HUMAN SERVICES GRANTS PROGRAM (HSGP)

FY 2022-23 PROGRAM STATUS REPORT

St. Joseph Center

Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SM Retention

Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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###### FY 2022-23 SUBMISSION CALENDAR



**Instructions:**

* This document should be used by HSGP grantees to report on mid-year and year-end outcomes and accomplishments.
* All reports submitted to the City are considered public record. Please note that staff will use the information provided in the mid-year and year-end reports to provide Council and the public with summary reports of agency performance highlighting key outcomes, successes, findings and concerns.
* Some programs or agencies may be subject to additional or different reporting requirements per the program’s Exhibit A, Special Funding Conditions, of your executed Grant Agreement with the City.
* It is important, when preparing this report, to be familiar with the program’s Exhibit B, Program Plan, of your executed Grant Agreement with the City.
* Please insert responses in the spaces provided for Sections I-VII for both the Mid-Year and Year-End Program Status Reports.
* A separate Program Status Report must be prepared for each Program Plan specified in your contract.
* To submit your completed report to the City, upload the file to your agency’s SharePoint folder. A link to your agency’s SharePoint folder as well as instructions on how to use the site will be emailed to your staff separately.

###### SECTION I: PROGRAM ACCOMPLISHMENTS, CHALLENGES, AND CHANGES

Provide a brief summary of your program accomplishments, challenges, and changes that occurred during the reporting period. Please also provide information or observations related to population or service trends.

St. Joseph Center’s SM Retention program served 169 adult individuals living in 150 households during this reporting period. These households also included 10 children under the age of 18. Since July 1, 2022, the program has received 54 referrals and enrolled 49 new participants. During the reporting period, 16 individuals and 1 child left the program. These 16 participants were compromised of 15 households and left for the following reasons:

3 participants elected to exit the program and remain housed

8 participants completed the program and remain housed

4 participants passed away

1 participant lost contact and is presumed to be homeless

SM Retention continues to support participants in utilizing food bank linkages, low-income childcare resources, and employment support resources via the SJC Employment Specialist. SM Retention has also supported participants with linkages to mental health services. These linkages have continued to help the program increase housing stabilization through community resources and increasing quality of life.

With the ending of the COVID-19 emergency, case management services that SM Retention provides have continued to increase in frequency closer to pre-pandemic levels. The SM Retention team continues to provide services that aim to improve the health and stability of clients in their homes and be successful at being able to assist with meeting their needs without clients having to leave their homes.

The SM Retention team continues to provide food support by delivering groceries, providing gift cards, providing linkages to educational and vocational services, as well as emergency rental assistance, with the goal of maintaining 100% housing retention.

The SM Retention team continues to work collaboratively with outside providers including WISE & Healthy Aging, street outreach teams, and mental health teams. This collaboration approach creates wrap around services for some of the most vulnerable older adult residents. The increased technology support that was implemented during the previous reporting period continues to assist our clients with decreasing isolation and maintaining school and work obligations and responsibilities. The Program Manager is actively engaged with the Santa Monica Task Force meetings to help strengthen the relationship with partnering agencies, brainstorm interventions and solutions, and work more collaboratively with the most difficult clients.

Previous challenges with IHSS homecare workers not wanting to enter units and difficulties identifying new IHSS workers, and IHSS home care workers not being willing to commute because of gas mileage costs have slightly improved. Some participants are less resistant to denying IHSS services due to their need for additional in-home support. Case managers remain flexible with their schedules and meet with participants as needed, leveraging other case managers, and attempt to meet with isolated participants in person at their homes in a safe, socially distanced manner. In addition to wearing masks, case managers continue to meet with participants in open-air environments, such as their patios, local businesses, and parks. While the needs of our participants change over time, case managers still encounter barriers that occasionally impact on the team’s ability to provide support for participants more effectively. This has resulted in some delays with participants completing paperwork such as annual housing recertifications, scheduled housing inspections, and submitting HOME applications.

The SM Retention team has also observed an increase in participants who need rental assistance to assist with falling into homelessness. With the upcoming expirations of pandemic era tenant protections and rent-relief programs, the team anticipates a continued increase in both participants and frequency of which participants will need to access rent relief funds.

This is the last year of the Santa Monica Retention program, as the organization has decided to transition to a Santa Monica Older Adult Health and Wellness Program (OAHWP). Retention clients who meet the age criteria of 55+ and who are interested in remaining enrolled in SJC services will automatically be transferred to the OAHWP. Staff have been working with clients who don’t meet the age eligibility criteria of 55+ for the OAHWP to assess their needs and refer and link them to appropriate services within St. Joseph’s and partner organizations.

###### SECTION II: ASSESSMENT, EVALUATION AND PARTICIPANT INVOLVEMENT

Briefly describe or list any program assessment or evaluation efforts during the reporting period and summarize the results achieved. Specifically highlight any program participant involvement in these efforts.

**Please highlight any new efforts to collaborate with other service providers and/or leverage services. Please include the agency name(s) and service(s) provided**.

SM Retention applies the CES (Homeless Coordinated Entry System) screening tool as a means for new intake entries and triage for applicable housing interventions which include Time-Limited Subsidies, CES for Families and Permanent Supportive Housing (PSH) Housing Programs that assist with streamlining staffs’ ability to determine clients’ eligibility for services and diverts refer appropriately. SM Retention also assesses clients’ needs to help identify barriers, interest, and risk to housing stability, and to make adequate referrals to services such as food pantry, CBEST (county program that supports clients in securing benefits), behavioral health programs, employment development, and educational training programs.

St. Joseph Center also implemented a Universal Client Feedback Survey that was used across the agency as a gauge of client participation. This survey is available in hard copy and electronic form along with being available in Spanish and English. 61 retention clients completed the survey. The following are highlights of the Universal Client Feedback Survey:

* 62% of participants report “strongly agree”/”agree” to doing better at work and in school
* 67% of participants report “strongly agree” /”agree” to improvement in mental health
* 77% of participants report “strongly agree” /”agree” to better ability to deal with crisis.
* 80% of participants report “strongly agree” /”agree” to being more equipped to effectively deal with daily challenges
* 75% of participants report “strongly agree” /”agree” to getting along better with friends and families.
* 85% of participants report “strongly agree” /”agree” to overall satisfaction of services with SJC

###### SECTION III: BOARD INVOLVEMENT

Please indicate:

* Number of Board meetings conducted during the reporting period – 3 board meetings have occurred this reporting period. The Board met on January 26th, 2023, April 27th, 2023, and June 22nd, 2023. The board met for a retreat on October 15th, 2022, but did not conduct official business. The board is next scheduled to meet on October 14th, 2023.
* Average Board member attendance – The average attendance for the board meetings this period varied between 60%-70% of board members attending.
* Board development activities conducted during the reporting period – The board met on January 9th, 2023 and May 30th, 2023 to coordinate and plan out he St. Joseph Center 46th Anniversary fundraising Gala which took place on June 3rd, 2023.
* Significant policy directions or actions taken by the Board during the reporting period - With all the transitions that have occurred throughout this reporting period at St. Joseph Center, such as departures of several high-level executive management positions – the boards’ most impactful decision has been appointing LaTonya Smith, Interim President and CEO.
* Number of board members who reside and/or work in Santa Monica - 2
* Board vacancies and plans to fill those vacancies, if applicable – There are 3 current vacancies. The

board is actively taking accepting and vetting recommendations to fill the vacant seats.

###### SECTION IV: STAFFING PATTERN

Have there been any staffing changes during the reporting period (i.e., staff vacancies, staff recruitment, changes in FTE)? Please describe. If staff vacancies exist, please provide an anticipated hiring date and explain how caseloads and work have been distributed to ensure service levels are maintained.

Please indicate how volunteers or paid or unpaid interns were used during the reporting period. Provide the total number of volunteers or interns and hours provided. If interns were used, please indicate their program level (e.g. undergraduate, masters):

As of June 2023, all case management positions on the SM Retention team have been filled. This includes 4 case managers, as well as 1 senior case manager. The mental health therapist position remains vacant. The SM Retention team has worked closely with the internal clinical team at St. Joseph Center to develop a pilot clinical supervision program that will remove existing barriers to clinicans accruing clinical hours, which has been the biggest challenge to filling the role.

When at full capacity, the caseload of the case managers is approximately 30-35 clients, and the program manager provides additional support when needed. Based on the case managers’ experience and capabilities, each caseload is assed and distributed adequately to ensure continuity of care for each client. Effective caseload management allows case managers to be more efficient at their job.

The program manager is collaborating with the St. Joseph Center Human Resources Recruitment Manager and is utilizing online job boards to fill open positions. This recruiting plan not only target optimal candidates, but it also provides an opportunity for employees to get hired within St. Joseph Center, who is committed to the staffs’ professional development.

**SECTION V: SPECIAL FUNDING CONDITIONS**

Provide a status report on how the agency is meeting its funding conditions listed in Exhibit A of your Grant Agreement, clearly addressing each individual funding condition in bullet point format.

**Standard Funding Conditions:**

1. Participate in the City’s efforts to develop an outcomes measurement system to better track human services program demographics and outcomes. Participation may include, but is not limited to: meeting with City staff, consultants, and; providing information regarding current data systems, technology infrastructure, policies and procedures, needs, opportunities, and concerns; incorporating the City into existing consent for release of information forms; signing and adhering to the City’s data management Agency Agreement; and contributing data to a centralized data management system. Aggregated or de-identified information may be requested for the purposes of analyzing data being collected.
   1. SJC continues to comply with the City’s efforts to develop a centralized human services management system in order to better track program demographics and outcomes. SJC’s data and outcomes team has worked with our administrative assistant and program team to clean up data in the client services database, specifically as it relates to how historically separate program contracts have been merged together in recent years. SJC will continue to work collaboratively with City staff and consultants by attending meetings, trainings, informational sessions as well as provide feedback and actively participate in activities that support the implementation of policies or strategies that further support these efforts. SJC will continue to remain in compliance with incorporating existing forms and adhering to the City’s data management agency agreement, etc.

1. Detail steps taken to safely reopen facilities and provide services in response to needs emerging from the COVID-19 pandemic, including modifications to service delivery and program facilities to ensure compliance with current public health guidance.
   1. St. Joseph Center established a TaskForce to discuss return to the office. We are meeting weekly to discuss safety protocols to allow for a hybrid schedule that will follow the guidelines for compliance with current public health guidance.
   2. Case management is provided via the phone and virtual meeting platforms. Staff are able to work remotely in order to reduce transmission. Staff will also meet clients in a public space if needed.
   3. When case management is needed in person to address crises, staff have been provided with PPE, and are following DPH safety guidelines
   4. Basic needs such as food are being provided to clients through vendor delivery, e-gift cards and using a no contact method of food pantry drop off.
   5. Mental health needs are being met with tele-health or in person by assessed need via DMH outside agencies. At intake as well as at their annual recertification, a mental health assessment is completed and clients are referred to appropriate services. In addition, staff regularly discuss mental health needs with their clients.
   6. Transportation is offered to all clients via Lyft and Uber to clients who typically would take public transportation but are not able to do so due to medical and public health concerns to meet basic needs and get to critical appointments. SM Retention also offers Big Blue Bus passes and MTA passes for clients who prefer to utilize public transportation

1. Agency will assist eligible participants in submitting applications to applicable relief and housing sustainability programs, including local, state, and federal rental assistance programs, including but not limited to: Housing Choice Voucher (HCV) and Below Market Housing (BMH) Waitlists, Preserving Our Diversity (POD), Continuum of Care (CoC), and HOME voucher programs.

* SJC remains in compliance with assisting eligible participants in submitting applications and renewing certifications for stable housing purposes. SJC staff members continue to assist Section 8, HOME, CoC, and other Housing Voucher holders with re-certifications and collecting any needed essential documents requested to ensure clients are up to date and in compliance with the Housing Authority and tenant-based sites.  In addition, staff continue to educate, inform and direct clients to resources that can support housing sustainability, including support with rental arrears, waitlists for permanent supportive housing through the Housing Authority, and other low-income housing opportunities and/or waitlists in the community.

**Family Self-Sufficiency (FSS):**

The Santa Monica Housing Authority (SMHA) is phasing out the FSS program. At this time, SMHA will no longer accept new applicants or provide extensions for existing participants except where denial of the extension will result in loss of escrow or when required by the U.S. Department of Housing and Urban Development. SMHA still expects to receive updated ITSP reports as well as graduation or termination requests for existing participants.

1. Agency will submit the Family Self-Sufficiency (FSS) Worksheets and Individual Training Service Plans (ITSP) to the FSS Coordinator annually 30 days prior to each FSS participant's annual re-certification date with the Santa Monica Housing Authority.
   1. See below

1. Agency will participate in file reviews of FSS participant files with Housing Authority and Human Services Division staff at least twice annually or more often as needed.
   1. See below

1. Agency will submit the FSS Graduation, Early Graduation, Withdrawal, or Termination Request and required FSS Exit documents to the SMHA FSS Coordinator 30 days prior to expiration of FSS participant’s Contract of Participation (COP).
   1. St. Joseph Center is actively working with City of Santa Monica staff on corrective action to ensure that all FSS program requirements are met. Not all of these conditions have been met within the specified timeframes due to St. Joseph Center and City staff shifting time to COVID-19 response efforts, as well as staff turnover.

**Homeless Programs:**

1. Align resources, including services and existing bed capacity, with the goal of permanently housing priority populations consistent with the City’s Santa Monica Program Participant criteria (SMPP);

1. Ensure clients have access to services outside of Santa Monica. Link clients with services and resources in their community of origin or other appropriate regional services through program referrals or transportation assistance, such as Project Homecoming;

1. Provide adequate supportive services based on individual need to Santa Monica Program Participants placed in permanent housing to promote housing retention, regardless of the type of subsidy or housing utilized;

1. Participate in the City’s HMIS by signing and adhering to the HMIS Agency Agreement; use the HMIS to comply with reporting requirements for participants in the City’s homeless initiatives; participate in other efforts to collect data and evaluate services.

1. Document service match in the City’s Homeless Management Information System (HMIS) for all clients utilizing SMHA Continuum of Care vouchers~~;~~

1. All SMPP individuals who receive case management services should be assessed through the VI-SPDAT and be co-enrolled in the Coordinated Entry System (CES);

1. Program staff will submit Santa Monica Service Registry applications to Human Services staff for SMPP clients who score high acuity (8 or higher) on the VI-SPDAT;

1. Notify Human Services staff when SMPP program participants are at risk of eviction; and

1. Adhere to the attached Intake Policy for documenting homelessness.

St. Joseph Center remains in compliance with all Homeless Program funding requirements. St. Joseph Center continues to align resources with the goal of permanently housing priority populations consistent with City’s program requirements by doing the following:

* Ensure clients have access to and are successfully linked to regional resources and services such as transportation assistance, food pantry, medical and health, wellness services, and other CoC programs that meet the clients’ specific needs.
* Provide ongoing, individualized supportive services based on individual need to participants placed in permanent housing to promote housing stabilization and retention, regardless of the type of housing or subsidy utilized.
* Use the City’s HMIS to comply with reporting requirements for participants in the City’s homeless initiatives. The agency will collect client level data and evaluate services needs on an on-going basis.
* Document service match in the City’s Homeless Management Information System (HMIS) for all clients utilizing SMHA Continuum of Care vouchers.
* Notify Human Services Division staff when SMPP program participants are at risk of eviction.
* Adhere to the City’s Intake Policy for documenting homelessness.

**CDBG Funding:**

1. Eligible Activities: Contractor shall comply with eligibility requirements for Community Development Block Grant (CDBG) funded projects as detailed in [24 CFR Part 570](https://www.hudexchange.info/resources/documents/24-CFR-Part%20-570-CDBGs.pdf) Subpart C of the Housing and Urban Development (HUD) Regulations. This project is deemed eligible for CDBG funding as an activity which benefits a limited clientele who are generally presumed to be principally low- and moderate-income persons or serves participants that provide family size and income evidence (24 CFR 570.208a2(A)(B)). Contractor must collect income verification documentation at the time of intake and at least annually while the participant is receiving CDBG-funded services. Contractor shall work with City staff to comply with fiscal year-end reporting as required by HUD in the preparation of the Consolidated Annual Performance and Evaluation Report (CAPER).
   1. SJC complies with all eligibility requirements for CDBG funded projects as detailed in 24 CFR Part 570 Subpart C of the HUD regulations by ensuring income verification documentation is collected for all participants at intake and at least annually while the participant is receiving CDBG funded services. Documentation will be retained in client files and entered into an HMIS database system for record keeping, data management, and future monitoring. SJC will work with City staff in providing information as requested to comply with fiscal year-end reporting as required by HUD in the preparation and submission of the CAPER.

1. Program Income: Any program income generated by Contractor through the award of CDBG funds shall be returned to the City. “Program income” is herein defined as: a) proceeds from the disposition by sale or long-term lease of real property purchased or improved with CDBG funds; b) proceeds from the disposition of equipment purchased with CDBG funds; c) gross income from the use or rental of real or personal property acquired by the Contractor with CDBG funds, less costs incidental to generation of the income; d) gross income from the use or rental of real property, owned by Contractor, that was constructed or improved with CDBG funds, less costs incidental to generation of the income; e) payments of principal and interest on loans made using CDBG funds; f) proceeds from the sale of loans made with CDBG funds; g) proceeds from the sale of obligations secured by loans made with CDBG funds; h) interest earned on funds held in a revolving fund account; and i) interest earned on program income pending its disposition.
   1. SJC does not have any program income generated directly from activities associated with the CDBG sponsored award or from the sale of property and/or equipment leased or purchased using CDBG funds. This also includes any payments of principal and interests on loans made using CDBG funds, and interests generated from funds held in a revolving fund account. SJC’s Chief Financial Officer and Director of Finance review the agency’s financial records on a monthly basis to ensure compliance with 2 CFR 200 and will document if any program income is generated during the operation of the contract and return any program income to the City at the end of the fiscal year.
2. Uniform Administrative Requirements: Contractor shall comply with applicable uniform administrative requirements as described in 24 C.F.R. 570.502 of the HUD CDBG regulations.
   1. SJC complies with all applicable uniform administrative and program management standards requirements as described in 24 CFR 570.502 by ensuring adequate financial management is maintained (financial reporting, budget management, procurement records, compensation, method of payment), and follow standard record keeping requirements for audits and grant close out.

1. Financial Management: Contractor shall maintain a fiscal management and accounting system based on Generally Accepted Accounting Principles (GAAP) and shall conduct an agency audit according to these principles on an annual basis. Contractor further agrees to conform to all requirements as contained in 2 CFR 200 “Uniform Administrative Requirements, Cost principles, and Audit Requirements for Federal Awards”, which incorporates elements of past guidance contained in OMB Circular No. A-122, and OMB Circular No. A-110. These items shall be in sufficient detail to provide a sound basis for the City to effectively monitor performance under the Agreement.
   1. SJC maintains a fiscal management and accounting system based on GAAP as detailed in the agency’s Accounting Policies and Procedures manual. SJC further ensures compliance by undergoing a rigorous external audit conducted by a third-party company of the agency’s financial management principles on an annual basis and conforms with all requirements as outlined in 2 CFR 200 along with past guidance contained in OMB Circular No. A-122 and OMB Circular No. A-110. All accounting and fiscal records (chart of accounts, general ledger, cash receipts journal, cash disbursements journal, etc.) are recorded in a fiscal management software (Abila MIP), with external budget controls maintained outside the system to allow for monthly analysis and review with program team members (Director, Program Manager) to ensure for accuracy, that all expenses are eligible and align with contractual goals/outcomes and requirements, and there is a program-fiscal review to compare progress toward achievement of annual goals with the rate of expenditure of program funds.

**Continuum of Care (CoC) Sponsor Agencies:**  
  
Adhere to all Department of Housing and Urban Development Continuum of Careregulations, as specified in 24 CFR, Part 578, Continuum of Care Interim Rule updated on April 1, 2017, HEARTH Act of 2009, and Chapter 19 of the Santa Monica Housing Authority Administrative Plan.

1. Refer qualifying individuals and families to the Santa Monica Housing Authority for Continuum of Care program. In order to qualify, the individuals and families must meet the definition of Dedicated Plus per HUD Notice of Funding Availability for 2017 as described below:

* 1. Chronically homeless as defined in 24 CFR 578.3:
     1. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
     2. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and
     3. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
     4. Has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph 1. of this definition, before entering that facility;
     5. Or 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. of this definition, including a family whose composition has fluctuated while the head of household has been homeless.
  2. Residing in a transitional housing project that will be eliminated and meets the definition of chronically homeless in effect at the time in which the individual or family entered the transitional housing project;
  3. Was experiencing chronic homelessness, had been placed in permanent housing within the last year, but was unable to maintain the housing, and as a result currently residing in a place not meant for human habitation, emergency shelter, or safe haven;
  4. Residing in transitional housing funded by a Joint Transitional Housing and Permanent Housing Rapid Re-Housing component project and who were experiencing chronic homelessness prior to entering the project;
  5. Residing and has resided in a place not meant for human habitation, a safe haven, or emergency shelter for at least 12 months in the last three years, but has not done so on four separate occasions; or
  6. Receiving assistance through a Department of Veterans Affairs (VA)-funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system.

1. Provide the Housing Authority with a complete Application Referral Packet that includes the following documentation and forms:
2. Agency Referral letter which contains the following information: brief description of the person (name, age, where they are staying right now, their VI-SPDAT Score), chronological history of homelessness, when and how the person became homeless, explanation of their disability without stating diagnosis, explanation of how they meet the definition of Dedicated Plus, how will they work on maintaining permanent housing once housed.
3. Copy of client’s Social Security card, Birth Certificate (for US born applicants), Eligible Immigration document for non-US born applicants (Work Permits, Alien Cards, Naturalization Certificates, etc.) and Government issued picture identification;
4. Applicant/Tenant Information Disclosure Certification and Application Forms
5. Declaration of Citizen/Lawful Resident Status Form
6. Certification of Disabling Condition
7. Homeless and At Risk of Homelessness Certification Form
8. Notice of Occupancy Rights under the Violence Against Women Act – HUD-5380
9. Certification of Domestic Violence, Dating Violence, Sexual Assault, or Stalking, and Alternate Documentation – HUD-5382 (if applicable)
10. Criminal and Sex-Offender History/Disclosure
11. HMIS/VI SPDAT Report
12. Authorization for Release of Information Forms for the PHA and HUD
13. Verification of income (dated less than 60 days from application submittal)

1. Ensure case managers conduct a thorough screening and assessment of each individual’s care needs. The screening will include assessment of the individual’s ability to live independently. In addition, the individual must not present a danger to self or others and the individual must not require a higher level of care than what is offered by the voucher program. Based on the applicant’s needs, case managers will recommend applicants for either a Scattered Site Housing or a Site-Specific Housing.

1. Once housed, ensure that the participant is providing SMHA with accurate and timely information regarding changes in household composition, income, disability or other matters pertinent to Continuum of Care program participation or lease terms. Case managers must assist tenant with submitting annual recertification documents via email or be present during annual recertification meetings with the Housing Authority and at inspections.

1. Provide, ensure, document and monitor the provision of housing placement assistance and supportive services on an ongoing basis according to the needs of the participants and the requirements of Continuum of Care for the entire term of the agreement or the entire term of the rental assistance, whichever is longer. Housing placement assistance is defined as referring qualified applicants, working with applicants to complete all required Housing Authority and owner lease-related documents and assisting the tenant in locating permanent housing.

CoC grant funding may be used to pay for the delivery of direct supportive services. The CoC grant funding portion of this contract shall be used exclusively for salaries and benefits for case management staff. The grantee is expected to provide in-kind matching services as outlined in 24CFR 578.53 including:

Address the special needs of program participants, including conducting an annual assessment for each participant~~;~~

1. Provide appropriate services or assist such persons in obtaining and maintaining housing;

1. Conduct annual assessments of the service needs and benefits needs of program participants and adjusting services accordingly;

1. Provide supportive services for residents to enable them to live as independently as practicable throughout the duration of their residence in the property. [Appropriate services can include out-patient health care, mental health treatment, alcohol and other substance abuse services, child care services, case management services, counseling, supervision, education, job training, and other services essential for achieving and maintaining independent living].

* St. Joseph Center remains in compliance and adheres to all Continuum of Care Sponsor Agencies requirements, delivering and documenting services and outcomes as detailed in Exhibit A-1.
* SJC adheres to all Department of Housing and Urban Development Continuum of Care regulations as specified in 24 CFR, Part 578 CoC Interim Rule updated 4/1/17, the Hearth Act of 2009, and Chapter 19 of the Santa Monica Housing Authority Administrative Plan by ensuring the following:
* Refer all qualifying individuals and families who meet the Dedicated Plus HUD requirements as defined under 24 CFR 578.3 to the SMHA for CoC program.
* Assist individuals and families with completing an Application Referral Packet along with required documentation such as but not limited to an agency referral letter (including homeless status, VI-SPDAT score, disability, etc.), copy of social security card, birth certificate, eligible immigrant documents (work permits, alien cards, naturalization certificates, etc.), government issued identification, applicant/tenant disclosures, certification of disabling conditions, information releases, etc.
* Complete an assessment and screening of each individual’s care needs and ability to live independently. Identify if the CoC voucher program is appropriate for the level of care required for the client to live and thrive in the program, Case Mangers will assist with recommending the site placement to be either Scattered Site Housing of Site-Specific Housing based on assessment and needs.
* Once housed, SJC will assist with retention and stabilization services to ensure the participant is providing SMHA with accurate and timely information in changes to household such as income, disability, household composition, and any other relevant changes that could affect their housing status.
* Assist with completion of annual recertification documents.
* Case managers will document and monitor the participants to ensure housing stability and offer other supportive services they may be eligible for on an on-going bases according to the needs of the participant for the entire term of their program participation.

**All Agencies are Responsible for**:

1. Updating all client information in HMIS within 10 working days of that information being provided.

1. Maintaining hard copy and electronic Continuum of Care participant files and data as follows:
   1. Hard Copy Files must contain:
      1. Face Sheet
      2. Copies of Application Materials (see 3 above)
      3. Copies of Continuum of Care Contract, the Voucher, SMHA Grievance Procedures and Termination Policy
      4. Consent for Services and Releases of Information
      5. Annual Service Plan (updated quarterly)
      6. Service Match Documentation (e.g., doctor’s verifications, transcripts, receipts)

* 1. Electronic Files and Data
     1. Enter accurate and timely tenant information into the City’s HMIS (as required by the most recent version of HUD form 40118), as well as progress notes.
     2. All HMIS data entry must be maintained on a regular basis and must be complete by the last day of the grant year. The City of Santa Monica will monitor data entry on a monthly and quarterly basis.
     3. Corrective Action Plan if i. and ii. above are not met.

1. Maintaining data consistent with HUD, Human Services and SMHA grant requirements, including timely entry and provision of data for reporting purposes including:

1. Providing SMHA with an Annual Progress Report (APR) from HMIS, including accurate and documented service match figures within 30 days of the end of the grant reporting year. The grant ends on May 31, 2022, and the APR reports and match reports are due no later than June 30, 2022. Providing SMHA with participant rosters and annual outcomes for the grant listed below within 30 days of the end of the grant reporting year. The grant ends on May 31, 2022, and the annual outcomes for the grant are due no later than June 30, 2022

1. Attending all Chronic Homeless Program (CHP) monthly case managers’ meetings as scheduled by Housing & Human Services Division (HHSD).

1. Informing SMHA of any personnel or program issues, including but not limited to, extended staff illness, injury, terminations, or staff resignations that may negatively affect the ability of the grantee to fulfill its Continuum of Care funding conditions as defined in this contract.

* 1. When a case manager is assigned or re-assigned to a Continuum of Care participant, the Agency must inform SMHA in writing within 10 working days. If a property owner informs the agency that he/she plans to evict a participating tenant, that the participating tenant is violating lease agreement, or that for any other reason tenant’s housing might be affected the agency must inform the SMHA within 10 working days
* SJC will enter and manage participant level data in an HMIS database on a regular basis as outlined in the agency’s data management policy. Information will be entered into HMIS no later than 10 business days after the information being provided to their Case Manager.
* SJC will also maintain a participant file for household in the program. Information maintained in the file will include progress notes, core demographic information, paperwork submitted such as income verification, housing plans, applications, and any other hardcopies, as well as housing packets.
* Data maintained will be used to complete the APR and CAPER for the CDBG funded project no later than 30 days after the end of the grant reporting year. SJC will work with the City to provide all necessary information to complete the required service match, fiscal expenditure reports and annual outcomes reporting to complete by the stated deadline in Exhibit A-1.
* SJC participates and attends all meetings as scheduled by the City.
* SJC continues to communicate and informs the City of any personnel or program issues such as vacancies, extended staff illnesses or injuries, terminations, or staff resignations that may negatively affect the ability to meet all the conditions and outcomes of the contract.

**SECTION VI: SERVICE NEEDS AND REFERRALS**

The following tables track data on program participant needs and the inter-agency relationships utilized to address them. Please provide this information as completely and accurately as possible for participants entering your program.

|  |  |  |
| --- | --- | --- |
| **ASSESSMENT OF ADDITIONAL SERVICE NEEDS**  **(Santa Monica Participants)** | **FY 2022-23**  **Number Responding “Yes”**  **at Mid-year** | **FY 2022-23**  **Number Responding “Yes”**  **at Year-end** |
| 1. “Do you or anyone in your household have unmet employment needs?” | 23 | 44 |
| 1. ”Have you missed or been late on a home rental or mortgage payment within the last 12 months?” | 47 | 59 |
| 1. “Do you or anyone in your household have an unmet childcare/afterschool need?” | 0 | 0 |
|  | | |
| INCOMING PARTICIPANT REFERRALS  (Santa Monica Participants) | FY 2022-23  Number  at Mid-year | FY 2022-23  Number  at Year-end |
| Participants referred by another agency |  |  |
| Please list the top 3 referring agencies |  |  |
| * 1. City of Santa Monica | 19 | 22 |
| * 1. LAFLA | 17 | 21 |
| * 1. CCSM | 3 | 6 |

**SECTION VII: PROGRAM SERVICES AND OUTCOMES**

Provide a status report on the program activity levels and outcomes for Santa Monica program participants as indicated in Section VII of your Program Plan. Examples have been provided for your reference; please insert rows as needed to align with your Program Plan. For outcome achievement not documented in a report, please provide narrative explanation and/or documentation of how outcome data is captured.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Service Category/ Program Goal** | **Activity Type** | **Activity Description** | **Annual Target\*** | **Documentation**  **Method** | **Mid-Year Status Report** | **End of Year Status Report** |
| 1 | Housing Retention | Output | Adult participant will be served through this grant. | 150 SMPP | ServicePoint | 158 | 169 |
| Outcome | Adult participant will maintain housing through the end of the program year | 135 SMPP | ServicePoint | 154 | 161 |
| 2 | Maintain or Improve Economic Vitality | Output | Adult participants will receive income development services | 150 SMPP | ServicePoint | 158 | 169 |
| Outcome | Adult participant will increase or maintain income through the end of the program year | 135 SMPP | ServicePoint | 118 | 134 |
| 2 | Mental Health | Output | Adult participant will be assessed for mental health service needs and be referred to appropriate internal and external programs | 150 SMPP | ServicePoint | 74 | 114 |
| Outcome | Adult participant will engage in mental health services | 50 SMPP | ServicePoint | 16 | 33 |

###### VARIANCE REPORT:

###### Year-end: Please provide an explanation for each output or outcome for which achievement is above or below 10% of the projected target.

**Outputs/Outcomes 10% above target**

* **Total participants:** 169 adult participants were served this fiscal year, which is 13% above the target of 150. The need for housing retention and other supportive services continued to increase as COVID renter protections lifted, more individuals sought new employment opportunities, and households faced increased cost of living due to inflation. Of the 169 clients served, 95% maintained housing through the end of the year, which is higher than the target of 90%. Of the 8 clients who did not maintain their housing: 4 participants passed away, 1 was lost to follow up and is presumed homeless, 2 moved to temporary living situations with friends/family, and 1 client lost his housing and staff are working with them to identify new housing.

**Outputs/outcomes 10% below target**

* **Adult participant will increase or maintain income through the end of the program year:** 134/169 (79%) of participants increased or maintained their income, which is below the target of 90%. With shifts in the job market, a number of clients lost their employment and are still seeking work or secured jobs that pay less, causing a decrease in their overall income. In addition, the wait time for processing benefits applications has been lengthy. Staff work with clients regarding employment services and benefits to support with income development.
* **150 adult participants will be assessed for mental health service needs and be referred to appropriate internal and external programs:** 114/169 (67%) of participants received a mental health screening during FY 22-23. 16 participants were unable to receive a reassessment due to program exit (see Section 1). The remaining outstanding assessments were due to clients declining the assessment due to the sensitivity and stigma around mental health services and/or clients who were not actively engaged in the program. New clients receive a mental health assessment as part of their intake, and then receive an annual assessment. However, for clients who were screened, the team was able to connect 29% (33/114) of adult participants screened to mental health services, which is within 10% of the target of 33%.

To address mental health screening and service needs, staff continue to work with City personnel and staff at partner agencies to develop creative strategies to increase engagement with clients and address the stigma around mental health services. In addition, the extended vacancy of the mental health specialist position, as well as the shortage of available mental health services providers in Service Area 5. SM Retention Program Manager and Director will continue to work with the internal Human Resources department to fill the Mental Health Specialist position. SM Retention staff will also continue to work with internal and external partners to refer clients to mental health services.

**SECTION VIII: PROPERTY MANAGEMENT**

If this program has entered into a lease agreement with the City of Santa Monica, please provide a status report of facility improvements and routine maintenance performed during the reporting period.

**n/a**

**By submitting this report to the Housing and Human Services Division, I certify that this report is true, complete and accurate to the best of my knowledge and that all disbursements have been made in compliance with the conditions of the Grantee Agreement and for the purposes indicate**