stable housing placements Over time, this approach improves both housing stability and long-term recovery success.

With consent, sharing SUD information is not about breaching privacy. It's about removing barriers, improving client experience, and helping people thrive in both housing and recovery.

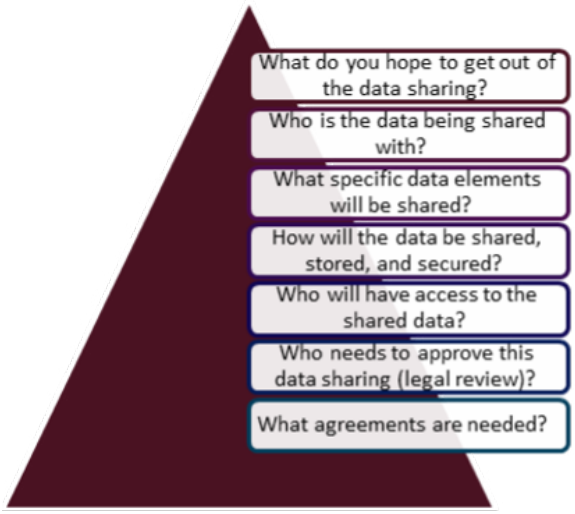
Community Spotlight: San Luis Obispo 815 Release of Information Form

In Abt's interview with several county behavioral health departments, many described the difficulties sharing information with homeless service providers. However, one community identified a release of information that has helped their community overcome these barriers. In San Luis Obispo (SLO) County, they discussed how their ROI has helped them achieve better collaboration with community partners. After a detailed compliance review of the ROI, the Abt team found that this form met HIPAA, 42 CFR Part 2, and state law.

Getting Started with Data Sharing

Data covered by HIPAA, 42 CFR Part 2, and local California laws are permitted with the allowable consents. Follow these steps to get started.

Before starting, ask the following questions:



These questions will help form a plan of action to implement data-sharing communities. The best practice for data sharing is to have a data sharing agreement in place. This is a contract with two or more parties that outlines how data will be shared, who it will be shared with, and what each party is responsible for.

A template MOU has also been enclosed for communities to consider and adapt for their own needs.

Resources, Handouts, & Tools:

- DHCS Data Exchange webpage, which includes:
  - Authorization to Share Confidential Medi-Cal Information (ASCMI) Initiative, which includes a standardized consent form to support the exchange of housing information
  - Data Sharing Authorization Guidance
  - CalAIM Data Sharing Authorization Medi-Cal Housing Support Services toolkit
- State Health Information Guidance
- California Data Exchange Framework
  - APPENDIX K: ROI Compliance Checklist on page 91
  - APPENDIX L: REFUSING ROI on page 93
  - APPENDIX M: Release of Information (ROI) Template on page 94
  - APPENDIX N: Sample MOU Template" on page 97

ROI forms in California must:

- Be in plain language, understandable to the client
- Clearly identify each recipient or specific class of recipients
- State the specific uses and disclosures authorized
- Include expiration date or event
- Be signed and dated by the client (or legal representative)

Attributes of Effective Utilization of HMIS

Attributes of Effective Utilization of HMIS

Homeless Management Information System (HMIS) Background

A Homeless Management Information System (HMIS) is a locally implemented web-based data system used to record and analyze client, service, and housing data for individuals and families who are experiencing or at risk of homelessness within a CoC's geographic region. It is a tool that can be leveraged to more equitably serve and support people who are experiencing or at risk of homelessness. The HEARTH Act requires that all communities have an HMIS with the capacity to collect unduplicated counts of individuals and families experiencing homelessness

The CoC is responsible for designating an HMIS lead agency to manage the operation of the HMIS, including setting up projects, training users, and generating reports. In California, there are over 40 CoCs, and most CoC operate their own HMIS Implementation. This means that although CoCs may use the same vendor, they have separate implementations of the same software, and their systems may operate differently depending on the local CoCs' customizations. The federal standards guiding the implementation of HMIS are administered by the U.S. Department of Housing and Urban Development (HUD) through the Office of Special Needs Assistance Programs (SNAPS), as part of its comprehensive data response to the congressional mandate to report annually on national homelessness.

Key Terms:

Homeless Management Information System (HMIS): Local data system used to collect, manage, and report information about individuals and families experiencing homelessness.

Homeless Data Integration System (HDIS): A statewide data warehouse of data from the 44 local homelessness response systems in California.

Continuum of Care: Regional planning body that coordinates housing and services funding for people experiencing homelessness.

(CoC) HMIS Lead: The organization designated by the CoC to operate and manage the HMIS on behalf of the community.

Recipient: Grantees, subgrantees, or other entities receiving homelessness funding.

Program: The umbrella effort or initiative run by an agency. It can include multiple projects in HMIS.

HMIS Project: A specific project set up in HMIS that corresponds to a funded program.

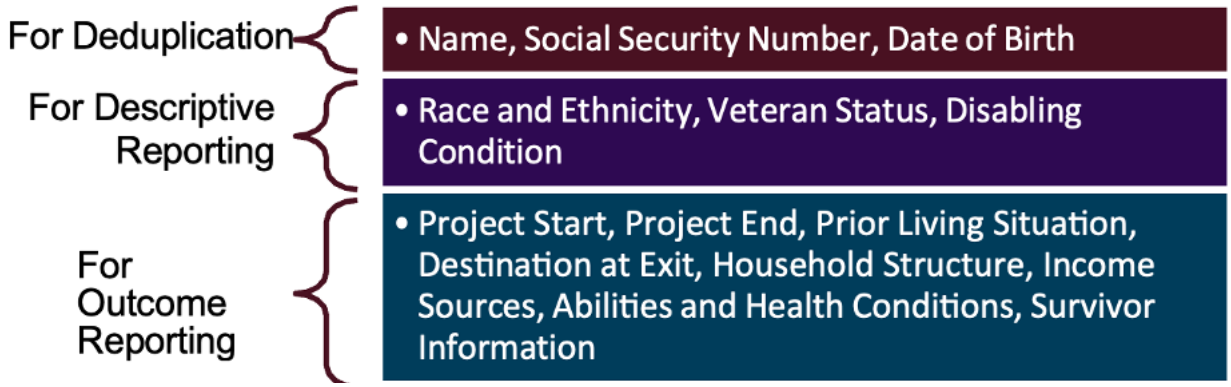
HMIS Requirements under BHSA

County Behavioral Health Departments in California are required to enter data into the local HMIS for all individuals and families served under BHSA-funded housing interventions. Universal data elements are collected for everyone. Common Data Elements are collected by most, though some types of projects and funders don't require them all. The data elements that must be captured are:

Universal Data Elements	Common Data Elements
At record creation, HMIS asks for client's · 3.01 Name · 3.02 Social Security Number · 3.03 Date of Birth · 3.04 Race and Ethnicity · 3.07 Veteran Status At project enrollment, HMIS asks for client's: · 3.08 Disabling Condition · 3.10 Project Start Date · 3.11 Project Exit Date · 3.12 Destination · 3.15 Relationshipto Headof Household · 3.16 Client Location · 3.917 Living Situation	These data are collected throughout a client's project enrollment, sometimes at project start, update, annual assessments, and exit: · 4.02 Income and Sources · 4.03 Non-cash benefits · 4.04 HealthInsurance · 4.05 Physical Disability · 4.06 Developmental Disability · 4.07 Chronic Health Condition · 4.08 HIV/AIDS · 4.09 Mental Health Disorder · 4.10 Substance Use Disorder · 4.11 Domestic Violence · 4.12 Current Living Situation · 4.13 Date of Engagement · 4.14 Bed-Night Date · 4.19 CE Assessment · 4.20 CE

In addition to the data elements above, BHSA-funded housing interventions are required to capture W5 Housing Assessment at Exit of the Individual Federal Partner Program Elements. These correspond to HUD's HMIS Data Standards and are mandated under Welfare & Institutions Code § 8256(d)(8).

While data collection is mandated, it also has a purpose. Data can be collected for deduplication, descriptive reporting, or outcome reporting.



Roles and Responsibilities

HMIS Lead/System Administrator in each CoC: Responsible for providing project set-up services for funding recipients, training opportunities locally for HMIS users, and technical support to help recipients and subrecipients use and understand the local HMIS. The HMIS Lead also inputs quarterly data uploads into HDIS.

This list of CoC leads in California includes the HMIS leads for most communities.

Funding Recipients (County Behavioral Health): Responsible for ensuring that data is collected and entered in HMIS, though they may designate a subrecipient or service partner to oversee data entry. Recipients must understand what HMIS is, how it is used, and how to access it, and they are required to follow all local HMIS policies, including participation in HMIS- required training courses. They are also expected to work closely with their HMIS Lead to ensure programs are set up correctly, and that high-quality data is maintained.

Advantages of Getting Clients into the System (HMIS)

Entering clients into HMIS ensures they are visible within the broader homeless and behavioral health system of care. This allows providers to connect clients more quickly to available housing interventions and supportive services, reduces duplication of efforts across agencies, and supports better coordination of care. For counties and providers, accurate client data also strengthens compliance with funding requirements, demonstrates program effectiveness, and helps secure future resources to expand services.

Obtaining Access

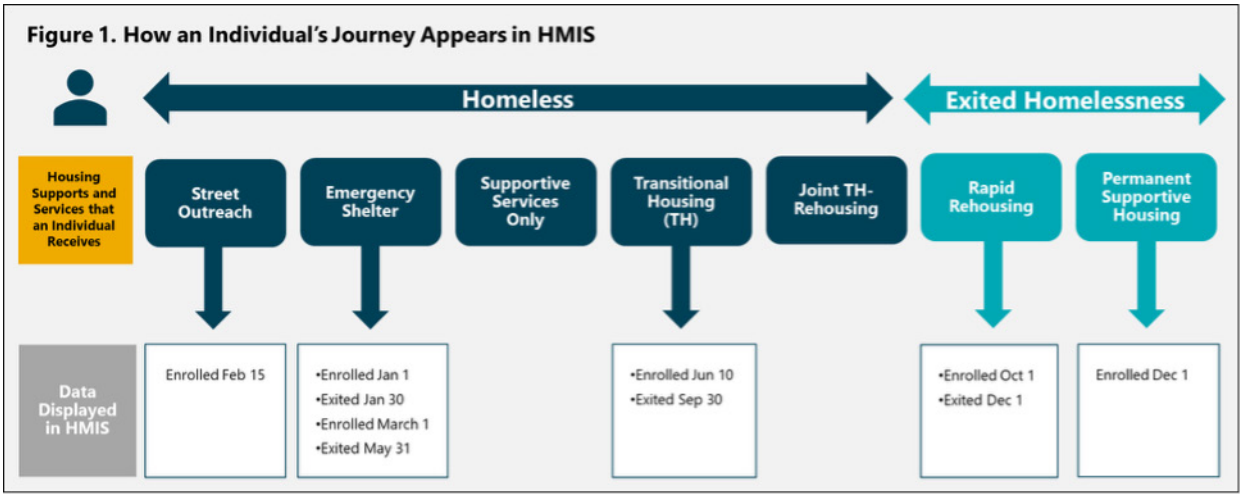
Recipients who have not yet started entering client data into HMIS should coordinate with their local HMIS lead agency, usually by reaching out to the agency's designated HMIS lead, to obtain access. Most HMIS lead agencies require end users to complete training before granting access.

HUD also requires HMIS lead agencies to execute an HMIS End User Agreement with every individual who has access to HMIS and its data. These agreements outline expectations regarding data security, client privacy and confidentiality, compliance with CoC HMIS policies and procedures, training requirements, responsibilities for reporting policy violations, and potential disciplinary actions for noncompliance. All end users must sign this agreement to confirm their commitment to follow CoC HMIS policies.

Each HMIS lead agency will provide users with details about required training, user licenses, signed agreements, local HMIS policies, and any additional data entry requirements specific to that implementation.

Understanding the Architecture of HMIS

HMIS data is organized around two basic types of records: clients and projects. Client data includes identifying information, demographic information, as well as information regarding needs and assets (e.g., employment and earnings, mental health needs, etc.) based on the universal data elements. Project data includes information on homeless services and housing interventions available within the CoC network to serve people experiencing homelessness. When people experiencing homelessness are encountered by a homeless services program within a CoC, a new client record will be created. The person is assigned an HMIS number that is tied to the person's identifying information. As the person receives assistance from services and programs, they are enrolled and exited in these projects. Therefore, a client's record in HMIS may include multiple project enrollments and exits, which can show their journey through homeless services (See figure on page 73.)



Information The HMIS Lead Will Need To Set Up New Projects

HMIS records information both about the people who are at risk of experiencing or are experiencing homelessness and about the type of assistance (including housing) provided to those individuals. All projects providing assistance within a CoC that enter client information into HMIS must first be set up within the HMIS.

The project setup process will vary from CoC to CoC. Communities will need to provide a specific set of information, so the HMIS lead can configure the program correctly and ensure compliance with BHSA and AB 977 requirements. Some HMIS leads may require a Project Setup Form or AB 977 Project Intake Form, where projects will fill in all the information; others may want to set up a meeting to talk through the information below. In either scenario, having the grant award letter, contract, and project scope of work at hand can help speed up this process.

Project-level data elements recipients should be prepared to share:

Basic Project Information

- Project name (as it should appear in HMIS)
- Agency/organization name
- Contact information for the project lead and HMIS users

Funding Sources & Identifiers

- Start date of the project (and, if applicable, retroactive start date for services)
- Funding source(s) (must include Behavioral Health Services Act-BHSA)
- Grant identifier/contract number from DHCS or county behavioral health agency

Project Descriptor Data Elements (PDDEs)

- May additional funding streams tied to the project
- Description of the project so the HMIS lead can identify the project type
- Bed/Unit inventory for residential projects: number of beds/units, household types served, availability year-round or seasonal
- Target population(s) (e.g., DV: Survivor of Domestic Violence, HIV: Person with HIV/AIDS)
- Address and geocode of the project's physical location

How Behavioral Health's HMIS Participation Supports Integration with CoCs

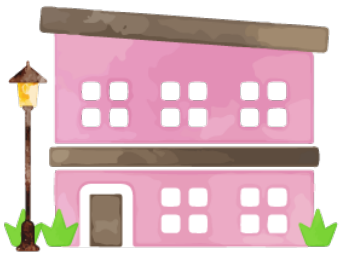
Behavioral health providers' participation in HMIS is essential to strengthening integration with Continuums of Care (CoCs). By participating, behavioral health programs ensure that the system captures not only housing needs but also the mental health, substance use, and wellness challenges that often drive or prolong homelessness. This fuller picture allows communities to better understand the complexity of client needs and plan resources more effectively.

When behavioral health data is part of HMIS, providers across systems gain the ability to collaborate more closely. Shared information supports streamlined referrals, reduces duplication of services, and enables the development of individualized care plans that address both behavioral health and housing needs. This cross-system coordination helps ensure that clients receive timely, holistic support rather than fragmented or siloed services.

Participation also strengthens the effectiveness of Coordinated Entry and overall system performance. With behavioral health represented in HMIS, CoCs can more accurately identify service gaps, align resources, and promote fairness and equity in placements. Ultimately, this integration leads to stronger accountability across programs and a more responsive, person-centered homelessness response system.

Resources:

- APPENDIX J: Sample Project Setup on page 90



APPENDIX A: CoC Partnership Connection

Strengthening partnerships with a local Continuum of Care (CoC) to improve client access to housing resources is key for California behavioral health leadership and staff.

County behavioral health department leaders are working to deepen communications and collaboration pathways with local leaders in homelessness and housing systems of care, including the CoC, other county departments, and Public Housing Authorities. Staff members and their managers, too, can take steps to identify housing and homelessness partners and ways in which their departments can align and better serve their clients who are experiencing homelessness.

Step 1: Find Your Local CoC Contact

Use the HUD CoC Program contact list to identify your CoC Lead:

Find your CoC here:
HUD CoC Contacts by State
Select *California*, then find your county or region.

Step 2: Reach Out

Start with an email or phone call to the CoC Lead Agency. Introduce yourself, your agency, and your role. Example opening:

Hi, I'm [Your Name] from [Agency Name], working on behavioral health and housing coordination. I'd like to connect with you to better understand how we can support the system working to prevent and end homelessness in our community and strengthen referral pathways for our clients. Would you be available for a short call or meeting?

Step 3: Ask Key Questions

Use this list to guide your first meeting or conversation. Feel free to adjust language to fit your tone, style, and the point of contact.

Questions About the CoC and Its Structure

- What agency serves as the CoC lead in this region?
- Who are the main partners in your CoC (e.g., housing providers, outreach teams, local government)?
- How is the Coordinated Entry System (CES) structured in our area?

Questions About Referrals and Access

- How can behavioral health staff refer clients into CES?
- Where can we find eligibility or documentation requirements?
- How can we learn more about the prioritization process?

Questions About Meetings and Participation

- When and how often does the CoC or CES committee meet? Can we attend or join any working groups?
- Is there a behavioral health seat on any CoC committees?

Questions About Coordinating Housing Planning

- What is the process for accessing information about our behavioral health clients' CES prioritization, housing options?
- Are there any client-focused housing planning or other conferencing we can attend or support? What are the data agreements necessary so we can participate?

Questions About Support and Training

- Is there training available for CES or HMIS for our staff?
- Are there tools/templates we can use to help with housing referrals or data entry?

Questions About Shared Goals

- What housing resources within the CoC are available for people with serious mental illness or substance use disorders? Do you know of other housing resources specific to this population not covered within CES?
- Are there opportunities to collaborate on grants or joint funding applications?
- What would help the CoC housing programs better serve people with behavioral health needs?

Step 4: Follow Up

- Send a thank-you note
- Ask to attend the next CoC meeting. Request the schedule, or to be added to the email list.
- Ask about upcoming opportunities for collaboration
- Begin identifying clients you could refer into CES

Tips for Success

- Be clear about what your agency can offer (e.g., case management, housing navigation, outreach).
- Ask how your staff can get trained on CES and HMIS.
- If you hit a barrier, reach out to your County's Housing or Homeless Coordinator for help.
- Consider introducing the CoC lead to key behavioral health leaders in your agency to build strategic connections.

Additional Resources

- When you start to talk to CoC partners or attend meetings, you may hear people talk more in acronyms than actual words. You can also use this list of Common System of Care Acronyms. This list may not include every acronym you'll hear, because some will be specific to the local community. It's perfectly fine to ask for an explanation.

APPENDIX B: Public Housing Authority Partnership Starter Guide

The steps below are intended to assist county behavioral health staff establish or strengthen partnerships with their local Public Housing Authority (PHA) or housing providers to improve access to affordable housing resources.

Step 1: Identify Your Local Public Housing Authority (PHA)

Use the Department of Housing and Urban Development (HUD) PHA1 directory to find contact information for PHAs in your area.
Find your PHA here
Search by California and select your city, county, or region.

Step 2: Reach Out

Start with an email or phone call to the PHA's resident services coordinator, housing choice voucher program manager, or executive director.

Example Opening Message:
Hi, I'm [Your Name] from [Agency Name], working on behavioral health and housing coordination. I'd love to connect to learn more about your housing programs and explore ways we can collaborate to improve housing access for people with behavioral health needs. Would you be open to a short meeting or phone call?

Step 3: Ask These Key Questions

About the PHA and Its Programs

- What housing programs do you administer (e.g., Housing Choice Vouchers, Project-Based Vouchers, PBV set-asides for special populations)?
- Do you have any set-aside units, vouchers, or preferences for people with disabilities, experiencing homelessness, mental illness, or substance use disorders?
- Are you participating in HUD's Special Purpose Voucher programs (e.g., Mainstream, VASH, FUP, EHV)?

About Waitlists and Access

- Is the waitlist currently open for tenant-based housing choice vouchers? Are waitlists currently open for any projects with Project based vouchers?
- If not, when do you anticipate opening waiting lists?
- How can we find out more information about waitlists and openings? Is there an email list we can join?
- Are there any special referral pathways behavioral health providers can use?
- What documentation or eligibility criteria should we be aware of?

About Partnerships and Coordination

- Do you partner with behavioral health or social services agencies? Would you be open to discussing more?
- What do you need from providers like us to support successful tenancies?

1 HUD is a federal agency that calls these entities Public Housing Agencies, as opposed to Public Housing Authorities. Generally, in California, these organizations are referred to as Public Housing Authorities. When using the Find Your PHA tool on HUD's website, you will see "Public Housing Agency."

About Case Management and Support

- What supportive services are available to tenants with behavioral health needs?
- Can our agency provide tenancy support for voucher recipients?
- Are there challenges you face in serving clients with complex needs?

About Meetings and Collaboration

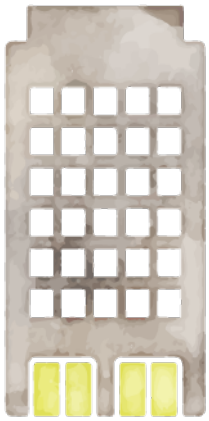
- Are there local housing working groups or cross-sector meetings we can join?
- Are you working with the local CoC, county housing agency, or other partners on joint projects?
- Is there interest in applying for new housing resources together?

Step 4: Follow Up

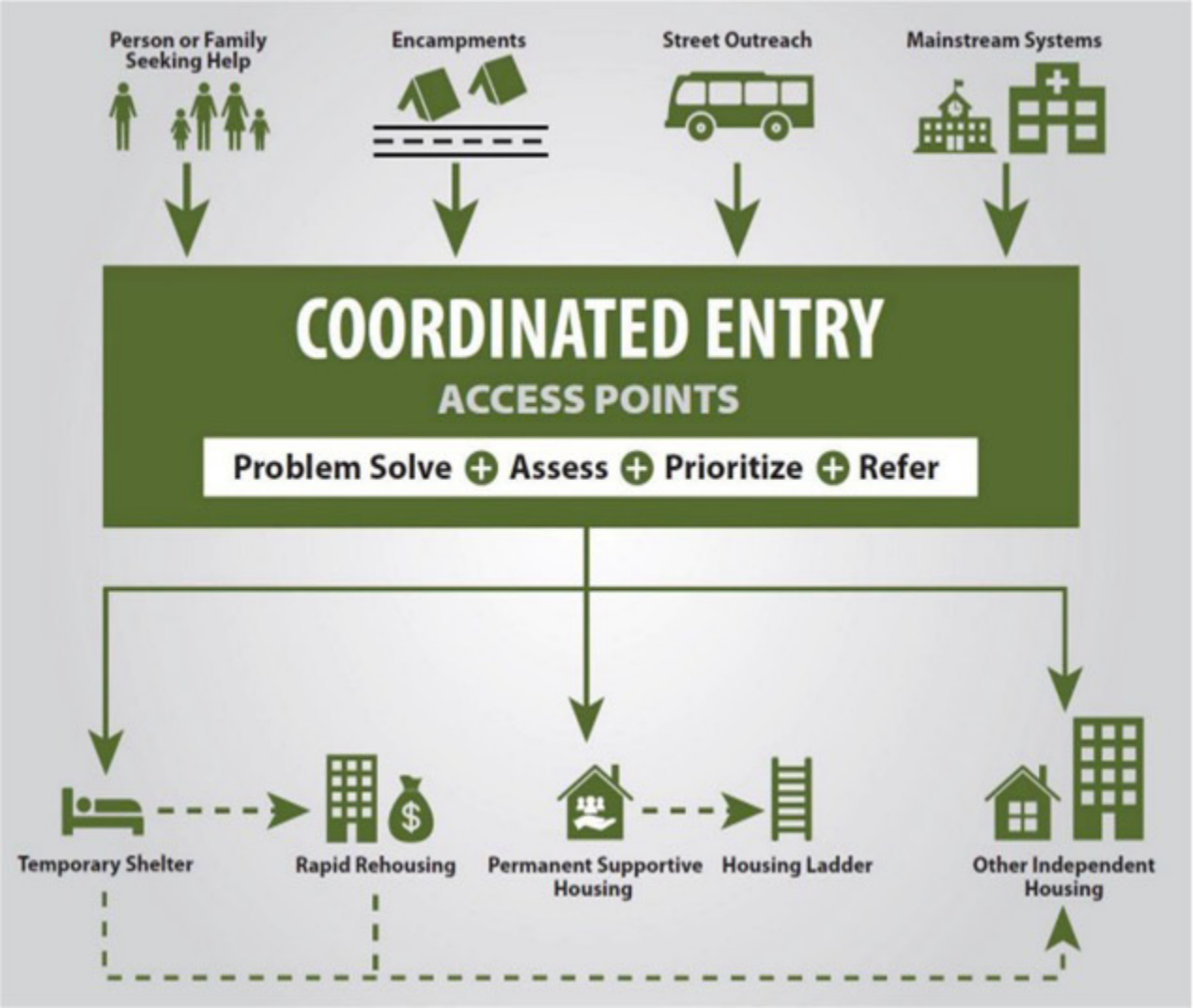
- Send a thank-you email
- Share any relevant program flyers or fact sheets
- Offer to attend a future meeting or support new tenants referred to your agency
- Begin identifying clients who could benefit from PHA programs
- Explore opportunities for a Memorandum of Understanding (MOU) or Data Sharing Agreement

Tips for Success

- Be prepared to explain how your agency supports clients in maintaining housing
- Bring examples of how behavioral health staff have partnered with housing providers
- Offer to help with landlord engagement, housing navigation, or tenant education for people with behavioral health needs
- Consider starting with a small pilot or case conference to build trust
- Highlight your experience supporting high-needs tenants or wraparound services
- Ask about tools, resources, or trainings your staff can attend



APPENDIX C: Coordinated Entry Flow Chart Sample



This is a community example from San Francisco, California.

APPENDIX D: HUD Homeless Definition Categories

HUD Homeless Definition Categories

This guide provides a quick overview of HUD's homelessness definition categories to help behavioral health providers understand eligibility, support accurate documentation, and strengthen connections to housing resources. **The U.S. Department of Housing and Urban Development (HUD) defines** homelessness in four main categories. Understanding these categories is crucial for providing appropriate assistance and services. Note that this is a simplified overview and further details may be found on the HUD website.

This section lists several key national organizations that provide resources, training, and support to

Category 1: Literally Homeless	**Individuals and families who lack a fixed, regular, and adequate nighttime residence. This includes:** Living in a place not meant for human habitation (e.g., cars, parks, sidewalks). Living in emergency shelters. Living in transitional housing.
Category 2: Imminent Risk of Homelessness	**Individuals and families who will imminently lose their primary nighttime residence. This includes:** Having a court order for eviction/Having notice to leave premises. Facing loss of housing due to foreclosure or similar action. Lacking resources or support networks to obtain other permanent housing.
Category 3: Homeless Under Other Federal Statutes	**Unaccompanied youth and families with children and youth** who do not otherwise qualify as homeless under the HUD definition, but who meet the definition of homeless under other federal statutes.
Category 4: Fleeing Domestic Violence	**Individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member,** and who have no other residence or means to obtain other permanent housing.

organizations working to address homelessness. *This list is not exhaustive, and organizations should research additional resources relevant to their specific needs and service area.*

Resources	**U.S. Department of Housing and Urban Development (HUD)**	https://www.hud.gov/
	National Coalition for the Homeless (NCH)	https://nationalhomeless.org/
	National Alliance to End Homelessness (NAEH)	https://endhomelessness.org/
	The Homelessness Research Institute	https://www.naeh.org/homelessness-research-institute/
	National Health Care for the Homeless Council	https://www.nhchc.org/

APPENDIX E: Document Ready Checklist

Document Ready Checklist

This checklist is designed to help communities within the homeless system of care ***organize and prepare necessary documentation*** for housing and supportive service programs. It ensures alignment with HUD and program requirements while minimizing barriers for participants.

PROOF OF HOMELESSNESS

- ☐ Third-party documentation (e.g., shelter records, outreach worker observations).
- ☐ HMIS (Homeless Management Information System) or comparable database records.
- ☐ Written observation by outreach or intake worker detailing living conditions.
- ☐ Self-certification (in rare, documented cases, with attempts to obtain third-party verification).

INCOME & FINANCIAL INFORMATION

- ☐ Proof of income (e.g., pay stubs, benefits statements, disability income).
- ☐ Bank statements (if applicable).
- ☐ Information regarding any outstanding debts or financial obligations.

PERSONAL IDENTIFICATION

- ☐ Government-issued photo identification (e.g., state ID, driver's license).
- ☐ Social Security card or proof of Social Security number.
- ☐ Birth certificates for all household members, especially minor children.

HEALTH & MEDICAL INFORMATION

- ☐ Documentation of disabilities or chronic health conditions if applying for programs like Permanent Supportive Housing.

LEGAL DOCUMENTATION

- ☐ Custody agreements for children.
- ☐ Legal status documentation (for non-citizens).
- ☐ Documentation related to criminal history (if required by specific housing programs, though Housing First models minimize this barrier).

APPENDIX F: Shared Roles & Responsibilities

Housing and Behavioral Health Roles & Responsibilities Guide

A Resource for Case Managers, Supervisors, and Directors

Purpose and Importance

Housing and behavioral health providers often work with the same individuals but may not fully understand each other's roles, scope of practice, or areas of expertise. This lack of clarity can result in:

Role confusion leading to either service gaps or inappropriate role assumption

Boundary violations when providers exceed their training or authorization

Inefficient resource use through duplicated efforts or missed opportunities for collaboration

Provider burnout from attempting to address needs outside their expertise

Client frustration when expectations don't match what providers can actually deliver

Understanding roles and responsibilities is essential for:

- **System Integration:** Clear role definition enables seamless care coordination, appropriate referrals, and effective team-based approaches that leverage each system's strengths.
- **Professional Practice:** Providers can work confidently within their scope while knowing when and how to engage partners for comprehensive support.
- **Quality Outcomes:** When each provider focuses on their area of expertise while maintaining strong communication, clients receive higher quality, more effective interventions.
- **Accountability:** Defined responsibilities create clear expectations for performance, documentation, and outcomes measurement across both systems.

Shared Roles & Responsibilities, continued

This guide ***clarifies the distinct yet complementary roles within housing and behavioral health systems***, promoting effective collaboration while respecting professional boundaries and expertise.

Role/Position	*Primary Responsibilities*	*Key Collaboration Points*	*What This Role CANNOT Do*
Behavioral Health Case Manager	• Coordinate mental health/substance abuse services • Link to community resources • Monitor treatment plan progress • Provide crisis support • Facilitate benefit applications	• Share treatment goals with housing team • Coordinate around housing-related triggers • Provide behavioral health context for housing decisions • Support housing retention through clinical coordination	• Cannot provide therapy or clinical treatment • Cannot diagnose mental health conditions • Cannot override housing program requirements • Cannot guarantee housing placement
Clinical Therapist or Counselor	• Provide individual/group therapy • Develop treatment plans • Conduct clinical assessments • Manage medication compliance (with prescriber) • Document clinical progress	• Provide clinical insights for housing planning • Address housing-related trauma or barriers • Support housing transitions through therapy • Communicate clinical needs affecting housing	• Cannot provide housing services directly • Cannot override housing eligibility requirements • Cannot guarantee specific housing outcomes • Cannot provide financial assistance
Psychiatrist or Prescriber	• Psychiatric evaluation and diagnosis • Medication management • Crisis psychiatric intervention • Medical clearance for housing • Coordinate with medical providers	• Provide medical information for housing decisions • Address medication compliance affecting tenancy • Support housing through symptom management • Communicate functional capacity	• Cannot provide ongoing case management • Cannot guarantee medication compliance • Cannot provide housing or financial assistance • Cannot override program admission criteria
Housing Case Manager or Navigator	• Housing search and application assistance • Landlord outreach and negotiation • Tenancy support and education	• Communicate housing barriers to clinical team • Coordinate move-in timing with treatment • Share tenancy concerns for clinical intervention	• Cannot provide clinical treatment or therapy • Cannot diagnose or treat mental health conditions • Cannot override clinical recommendations

Shared Roles & Responsibilities, continued

	• Move-in coordination • Housing retention services	• Support housing stability through team approach	• Cannot guarantee behavior change
Housing Program Manager or Director	• Program compliance and oversight • Staff supervision and training • Policy development and implementation • Data collection and reporting • Stakeholder relationship management	• Coordinate program policies with clinical needs • Share outcome data with behavioral health partners • Develop integrated service protocols • Address system-level barriers	• Cannot make individual clinical decisions • Cannot override clinical professional judgment Cannot provide direct services to clients • Cannot guarantee individual housing outcomes
Behavioral Health Program Supervisor	• Clinical supervision and training • Quality assurance and compliance • Crisis response coordination • Documentation review • Performance management	• Coordinate care protocols with housing programs • Address system barriers affecting clients • Develop integrated training curricula • Support cross-system problem-solving	• Cannot provide direct housing services • Cannot override housing program requirements • Cannot guarantee housing placement • Cannot provide financial assistance
Peer Support Specialist	• Share lived experience and hope • Provide non-clinical support and encouragement • Assist with goal setting and planning • Model recovery and housing success • Bridge communication between client and providers	• Share insights about barriers from lived experience • Support engagement across both systems • Provide unique perspective on service needs Model successful integration of services	Cannot provide clinical treatment or diagnosis • Cannot override professional clinical judgment • Cannot guarantee specific outcomes • Cannot provide financial assistance or housing placement

Shared Roles & Responsibilities, continued

Collaborative Care Principles

Shared Responsibilities

All providers across both systems share responsibility for:

- **Person-centered planning** that honors client choice and self-determination
- **Cultural responsiveness** addressing individual identity, background, and preferences
- **Safety planning** ensuring physical and emotional safety in all interventions
- **Confidentiality** maintaining appropriate information sharing with proper releases

Communication Protocols

- **Regular team meetings** with clear agendas focusing on coordination needs
- **Warm handoffs** when transitioning between providers or levels of care
- **Shared documentation** systems when possible, with appropriate releases
- **Crisis communication** procedures ensuring 24/7 coordination capability
- **Outcome sharing** to track progress and adjust interventions accordingly

Boundary Management

- **Stay within scope** of training, licensure, and program requirements
- **Refer appropriately** when client needs exceed your role capabilities
- **Communicate limitations** clearly to clients and team members
- **Seek supervision** when role boundaries are unclear or challenging
- **Document decisions** about role boundaries and referral rationale

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This guide promotes effective collaboration while maintaining professional integrity and expertise within each role. Regular review and updates ensure alignment with evolving practices and regulations.

APPENDIX G: Housing & Behavioral Health Terminology Guide

Housing and Behavioral Health Terminology Guide

A Resource for Case Managers, Supervisors, and Directors

Housing and behavioral health systems often operate with different terminology, documentation requirements, and service approaches, yet serve many of the same individuals and families.

When providers from both systems use ***inconsistent language***, it can lead to:

- **Miscommunication** during case conferences and care coordination meetings
- **Duplicated services** when systems don't recognize they're addressing similar goals
- **Service gaps** when assumptions about roles and responsibilities aren't aligned
- **Frustration** for clients who must navigate conflicting terminology and processes

Understanding shared terminology is critical because:

For Providers: Clear communication improves collaboration, reduces confusion during warm handoffs, and ensures comprehensive service planning that addresses both housing stability and behavioral health recovery simultaneously.

For Clients: Consistent language across systems creates a smoother experience, reduces the burden of explaining needs multiple times, and ensures that all providers understand their full spectrum of challenges and strengths.

For Outcomes: Aligned terminology supports integrated care planning, reduces system fragmentation, and ultimately leads to better housing retention and behavioral health outcomes.

This guide establishes common understanding across both systems, enabling more effective partnerships and improved outcomes for the people we serve.

Behavioral Health Term	*Housing Term*	*Why Shared Language Matters*
Client	**Tenant**	Aligns how we refer to the people we serve, avoiding confusion and ensuring person-centered communication across systems.
Treatment Plan	**Housing Stabilization Plan**	Helps both systems understand goals and supports as part of a unified plan, preventing duplicated efforts and ensuring comprehensive care.
Diagnosis / Symptoms	**Barriers to Housing**	Links clinical needs to housing challenges, ensuring both are addressed simultaneously and that housing interventions consider health impacts.

Housing & Behavioral Health Terminology Guide, continued

Engagement	**Enrollment in Program**	Clarifies when a person is connected and actively participating in services, ensuring both systems coordinate outreach and retention strategies.
Crisis Response/Crisis Residential Treatment	**Emergency Shelter / Interim Housing**	Connects immediate safety and stabilization responses across systems, ensuring coordinated crisis response that addresses both clinical and housing needs.
Continuity of Care	**Housing Retention / Stability**	Emphasizes long-term support that combines health and housing needs, ensuring sustainable outcomes and preventing cycling between systems.
Therapeutic Intervention	**Housing Services**	Ensures both clinical and practical supports are coordinated to address the whole person's needs for successful housing outcomes.
Discharge Planning	**Move-In Support**	Coordinates transitions to prevent gaps in services and ensure smooth movement from treatment settings to stable housing.
Case Management	**Housing Case Management**	Clarifies overlapping roles and ensures comprehensive support without duplication, maximizing resource efficiency.
Recovery Planning	**Independent Living Skills**	Links recovery goals with practical life skills needed for housing success, ensuring holistic approach to stability and wellness.

Integration Benefits

When both systems use shared language and understanding:

- **Reduced miscommunication** during case conferences and transitions
- **Improved care coordination** through common documentation standards
- **Enhanced client outcomes** by addressing interconnected needs holistically
- **Increased efficiency** by avoiding duplicated assessments and planning
- **Better resource utilization** through coordinated service delivery

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This terminology guide supports integrated service delivery by establishing common understanding across housing and behavioral health systems, ultimately improving outcomes for the individuals and families we serve.

APPENDIX H: Outreach to Housing Success Checklist

Outreach to Housing Success Checklist

OUTREACH & ENGAGEMENT

- [ ] Receive and respond to referrals from agencies, first responders, and the public to engage unsheltered individuals in non-habitable locations.
- [ ] Conduct ongoing general outreach to places frequented by unsheltered individuals and households.
- [ ] Field-based work for clients that may move among various programs and locations.

PARTNERSHIP DEVELOPMENT

- [ ] Build rapport and maintain client relationships through consistent contact
- [ ] Use harm reduction and motivational interviewing to build trust and address urgent needs (food, health, income, transportation)
- [ ] Establish reliable communication channels: phone, mail, email, meetings, support contacts
- [ ] Provide emotional support and preparation for housing/resources by setting realistic expectations (wait times, eligibility, systems), foster hope and address fears/ambivalence, address unhealthy coping skills, and strengthen communication skills.

TRIAGE ASSESSMENT

- [ ] Conduct brief assessments to determine needs and potential resources available to individuals in the community - chronic homelessness, health needs, public benefits, VA, HIV/AIDS, etc.
- [ ] Consider using an assessment triage tool to document high need.

LINKAGES

- [ ] Assist clients with housing navigation and resource centers; support transitions from unsheltered to sheltered housing.
- [ ] Connect clients to public benefits, including income supports and health insurance
- [ ] Link clients to health care services (primary care, behavioral health, dental) based on needs and priorities
- [ ] Connect clients with legal resources (CARE Program, record expungement, housing-related services)

APPENDIX I: Warm Handoff Checklist

Warm Handoffs in Home Visiting
CHECKLIST

Warm handoffs (sometimes called *warm transfers*) are dynamic spaces where staff from one program introduce a family to staff from another program. To support warm handoffs, this practice resource offers reflections and tips from local colleagues and families to guide you before, during, and after warm handoffs.

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Before

Pre-meeting
- ☐ "Pre-meeting" or "check-in" with colleague from new program before meeting the family
- ☐ Case coordination

Your colleague(s)
- ☐ Learn their name
- ☐ Learn their role
- ☐ Learn how they describe the services they provide

The "new" program
- ☐ Learn what the other program can provide
- ☐ Learn program goals, purposes, and benefits
- ☐ Learn what is and is not feasible

Working together
- ☐ Learn what to expect, roles and responsibilities during handoff process
- ☐ Share what each person needs to be successful
- ☐ For video calls, use visible county or program logo

During

Initiation
- ☐ Identify a client need to be met and a program that can meet it
- ☐ Check with staff: "Hey, I have somebody who may genuinely benefit from services. Can you please come in and have a brief chat with them?"

Permission
- ☐ Introduce to client the idea of the referral: "There's this program, they'd like to talk to you about it."
- ☐ Ask the client for permission: "Do you have a few minutes to meet with them?"

Introductions
- ☐ If in person, bring client face to face[1] with program staff. "Let me go get them for you and I'll be just a minute."
- ☐ If phone or video call, initiate call with colleague and client
- ☐ Make personal introductions both ways and use names

Communication
- ☐ Let clients hear what you are saying about their strengths, needs, and plan of care[1]
- ☐ Speak to clients and colleagues as equals
- ☐ Involve clients and make them an active member of the team[1] (e.g. "What are your thoughts on this? What questions do you have?")
- ☐ Check for accuracy of your understanding

Terminology
- ☐ Make room in the conversation for clients' equal participation
- ☐ Remember this may be clients' first time hearing this information
- ☐ Be conscious of terms you use to talk about your colleagues & program. Use terms program staff use (e.g. "in-home family support" instead of "home visiting program")
- ☐ Help alleviate stigma or fear of the unknown: explain staff roles, that you are here to help, and what that help looks like

The new program
- ☐ Encourage clients to speak up, ask questions, and join the conversation about the 'new' program[1]
- ☐ Help clients build an understanding of the 'new' program (e.g. point out similarities and differences from current program)
- ☐ Focus on benefits of the program
- ☐ Remember clients are deliberating about whether or not this program fits them, often under time pressure

Support
- ☐ Ask clients to correct or clarify any information[1] (e.g. "Did I get that right?" "What questions do you have for us?")
- ☐ Check to see if there are any needs that we can support immediately. This may also help build rapport and create value.
- ☐ Clients may not have anticipated this meeting, so respect their time
- ☐ Share program materials
- ☐ Complete initial consent forms if family is interested

After

- ☐ Schedule intake
- ☐ Send referral form for completion
- ☐ Identify potential barriers, and help family to problem-solve to reduce barriers[2]
- ☐ Follow up with family. If appropriate ask about their experience accessing services[2]
- ☐ Follow up with colleague

1. Adapted from Agency for Healthcare Research and Quality, *Design Guide for Implementing Warm Handoffs*
2. Adapted from Reproductive Health National Training Center. *Establishing and providing effective referrals for clients: A toolkit for family planning providers.*

APPENDIX J: HMIS Sample Project Setup

SAMPLE PROJECT SETUP

HMIS tracks client information and the assistance they receive. **All CoC projects entering data into HMIS must first be set up in the system. Setup processes vary by CoC, but you'll need to provide details so the HMIS Lead can configure the project correctly and ensure BHSA and AB 977 compliance.** Some Leads require a Project Setup or AB 977 Intake Form; others may schedule a meeting. Having the grant award letter, contract, and project scope ready will speed up the process.

Here's a sample list of project-level data elements you should be prepared to share:

Project Descriptor Data Element	•Example
Project Information	Organization - ABC County Behavioral Health Services Project Name - ABC County BHS Rapid Re-Housing Program Operating Start Date - 1/1/2025 Operating End Date - *Left blank, as he program is still active* Continuum Project - ["Yes"] ["No"] Project Type - Rapid Re-Housing HMIS Participating Project - Yes
Continuum of Care Information	Continuum Code - CA-000 Geocode - 000000 Project Street Address - 123 Main St Project City - Main City Project State - California Project Zip Code - 00000 Geography Type - Suburban
Funding Sources	Funder Program and Components - Local or Other Funding Source Grant Identifier - *Contract number or grant identifier* Grant Start Date - 1/1/2025 Grant End Date - *Left blank until grant year/funding round ends*
Bed and Unit Inventory	Inventory Start Date - 1/1/2025 Inventory End Date - *Left blank until inventory changes or is no longer active* CoC Code - *CA-000* Household Type - Households without children Bed Type - N/A (Only applicable for Emergency Shelter) Availability - N/A (Only applicable for Emergency Shelter) Beds dedicated to chronically homeless (CH) veterans - 0 Beds dedicated to youth veterans - 0 Beds dedicated to any other veterans - 0 Beds dedicated to chronically homeless youth - 0 Beds dedicated to any other youth - 0 Beds dedicated to any other CH - 0 Non-dedicated beds - 23 Total bed inventory - 23 Total unit inventory - 23

APPENDIX K: ROI Compliance Checklist

COMPLIANT RELEASE OF INFORMATION CHECKLIST

This checklist outlines the essential language elements required in a Release of Information (ROI) form to comply with HIPAA, California's Confidentiality of Medical Information Act (CMIA), Welfare & Institutions Code § 5328, and 42 CFR Part 2. To comply with CMIA, the release of information must be written in plain language understandable to the client.

☐ 1. Identify the Client's Full Name and Date of Birth

Example: "I, [Client Full Name], Date of Birth: [DOB], authorize the use and disclosure of my protected health information as described below."

☐ 2. Identify the Specific Names of the Parties Involved or Attach a Provider List

Example: "I authorize [Behavioral Health Provider Name] to share my information with:
- [Homeless Services Provider Name #1]
- [Homeless Services Provider Name #2]
(Or see attached Provider List dated [MM/DD/YYYY])"

☐ 3. Clear Categories of Information to Be Disclosed

Example: "I authorize disclosure of:
- Mental health diagnosis and treatment history
- Substance use disorder treatment (42 CFR Part 2)
- Medications, service notes, referrals, and housing information"

For SUD records: "I specifically authorize the disclosure of substance use disorder treatment records as protected under 42 CFR Part 2."

☐ 4. Clearly Stated Purpose of Disclosure

Example: "The purpose of this disclosure is to support:
- Coordination of care
- Housing placement and retention
- Mental health/substance use planning
- Crisis response"

ROI Compliance Checklist, continued

☐ 5. Defined Expiration Date or Event

Example: "This authorization expires:
☐ One year from the date signed
☐ Upon completion of care or housing placement
☐ On the following date: _____"

☐ 6. Revocation Clause

Example: "I understand that I may revoke this authorization in writing at any time. Revocation does not apply to information already shared in reliance on this authorization."

☐ 7. Redisclosure Notice

Example: "I understand that information disclosed may be subject to redisclosure and may no longer be protected under federal privacy rules. However, I understand that substance use disorder treatment information under 42 CFR Part 2 may not be redisclosed without my consent unless otherwise permitted by law."

☐ 8. Signature & Date

Example:
Client Signature:
Date:
Legal Representative (if applicable):
Relationship:

☐ 9. Optional: Mental Health Disclosure under WIC § 5328

Example: "I specifically authorize the disclosure of my county mental health records per California Welfare and Institutions Code § 5328."

APPENDIX L: Refusing ROI

WHAT TO DO WHEN A CLIENT REFUSES TO SIGN AN ROI

This quick-reference guide helps staff respond when a client declines to sign a Release of Information (ROI), while remaining compliant with HIPAA, California's CMIA, and 42 CFR Part 2.

Respect the Client's Right to Refuse

- Signing an ROI is voluntary unless a court order applies.
- Services generally cannot be denied solely for refusal, except where specific information is legally or operationally required.

Clarify Purpose and Scope

- Clearly explain what will be shared, with whom, and why.
- Emphasize benefits such as faster housing placement or coordinated care.
- Reassure them about what will NOT be shared.

Offer to Limit or Customize ROI

- Restrict the ROI to the minimum necessary information.
- Let the client choose specific providers, record types, or shorter expiration periods.

Explore Alternative Paths

- Encourage client self-disclosure directly to other providers.
- Hold case conferences with the client present (must consent in real-time).
- Share non-identifiable information where possible.

Document Refusal

- Record the refusal, the reason (if given), and alternatives offered.
- Documentation supports compliance and protects your agency.

Revisit Later

- Trust can grow over time; revisit ROI requests periodically.
- Link future requests to tangible benefits for the client.

APPENDIX M: Release of Information (ROI) Template

RELEASE OF INFORMATION TEMPLATE

Client Information

Client Name: _____

Date of Birth: _____

Address: _____

Phone/Email: _____

Authorization

I, [Client Full Name], authorize the use and disclosure of my protected health information as described below.

Parties to Disclose/Receive Information

Disclosing Provider: _____

Receiving Provider(s): _____

Note: You can optionally attach a dated list of authorized providers. For substance use disorder records under 42 CFR Part 2, the specific recipients **must be named** or attached in a list at the time of signature.

Description of Information to Be Disclosed

Check all that apply:

☐ Mental health diagnosis and treatment records (including records protected under California WIC § 5328)

☐ Substance Use Disorder treatment records (42 CFR Part 2)

☐ Medication and treatment plans

☐ Housing status, service referrals, and care coordination notes

☐ Crisis interventions and safety plans

☐ Other (specify): _____

Release of Information (ROI) Template, continued

Purpose of Disclosure

The purpose of this disclosure is to:

☐ Facilitate coordination of care between behavioral health and homeless services providers
☐ Support housing placement and retention
☐ Assist in mental health or substance use treatment planning
☐ Support crisis response and service referrals
☐ Other (specify): _____

Expiration of Authorization

This authorization expires:

☐ One year from the date signed
☐ Upon completion of services or housing placement
☐ On the following date/event: _____

Revocation of Authorization

I understand that I may revoke this authorization at any time by providing written notice to the disclosing provider.

Revocation does not apply to information already shared in reliance on this authorization.

Redisclosure Statement

I understand that information disclosed under this authorization may be subject to redisclosure and may no longer be protected under federal or state law.

However, substance use disorder treatment information disclosed under 42 CFR Part 2 is protected and may not be redisclosed without my written consent unless permitted by law.

Release of Information (ROI) Template, continued

Client Acknowledgement

I understand that my refusal to sign this form will not affect my ability to receive services from any provider, unless the services require the information being shared.

By signing below, the Parties agree to the terms of this MOU.

Client Signature: _____ Date: _____

If applicable, Legal Representative: _____

Relationship to Client: _____

Signature: _____ Date: _____

APPENDIX N: Sample MOU Template

MEMORANDUM OF UNDERSTANDING TEMPLATE

Purpose

This Memorandum of Understanding (MOU) establishes the terms under which the Parties agree to share client-level information to support care coordination and improve outcomes for individuals experiencing homelessness and behavioral health needs in California.

Parties

This MOU is entered into by and between:

Behavioral Health Provider:
Name: _____
Address: _____
Phone/Email: _____

Homeless Services Provider:
Name: _____
Address: _____
Phone/Email: _____

Collectively referred to as "the Parties."

Points of Contact

Each Party designates a primary point of contact (POC) responsible for managing communications, coordinating data sharing, and addressing questions regarding this MOU. The POC may be different from the individual who signs the MOU.

Behavioral Health Provider:
Name: _____
Title/Role: _____
Phone: _____
Email: _____

Homeless Services Provider:
Name: _____
Address: _____
Phone/Email: _____

The Parties agree to notify each other promptly in writing of any changes to their designated POC.

Sample MOU Template, continued

Legal Framework

The Parties agree to comply with all applicable federal and California state laws, including:

- HIPAA (45 CFR Parts 160 and 164)
- California Confidentiality of Medical Information Act (CMIA)
- California Welfare and Institutions Code § 5328 (mental health records)
- 42 CFR Part 2 (substance use disorder records)

The Parties will only share information to the extent authorized by the client and permitted under applicable law.

Scope of Information Sharing

The Parties agree to share the following client-level information as needed to coordinate services:

- Client demographics (name, DOB, contact info)
- Service enrollment and participation
- Behavioral health diagnoses and treatment history (as allowed)
- Housing status and history
- Referrals and service plans
- Emergency contacts
- Crisis episodes and stabilization plans

Any information protected under 42 CFR Part 2 (substance use disorder treatment records) will only be disclosed with valid written consent from the client.

Data Sharing Method

The Parties agree that client-level information may be shared in the following ways, depending on client consent and program needs. The Parties will indicate and agree upon the specific methods to be used:

☐ One-time data exchange: A single transfer of specific information to support an identified service or referral.

☐ Ongoing sharing between staff: Regular updates and exchanges of client information to support care coordination, housing stability, and treatment planning.

☐ Joint case conferencing: Scheduled meetings between staff of both Parties to review client progress, update service plans, and coordinate responses.

☐ Shared access to secure systems: Access to mutually agreed-upon electronic platforms, data systems, or portals, limited to authorized staff.

☐ Other (specify): _____

Sample MOU Template, continued

Consent and Authorization

- Each party agrees to obtain written, informed consent from clients before sharing personal health information, unless otherwise permitted or required by law.
- Consents shall comply with applicable laws, including HIPAA and CMIA requirements, California WIC § 5328, and 42 CFR Part 2
- A release of information (ROI) form, written in plain language, signed by the client, will be used and honored by both parties.
- Information will only be shared with staff members who have a legitimate need to know, for care coordination purposes.

Data Security and Safeguards

Each party agrees to:

- Maintain confidentiality and security measures for all client data.
- Use secure methods for data transfer (encrypted email, secure portals, etc.).
- Limit access to client-level data to authorized personnel.
- Report any breach of information within 24 hours of discovery to the other party.

Data Access

The Parties agree that access to client-level information under this MOU shall be limited to:

- Authorized staff who have a legitimate need to know the information in order to provide, coordinate, or manage services for the client.
- Staff positions may include (but are not limited to): case managers, clinicians, housing navigators, care coordinators, supervisors, and designated data administrators.
- Each Party will maintain an up-to-date internal list of staff roles authorized to access shared data and will make this list available to the other Party upon request.
- Access shall not extend to administrative, clerical, or other personnel who do not have a direct service, supervisory, or compliance function related to the client's care.
- Each Party is responsible for training its authorized staff on confidentiality obligations and monitoring compliance.

Data Sharing Limitations

No client data may be redisclosed without specific client consent unless explicitly allowed by law. Information protected under WIC § 5328 and 42 CFR Part 2 may not be shared unless each recipient is specifically named and authorized.

Sample MOU Template, continued

Term and Termination

- This MOU is effective upon signature and remains in effect for two years unless otherwise terminated.
- Either party may terminate this MOU with 30 days written notice.
- Upon termination, any client information previously shared shall remain protected under applicable confidentiality laws.

Amendments

This MOU may be amended only in writing, signed by both Parties.

Signatures

By signing below, the Parties agree to the terms of this MOU.

Behavioral Health Provider	Homeless Services Provider
Signature: _____	Signature: _____
Name/Title: _____	Name/Title: _____
Date: _____	Date: _____