

# Jewish Family Service

A Community Resource Since 1918

## Permanent Supportive Housing

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# Presentation Outline



1: Overview of JFSSD HUD Programs

2: Developing an Individualized Service Plan

3: Case Management Approach

4: Client Outcome and Successful Exit to Permanent Housing

5: Challenges and Lessons Learned

# 1: Overview of JFSSD HUD Programs

JFSSD currently operates 2 Permanent Supportive Housing programs in Riverside County

- Desert Vista PSH since 2011
- Desert Horizon PSH since 2014

# What is Permanent Supportive Housing?



A cost-effective combination of permanent, affordable housing with services that help people live more stable, productive lives.

# Desert Vista / Desert Horizon



- These two HUD grants serve a combined total of 58 PSH beds.
- Beds are scattered-site locations in Palm Springs, Cathedral City, and Desert Hot Springs
- We currently have 45 apartments including studios, 1-3 bedroom units. All shared units include a private bedroom and restroom for each client.

# Occupancy Agreements

- JFSSD maintains a master lease for each of our scattered site apartments.
- Every client in DH / DV PSH is provided with an Occupancy Agreement. Clients do not have a contract with the landlord.
- Each client pays 30% of their adjusted gross income for rent. Income is not a requirement for entry into the programs. If a client has \$0 income, their occupancy agreement would state \$0 rent.

# Housing Services

JFSSD  
acts as  
the  
landlord  
to our  
clients.



There is a  
functional  
separation  
of housing  
and  
supportive  
services.



We have separate  
staff providing these  
services. The  
housing staff  
advocate for  
compliance to the  
terms of the lease.  
Lease violations are  
documented by  
Housing staff.



Supportive Service  
staff advocate for  
their clients to  
assist in  
maintaining  
housing. Lease  
violation  
counseling and  
action plans are  
developed to  
support clients to  
comply with the  
terms of their  
lease.

# Life Skills Training

Component life skills training include

- budgeting of resources and money management
- household management
- conflict management
- shopping for food and other needed items
- Nutrition
- the use of public transportation, and more.





# Additional Supportive Services

In addition to Case Management JFSSD provides a wide variety of supportive services to our clients.

- Assistance with Moving Costs
- Food Assistance
- Housing Search and Housing Counseling Services
- Outreach Services
- Transportation Assistance

## 2: Developing Individual Service Plans

- Participation in Supportive Services is voluntary. Clients may accept or refuse to participate in supportive services.
- If a client refuses services, staff will still schedule a monthly meeting with them. Staff will attempt to meet with the client and offer services on a regular basis.



# Individual Service Plans

- Upon entry, Case management will complete an initial assessment of service needs. This assessment encompasses multiple service areas and assists in developing the service plan. Specific topics included are:
  - Documents (ID, SS Card, DD214, Birth Certificate)
  - Access to Medical/Mental Health/Substance Abuse services
  - Income / Pending applications
  - Employment / Educational needs and/or goals
  - Other personal Goals identified by client

# Developing an Individual Service Plan



- Each client in the program will work on an Individual Service Plan with their Case Manager.
- This is a working plan that changes as they work towards achieving their goals. Goals are documented in the monthly Service Plan.
- There should be an updated Service Plan for every month that a client is enrolled in the program.

# Quarterly Assessments

- HUD requires a regular reassessment of a client's need for the program and services.
- JFSSD has determined that we will complete a new case management assessment on a quarterly basis for each client.
- This is best completed with the clients during the course of their regularly scheduled meetings.

# Goal Progress

Part of reassessing includes a Quarterly Goal Progress Report.

This is essentially a summarization of the client's progress over the previous 3 months.



# 3: Case Management Approach



JFSSD has implemented a leveling approach to Case Management.

This allows for those clients with greater service needs to be provided with additional staff time, and those more stable clients to increase their self-sufficiency as they require less intensive services.

Goals will change as clients progress through the program.

# First steps into the program

- Upon entry clients will be placed in Level 1 of case management. They are coming directly from the street or an emergency shelter following an extended period of homelessness.
- These clients are in a crisis and have the greatest level of need.





# Level 1



- Provides the most intensive level of Case Management services
- This client may require two case managers to assist in addressing their urgent medical, mental health, and/or substance abuse needs.
- Minimum of 1 case management meeting per week. This may be increased due to the severity of need.

# Level 2

- Moderate level of intensity
- Minimum of 2-3 Case Management Meetings per month.
- Urgent Medical, Mental Health, and Substance Abuse needs are being addressed. Client is linked to services and working with their Primary Care Physician to address these concerns.



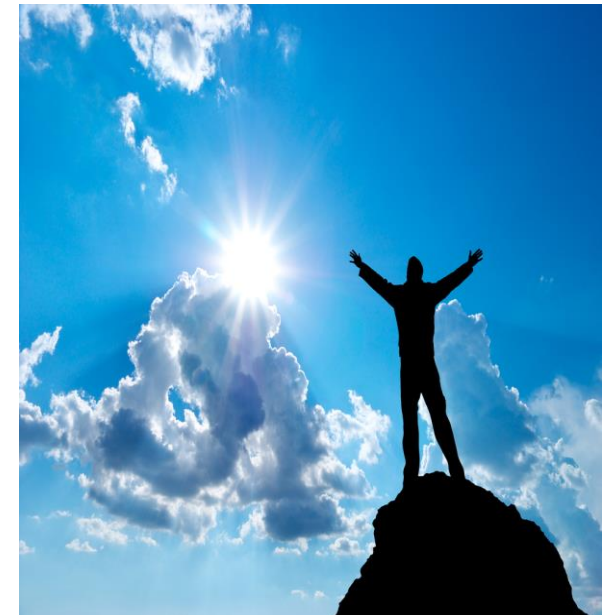
# Level 3



- Less Intensive Case Management
- Minimum of 1-2 Case Management meeting per month in addition to one phone appointment.
- Client has stable income, medical coverage, sobriety, and is maintaining their unit.

# Level 4

- Least Intensive Case Management
- Minimum of 1 Case Management meeting per month.
- Client has stable income, medical coverage, sobriety, and is maintaining their unit.
- For the last 12 months client needs to have obtained these goals:
  - No tenancy issues
  - Stable income and is possibly started saving money.
  - Paid their rent on time, in full each month
  - Stable medical, mental health, and sobriety.



# 4: Client Outcome and Successful exit to PH

- Health and well-being have improved
- Decreased involvement with the Justice System
- Decreased acute psychiatric care
- Ability to remain in own home or Independent Living
- Increased employment opportunities
- Increased ability to meet educational goals
- Ability to use community resources to fulfill needs
- Increased Ability to understand, recognize, and manage symptoms for both physical and psychiatric disabilities.

# Successful Exit to PH

- Staff work with clients to eliminate barriers for housing readiness. (Credit report, criminal record, security deposit, etc.)
- Staff work with clients to help establish natural support systems to assist them in maintaining their housing. (Family, community centers, religious organizations, in-home care, etc.)
- Staff will assist with housing applications as needed.

# 5: Challenges and Lessons Learned



## Lessons Learned

- What works for one client may not work for another.
- The greatest success may not be what you expect. Client goals may not reflect what staff think is best for the client and that is okay.
- There is always a new and different way to approach a situation.

# Challenges



- Staff must have the “Whatever-it-takes” attitude toward helping clients stay in their housing. This is very challenging for staff when clients continue to violate their lease.
- Securing alternative housing when clients violate their current lease.
- Clients can accept or refuse treatment and or other services, but staff must continue to offer support and use flexible engagement strategies.
- Lack of resources to meet the needs of our clients.



# Final Questions?