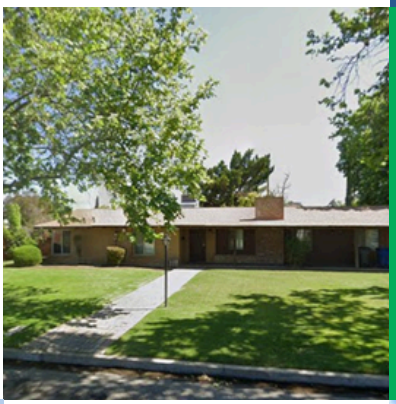
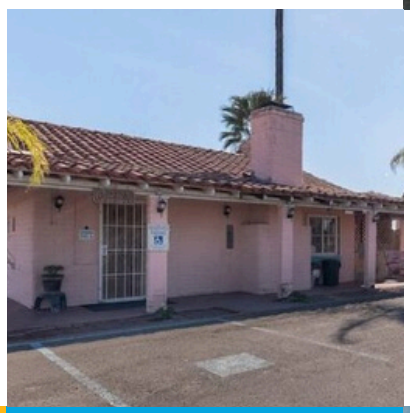
Madera County Department of Behavioral Health Services **Housing Guidebook**

Learn about the different types of housing supports and processes in Madera County.

2026





MADERA COUNTY
ESTABLISHED 1893
HEART OF CALIFORNIA
BEHAVIORAL HEALTH SERVICES







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WELCOME

The Madera County Department of Behavioral Health Services (BHS) Housing Guidebook provides comprehensive guidance for staff supporting individuals experiencing homelessness or housing instability. This manual outlines available BHS housing programs, details the specifc types of support offered, and establishes clear processes for connecting individuals to appropriate, stable housing resources.

The purpose of this guidebook is to:

- Provide an understanding of the different Behavioral Health housing programs
- Describe the types of housing interventions available
- Clarify funding sources that support housing services
- Outline workflows for referrals, assessments, prioritization, and placement into housing

This guidebook is intended to serve as both a training tool for new staff and a reference for ongoing housing coordination efforts.

Overview of BHSA and DMC-ODS

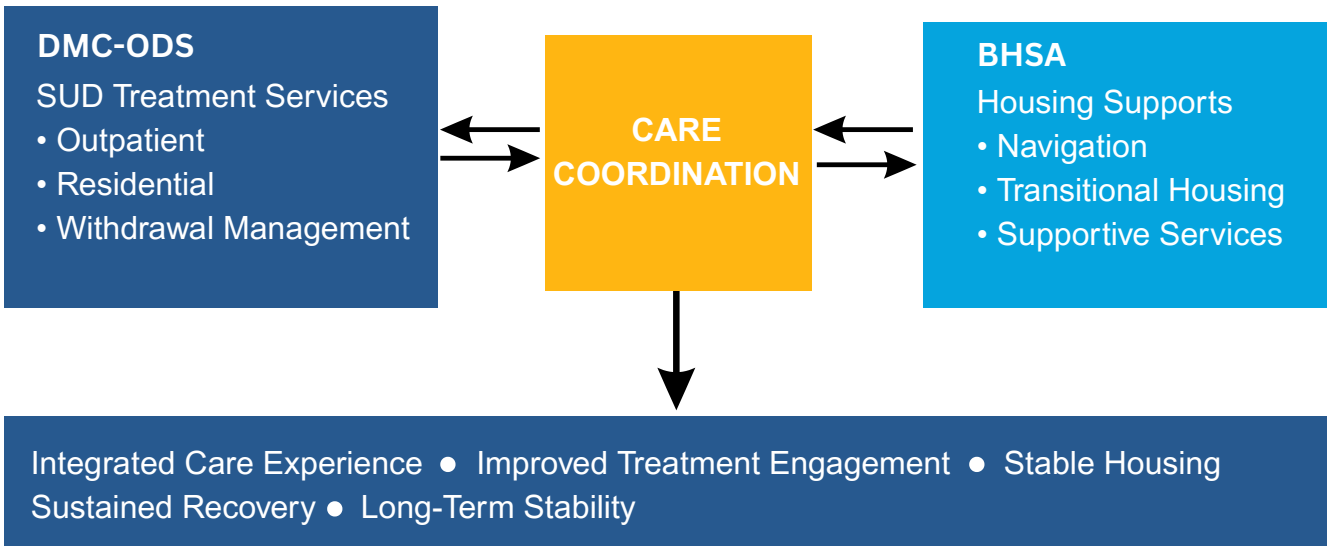
BEHAVIORAL HEALTH SERVICES ACT (BHSA) AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) ROLE IN HOUSING

Unlike in the past, housing support is now more intentionally integrated across behavioral health programs through both the Behavioral Health Services Act (BHSA) and the Drug Medi-Cal Organized Delivery System (DMC-ODS), each playing a complementary role.

The Behavioral Health Services Act supports housing as a core component of treatment and recovery. It prioritizes individuals experiencing or at risk of homelessness who have serious mental illness, serious emotional disturbance, or co-occurring substance use disorders.

The Drug Medi-Cal Organized Delivery System supports individuals with substance use disorders (SUD) through a comprehensive continuum of care. This includes treatment services and, when necessary, housing-related supports to help individuals successfully participate in treatment and sustain recovery.

Together, BHSA and DMC-ODS create a more integrated approach to ensure individuals have access to appropriate housing support across systems.



Target Populations and Eligibility Criteria

Madera County Behavioral Health Services Act (BHSA) Housing Program defines the primary target populations served through Behavioral Health housing resources in this section. These populations reflect funding requirements, program priorities, and service eligibility across Behavioral Health Services and Supports, including BHSA, substance use disorder services, and housing-focused programs. Because individuals may fall into more than one category, programs should prioritize those with the highest level of need and greatest barriers to housing stability.

BHSA PRIORITY POPULATIONS

Under BHSA Housing Interventions, eligible individuals must be open to mental health and/or substance use disorder services and meet BHSA behavioral health criteria. Additionally, they must be experiencing homelessness, chronically homeless, or at risk of homelessness.

PRIORITY POPULATIONS INCLUDE

- Individuals with serious mental illness (SMI) or serious emotional disturbance (SED)
- Individuals with substance use disorders (SUD)
- Individuals experiencing homelessness, chronic homelessness, or living in encampments
- Individuals at risk of homelessness or housing instability
- Individuals transitioning from institutional settings (psychiatric hospitals, residential treatment, jail/prison)
- Individuals at risk of institutionalization or conservatorship
- Justice-involved individuals reentering the community
- Individuals with high utilization of crisis, emergency, or inpatient services
- Children, youth, and families with significant behavioral health needs

Programs funded through BHSA housing resources will prioritize individuals who meet one or more of the following.

Individuals with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED)

Consistent with CalMHSA housing guidance and BHSA policy, housing interventions prioritize individuals who are:

- Diagnosed with a serious mental illness (SMI) and/or serious emotional disturbance (SED)
- Individuals with co-occurring mental health and substance use disorders (SUD)
- Those with significant functional impairments impacting independent living

Individuals Experiencing Homelessness or At Risk of Homelessness

Consistent with CalMHSA housing guidance and BHSA policy, housing interventions prioritize individuals who are:

- Unsheltered (street, vehicle, encampment, abandoned building)
- Individuals or families currently unsheltered, in emergency shelters, or transitional housing
- Chronically homeless individuals (as defined by U.S. Department of Housing and Urban Development guidelines)
- Living in encampments
- Exiting institutions (e.g., hospitals, jails, residential treatment) without stable housing
- Fleeing domestic violence or unsafe living conditions
- At imminent risk of losing housing

BHSA requires counties to track individuals experiencing chronic homelessness and those living in encampments as priority populations for housing interventions.



DMC-ODS Eligible Individuals

DMC-ODS housing-related supports are intended to assist individuals whose substance use disorder (SUD) creates barriers to treatment engagement and recovery.
Target populations include:

- Individuals diagnosed with a substance use disorder
- Medi-Cal eligible individuals meeting medical necessity for SUD treatment
- Individuals entering or participating in residential SUD treatment
- Individuals stepping down from residential treatment
- Individuals needing recovery-supportive housing
- Individuals experiencing homelessness with SUD
- Individuals at risk of relapse due to housing instability

Housing supports under DMC-ODS are treatment-supportive, meaning housing is used to improve treatment engagement, retention, and recovery outcomes.



Individuals Experiencing Co-Occurring Disorders:

Individuals with co-occurring mental health and substance use disorders are a high priority across both BHSA and DMC-ODS housing programs due to increased housing instability and service needs.
Target populations include:

- Individuals with both SMI/SED and substance use disorder
- Individuals cycling between homelessness, treatment, and crisis services
- Individuals with frequent hospitalizations or detox admissions
- Individuals requiring integrated mental health and SUD treatment
- Individuals with complex behavioral health and medical needs
- Individuals requiring intensive supportive housing services

Programs should prioritize integrated care coordination and supportive housing placements to effectively serve these individuals.

SPECIAL POPULATIONS

The following populations may receive priority consideration based on BHSA housing guidance, CalMHSA recommendations, and system coordination goals.



Veterans

- Veterans experiencing homelessness
- Veterans with behavioral health conditions
- Veterans with substance use disorders
- Veterans transitioning from institutional settings
- Veterans eligible for coordinated VA housing resources

BHSA housing allows for Veterans as a priority population for housing interventions.

Justice-Involved Individuals

- Individuals exiting jail or prison and reentering the community from incarceration
- Individuals on probation, parole, or diversion programs
- Individuals at risk of homelessness due to justice involvement
- Individuals requiring behavioral health stabilization to reduce recidivism

BHSA identifies justice-involved individuals as a priority population for housing interventions.

Note on Overlapping Eligibility

Individuals meeting criteria for multiple target populations. Programs should prioritize:

- Highest vulnerability
- Greatest barriers to housing
- Clinical need for supportive services
- Risk of homelessness or institutionalization
- Eligibility requirements tied to funding source

Final eligibility is determined based on program guidelines, funding requirements and clinical/service assessment.

Family With Children Involved In Child Welfare Systems

- Families where a parent or caregiver has behavioral health needs
- Families at risk of homelessness due to mental health or SUD conditions
- Families involved with child welfare systems
- Families requiring supportive services to maintain housing stability

BHSA housing allows for family housing models as a priority population for housing interventions.

Youth and Transition-Age Youth

- Youth ages approximately 16–25 with behavioral health needs
- Youth exiting foster care
- Youth exiting juvenile justice systems
- Youth experiencing family conflict or housing instability
- Youth at risk of homelessness

BHSA identifies Youth and Transition-Age Youth (TAY) as a priority population for housing interventions.



ELIGIBILITY CRITERIA

To qualify for BHSA-funded housing programs in Madera County, individuals must generally meet the following requirements:

Residency	Must be a resident of Madera County or demonstrate intent to reside in the county
Income Requirements	Typically, extremely low- to low-income (e.g., 30–50% of Area Median Income), depending on funding source
Behavioral Health Eligibility	Must meet medical necessity criteria for behavioral health services as defined by California Department of Health Care Services and Documentation of mental health and/or substance use diagnosis
Functional Need	Demonstrated need for supportive housing services to maintain stability, such as: Difficulty with activities of daily living or frequent hospitalizations, incarcerations, or crisis service utilization
Housing Need	Must be homeless, at imminent risk of homelessness, or unable to maintain housing without supportive services • Priority given to those with longest histories of homelessness and highest service needs

Prioritization Criteria

When demand for housing resources exceeds availability, prioritization is ensures that those with the greatest needs are served first. Priority is given to individuals who are chronically homeless and living with disabling behavioral health conditions, as well as high utilizers of emergency services (such as frequent emergency room visits or psychiatric hospitalizations).

Additional consideration is given to individuals with co-occurring mental health and substance use disorders. Highly vulnerable individuals, with urgency of need using standardized tools, such as the CESMAT. In addition, special attention is paid to disproportionately impacted populations, including communities experiencing significant health inequities, to promote more equitable access to housing opportunities.

Eligibility for housing programs may vary slightly depending on the type of program. Permanent Supportive Housing (PSH) typically requires that individuals meet the criteria for chronic homelessness and have a qualifying disability. Transitional Housing, by contrast, focuses on short- to medium-term stabilization and emphasizes engagement in treatment services. Recovery residences and substance use disorder (SUD) housing require residents to actively participate in substance use treatment or recovery programs as a condition of stay. Bridge or interim housing is designed as a short-term solution for individuals who are awaiting placement in permanent housing.

There are also certain exclusions and limitations to consider. Individuals whose primary needs are not related to behavioral health may be referred to other systems of care more appropriate to their circumstances. While participation in supportive services is strongly encouraged across programs, all housing models adhere to Housing First principles, which aim to minimize barriers to entry and prioritize immediate access to housing.

All Behavioral Health Services Act (BHSA) housing programs in Madera County operate according to a shared set of guiding principles. These include a commitment to the Housing First approach, the use of trauma-informed care practices, an emphasis on cultural humility and equity, and the integration of behavioral health services with housing support to promote long-term stability and well-being.





The Path Home

The path to long-term housing stability for our clients' experiencing homelessness is paved by the trust and hope created by our consistent and focused interactions.

1

Referral

Document the need for Housing Services by submitting a Housing Referral Form. Adopt a No Wrong Door approach; clients can self-refer, and referrals can come from Case Managers or community partners.

2

Housing Discussion

Within two working days upon receipt of a Housing Referral, the Case Manager will reach out to the client and set an appointment. Housing Team members begin engaging the client, collecting pertinent information and helping the client start to set goals.

3

Offer Shelter

Explore resources the client may have, like friends or family that can offer short-term housing. If no options exist, offer client the Madera Rescue Mission.

4

Connect to Resources

The Housing Team connects clients with outside resources to meet their needs. Assess for placement in any BHS dedicated bed vacancies, discuss site's rules and opportunities with client, have client sign Client Agreement prior to placement.

5

Case Management

Ongoing support to help the client achieve their goals. This includes navigating the client to more stable, permanent housing.

Point of Entry

Madera County Department of Behavioral Health Services (MCDBHS) shall establish multiple coordinated entry points to ensure equitable access to housing services under the Behavioral Health Services Act (BHSA).

BEHAVIORAL HEALTH ENTRY

Individuals may enter housing services through:

- Mental Health outpatient clinics
- Substance Use Disorder (SUD) treatment programs
- Crisis services (e.g., crisis stabilization, mobile crisis teams)
- Inpatient or residential discharge planning.

COMMUNITY-BASED ENTRY

Referrals may originate from:

Community-based organizations (CBOs)

Homeless service providers

Healthcare providers (hospitals, FQHCs)

Schools and family service agencies

JUSTICE INVOLVED ENTRY

Individuals who are considered justice involved may be referred from:

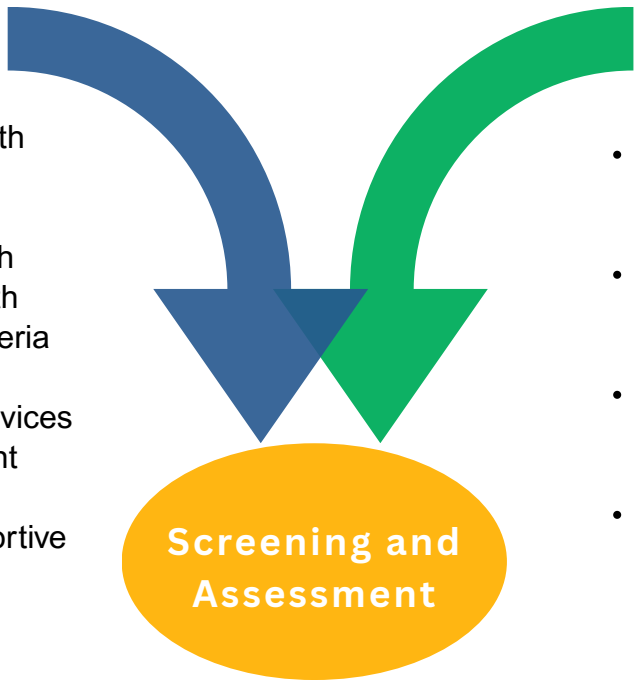
- Community-based organizations (CBOs)
- Homeless service providers
- Healthcare providers (hospitals, FQHCs)
- Schools and family service agencies



DUAL-TRACK INTAKE PROCESSES

Mental Health (MH) Pathway

- Entry via Mental Health Access Line or clinics
- Screening aligned with specialty mental health medical necessity criteria
- Linkage to clinical services and case management
- Integration with supportive housing programs



Substance Use Disorder (SUD) Pathway

- Entry via SUD programs or referral partners
- Screening aligned with ASAM criteria
- Coordination with SUD treatment providers
- Integration with recovery-oriented housing services

INITIAL AND ONGOING SCREENING AND ASSESSMENT

All individuals referred for housing services shall undergo a standardized screening and assessment process by a clinician or case manager.

Clinical Assessment

- Completed by a licensed or waivered clinician, when required
- Determines:
  - Medical necessity for behavioral health services
  - Functional impairments
  - Co-occurring mental health and SUD needs
  - Conducted at the first point of contact
  - Includes:
    - Basic eligibility verification
    - Housing status and history
    - Immediate risk factors (e.g., homelessness, safety concerns)

Risk Assessment

- Includes evaluation of:
  - Vulnerability (chronic homelessness, medical fragility)
  - Risk of harm to self or others
  - Housing instability and severity

Documentation Requirements

All screenings and assessments must be documented in:

- Electronic Health Record (EHR)
- HMIS (as applicable)

Documentation must meet Medi-Cal and CalAIM standards

COORDINATED ENTRY SYSTEM (CES)

MCDBHS must utilize the Coordinated Entry System (CES) to ensure standardized prioritization and placement into housing resources.

The Coordinated Entry System Matching Assistance Tool (CESMAT) is the Fresno-Madera Continuum of Care's official vulnerability and acuity assessment. To remain on the Community Queue or to be considered for matches, all clients must have a completed CESMAT.

Who Must be Assessed

All adults seeking to remain on or be placed on the Community Queue must have a completed CESMAT:

- Adults in a household with no children: complete the "Individual" CESMAT.
- Households that include minor children: complete the "Family" CESMAT and ensure every adult in the household is assessed.

Safety and Privacy (Critical)

The CESMAT contains sensitive questions about current victimization and intimate partner abuse.

- **Do not conduct a CESMAT** if an intimate partner is in the same room.
- If privacy cannot be ensured, postpone the assessment or arrange for a private setting.

Assessor Certification

Only approved CESMAT assessors may administer CESMATs. Any CESMAT administered by a non-approved assessor will be automatically denied.

- CESMAT Family Assessment Tool
- CESMAT Individual Assessment Tool

HMIS Data Entry

- All CES assessments must be entered into the Homeless Management Information System (HMIS)
- Staff shall follow the HMIS CES Data Entry Manual for:
  - Timely data entry
  - Data accuracy and completeness
  - Ongoing updates to client records

Compliance

- CES participation is required for all housing programs receiving public funding
- Data must align with HUD and local Continuum of Care (CoC) standards

REFERRAL AND PRIORITIZATION PROCESS

Follow this standardized process to ensure equitable housing placement.

1. Referral Submission

Referrals may be submitted by:

- Behavioral Health staff
- Community based entry
- Justice system partners

Required documentation:

- Housing Referral Form
- Release of Information (ROI)
- Assessment documentation

Prioritization Criteria

Prioritization shall be based on:

- CES score and vulnerability level
- Chronic homelessness status
- Medical and behavioral health acuity
- System involvement (e.g., frequent hospitalizations, justice involvement)

Queue Management

Referrals are entered into a centralized housing queue. The queue is monitored regularly to ensure:
Timely placement
Equity across populations
Compliance with funding requirements

CASE CONFERENCING

MCDBH shall conduct regular case conferencing meetings to support housing placement decisions. The purpose of these meetings is to review and prioritize housing referrals, match individuals to appropriate housing resources, and coordinate care across systems.

- Participants may include Behavioral Health clinicians, housing navigators, CES/HMIS staff, and community partners, as appropriate.
- Frequency: Meetings shall occur at a minimum on a **weekly or bi-weekly basis.**
- **Required Documentation:** Each meeting must document decisions made, assigned action steps, and the completed Housing Stabilization Form including client identifiers handled in accordance with confidentiality requirements.

CLINICAL TREATMENT PLAN INTEGRATION

All individuals receiving housing services through MCBH shall have a documented clinical treatment plan when applicable.

Requirements

- Developed by a qualified clinician
- Must include:
  - Behavioral health diagnoses (if applicable)
  - Measurable goals and objectives
  - Housing stability as a treatment goal (when appropriate)

Integration with Housing Services

- Housing services must be:
  - Reflected in the treatment plan
  - Linked to clinical goals (e.g., stability, recovery, reduced hospitalizations)

Updates and Review

- Treatment plans must be:
  - Reviewed and updated per Medi-Cal timelines
  - Adjusted based on housing status and client progress

KEY ROLES

Clinicians (Licensed/Waivered)

- Conduct assessments & treatment planning
- Establish medical necessity
- Provide clinical oversight

Housing Coordinator

- Assist clients with housing search
- Coordinate with landlords
- Support application processes

Case Managers

- Ongoing support & service coordination
- Monitor housing stability
- Link clients to community resources

HMIS/Data Staff

- Accurate data entry & reporting
- Maintain HMIS compliance

Program Supervisors

- Oversight & quality assurance
- Ensure BHSA, CalAIM, Medi-Cal compliance

Housing and Treatment Continuum

Madera County Department of Behavioral Health Services (MCDBHS) provides a continuum of housing and treatment options designed to support individuals with behavioral health needs across varying levels of acuity, stability, and independence. This continuum ensures immediate access to safe shelter, clear connection to treatment services, and steady progression toward long-term housing stability and recovery.

Individuals may enter the continuum at any point based on assessed need and may transition between levels as clinically appropriate.

EMERGENCY SHELTER

Emergency Shelter provides immediate, short-term housing for individuals experiencing homelessness or crisis.

Purpose

- Ensure safety and stabilization
- Address urgent basic needs (food, hygiene, shelter)
- Serve as an entry point into the behavioral health system

Key Features

- **Low-barrier access**
- **Short-term stays (typically days to a few weeks)**
- **Referral to ongoing services and housing resources**



TRANSITIONAL HOUSING

Transitional Housing provides interim housing with support services for individuals transitioning between higher- and lower-level care. higher levels of care provide 24/7 medical and clinical supervision, while lower levels offer independent living with minimal, part-time support.

Purpose:

- Bridge the gap between homelessness, treatment, and permanent housing
- Prevent returns to homelessness or hospitalization
- Provide stability while longer-term housing is arranged
- Engage individuals in behavioral health services

Key Features

- **Time-limited placement (typically up to 6 months, depending on program)**
- **Case management and service linkage**
- **Focus on stabilization and planning**





PERMANENT SUPPORTIVE HOUSING (PSH)

Permanent Supportive Housing combines long-term housing assistance with ongoing supportive services for individuals with chronic behavioral health conditions.

Purpose:

- Provide permanent housing stability
- Reduce homelessness, hospitalizations, and incarceration

Key Features

- No time limits on housing
- Voluntary supportive services
- Tenant lease rights

GUIDING PRINCIPLES

The BHSA Housing Continuum is guided by:

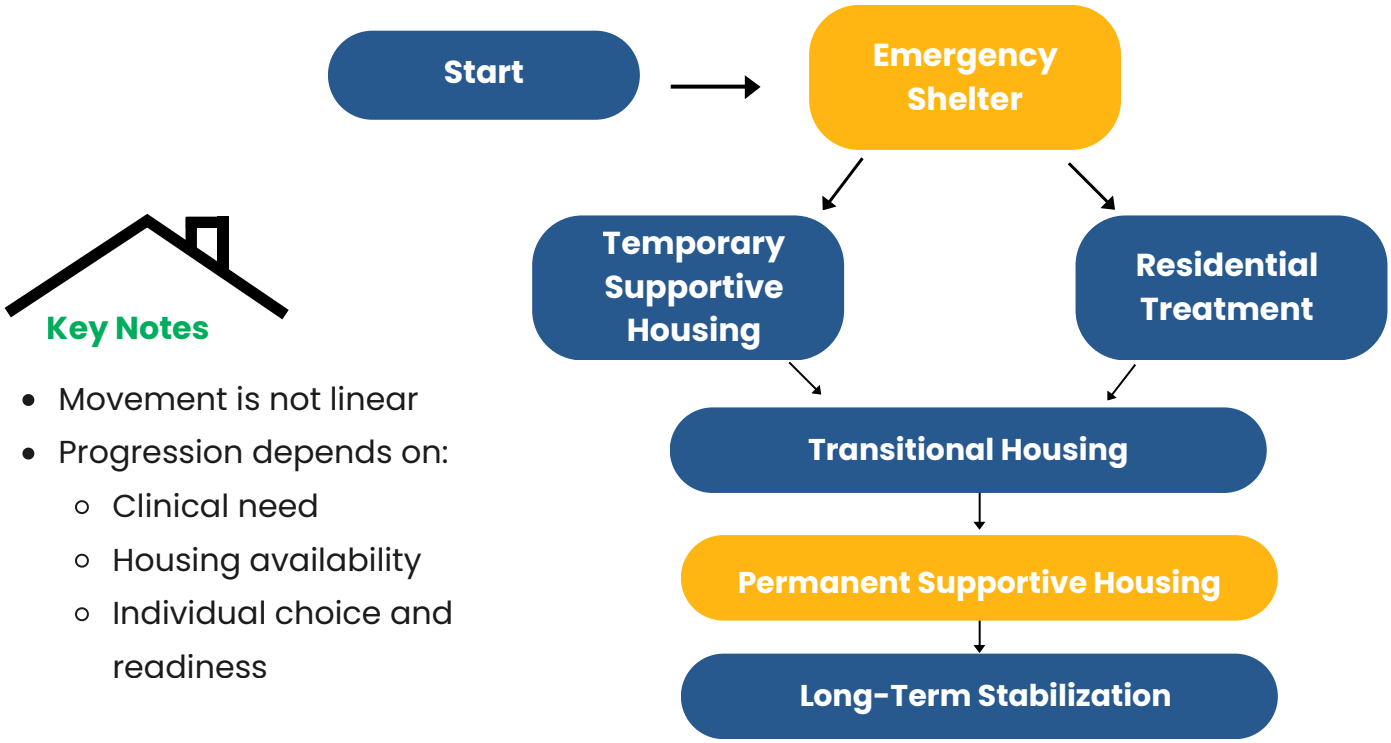
Trauma-Informed Care: Services are delivered with an understanding of the impact of trauma, prioritizing safety, trust, and empowerment while avoiding re-traumatization.

Client-Centered and Culturally Responsive Services: Care is tailored to each individual's unique needs, preferences, and cultural background, ensuring respect, inclusion, and meaningful engagement.

I**ntegration of Behavioral Health and Housing Support:** Housing services are coordinated with mental health and substance use treatment to provide comprehensive, holistic support that promotes long-term stability.

CONTINUUM FLOW

Individuals may move through the continuum as follows



Key Notes

- Movement is not linear
- Progression depends on:
  - Clinical need
  - Housing availability
  - Individual choice and readiness

MADERA COUNTY BEHAVIORAL HEALTH HOUSING

BHSA CATEGORY	PROGRAM	DESCRIPTION
Other Housing Supportive Services	**Home Connect**	**Mobile outreach** linking unhoused individuals to housing and behavioral health services (**Housing First**)
EMERGENCY HOUSING		
Operational Subsidies	**Madera Rescue Mission** 332 Elm Street Madera CA 93638	**Emergency/interim housing** with behavioral health, life skills, and employment support. Time frame is based upon availability up to 1 year.
TRANSITIONAL SUPPORTIVE HOUSING		
Rental Subsidies	**Casa Grande** 12390 Golden State Blvd Madera CA 93637	**Provides leased units** for behavioral health clients to ensure stable housing leading to permanent housing. Time frame 6 months to 1 year.
PERMANENT SUPPORTIVE HOUSING MMHSA		
Operational Subsidies (MMHSA)	**P – Street** 115 North P Street Madera CA 93637	**Shared supportive housing** with **case management** and independent living skill development.
Operational Subsidies	**Mariposa Four – Plex** 1404 Mariposa Ave. Chowchilla CA	**Shared supportive housing** with services including **peer support and employment assistance.**
Rental Subsidies & Other Housing Supportive	**Serenity Village** 48978 Park Rd. Oakhurst, CA 93644	Apartment-style **supportive housing** with **on-site** services for high-need individuals.

MADERA COUNTY BEHAVIORAL HEALTH HOUSING CONT.

Rental Subsidies & Other Housing Supportive	**Sugar Pine Village** **203** East Lewis St. Madera CA 93637	**Affordable** housing community with integrated permanent supportive housing units for individuals and families experiencing homelessness or housing instability.
Rental Subsidies & Other Housing Supportive	**River Grove I** 39963 Sierra Way Oakhurst, CA 93644	**Permanent supportive housing** to serve individuals with serious mental illness (SMI) and/or co-occurring disorders, offering stable housing and case management to support recovery and independent living.
Rental Subsidies & Other Housing Supportive	**River Grove II** 39963 Sierra Way Oakhurst, CA 93644	**An additional 50 units to River Grove I. Permanent supportive housing to serve individuals with serious mental illness (SMI) and/or co-occurring disorders, offering stable housing and case management to support recovery and independent living.**
Rental Subsidies & Other Housing Supportive	**Maple Meadows I** 1618 Meadows St. Chowchilla, CA 93610	**Affordable** housing community providing **low-income individuals and families** (with possible behavioral health needs) with access to **stable housing**, and **supportive services to improve housing retention and overall well-being.**
Operational Subsidies	**La Esperanza** 823 E. Cleveland Ave. Madera, CA 93638	**Affordable housing** with **designated supportive** units and **behavioral health services**.
Other Housing Support	**Landlord Outreach Program**	**Incentivizes** landlords with bonuses and damage coverage to **expand housing access**.

HOUSING PHASES

1 Emergency Housing (Madera Rescue Mission – Building B)

Purpose: Immediate safety, stabilization, and connection to services.

What Must Happen at This Stage

- Stabilize immediate needs: Provide safe shelter, food, and basic support.
- Engage in treatment: Build rapport with therapists, SUD counselors, medical providers, and staff.
- Obtain essential documentation: ID, birth certificate, Social Security card, Medi-Cal card.
- Connect to benefits: SNAP, General Assistance, Medi-Cal, government phone.
- Link to social services: DSS, SSA, DMV, CAPMC, managed care plans.
- Participate in MDT meetings: Coordinate care and prepare for next housing steps.
- Demonstrate engagement and stability: Consistent participation in treatment and case management.

2 Transitional/ Bridge Housing (Casa Grande)

Purpose: Temporary housing with wraparound services while preparing for permanent housing.

What Must Happen at This Stage

- Maintain treatment engagement: Continue therapy, medication support, and wellness programming.
- Build independent living skills: Daily routines, budgeting, cleaning, cooking, communication, coping skills.
- Work with Housing Navigator: Search for permanent housing and complete applications.
- Develop a Housing Stability Plan: Identify barriers, goals, and next steps.
- Participate in MDT collaboration: Regular coordination between RH staff, BHS providers, and partner agencies.
- Address income needs: Employment, vocational training, or disability benefits.
- Demonstrate readiness: Stable behavior, consistent participation, ability to manage daily living tasks.

Outcome: Client becomes eligible for Permanent Housing options once they show stability, engagement, and readiness for independent living.

3 Permanent Housing (Market-Rate, Affordable, Public Housing, PSH)

Purpose: Long-term housing stability and prevention of future homelessness.

What Must Happen at This Stage

- Secure a housing unit: Apply, meet income requirements, sign a lease.
- Maintain stability: Continue mental health treatment and use coping skills.
- Use supportive services as needed: PSH provides voluntary ongoing support for clients with disabilities or chronic homelessness.
- Budget and pay rent: Rent often capped at 30% of income in PSH.
- Sustain community connections: Maintain relationships with providers, peers, and support systems.

Residential Treatment

The individual's clinical diagnosis and treatment plan will determine placement. **Important Note:** This housing resource is available to individuals who have received the required diagnosis and are actively seeking housing. Please note that experiencing literal homelessness is not a prerequisite for accessing detoxification services.

RESIDENTIAL TREATMENT SPECIALTY MENTAL HEALTH

Residential Treatment Programs provide 24-hour structured living environments for individuals with significant mental health and/or co-occurring disorders.

Purpose:

- Stabilize psychiatric symptoms
- Build skills for independent living
- Prevent hospitalization or institutionalization

Key Features

- Therapeutic programming
- Medication support and monitoring
- Life skills development

RESIDENTIAL TREATMENT DMC-ODS ASAM LEVELS

Residential treatment programs under the Drug Medi-Cal Organized Delivery System (DMC-ODS) provide structured, 24-hour care for individuals with substance use disorders, based on ASAM Criteria levels of care.

Purpose

- Deliver clinically appropriate substance use treatment
- Support recovery in a structured environment.

Key Features

- 24/7 supervision and support
- Integrated behavioral health services
- Individualized treatment planning

ASAM Levels of Care in Appendix B

Procedures and Housing Placement

ELIGIBILITY AND PREPARATION (CLINICAL)

Responsible Staff: Clinician or Case Manager

The purpose is to establish standardized procedures for assessing, approving and placing clients into housing through the Path Home process. All clients must undergo a clinical eligibility and readiness assessment prior to housing placement. No client shall be referred for housing without completion of the required assessment and documentation.

Procedures

A. Clinical Assessment

The assigned clinician or case manager shall conduct an initial clinical assessment to determine:

The client's housing status, including homelessness or housing instability

Behavioral health needs, including mental health and substance use disorder (SUD) considerations

The appropriate level of care required

B. Eligibility Verification

The clinician or case manager shall verify that the client meets all eligibility criteria for BHSA Housing Programs. Verification must be documented in the client record.

C. Readiness Evaluation

The clinician or case manager shall assess the client's readiness for housing placement, including:

Willingness to participate in required services

Ability to comply with housing rules and program expectations

Housing Workflow

Follow the numbered stages, then continue through the applicable pathway.

1 Case Manager Meeting

Client meets with the assigned program case manager and case manager determines the client meets criteria for housing services referral.

2 Initial Housing Referral

Housing team receives the referral and documents the information. The housing case manager will reach out to the client to schedule a screening.

3 Housing Case Manager Screening

Housing case manager will conduct the screening to determine if the client meets criteria for the CESMAT and schedules a housing MDT.

4 Housing MDT

Housing case manager meets with the client, case manager and additional supports to complete the housing stabilization plan and schedules a CESMAT if appropriate or implement diversion.

Placement Referral

A: Standard Path

5a Housing case manager will intervene to preserve client's housing if needed.

6a Housing case manager will implement diversion by connecting client to resources and additional supports.

7a Housing case manager will follow up with the client and treatment team on a monthly basis to provide support as they find permanent houing or meet criteria for CESMAT

Monthly Follow Ups

B: Meets Chronic Homeless Criteria

5b Housing case manager completes the CESMAT and enters the client into the HMIS system

6b Client is connected with available permanent supportive housing programs.

7b Housing case manager will follow up with the client and treatment team on a monthy basis to provide support as they find permanent housing.

CESMAT

D. Housing Stabilization Planning

The clinician or case manager shall develop initial Housing Stabilization Goals based on assessment findings. These goals must:

- Address identified barriers to housing stability
- Support long-term housing retention
- Be documented and reviewed with the client

Clinical Intake Tool: Preparation Questions

All staff must complete and document the Clinical Intake Tool in full prior to housing placement consideration.

Required Documentation Areas

Staff shall obtain and record responses to the following:

- Current living situation of the client
- Identified barriers to stable housing
- Income status and/or access to benefits
- Safety concerns or risk factors
- Level of supervision or support required
- History of prior housing placements and associated outcomes

Documentation Requirements

All assessments, eligibility verifications, and intake responses must be documented in the client's record in accordance with agency documentation standards. Incomplete documentation may delay or prevent housing placement.



HOUSING PLACEMENT REQUEST FORM (ADMINISTRATIVE + CLINICAL)

Responsible Staff: Assigned Staff

Procedure

A. Complete Housing Placement Request Form, including:

- Client demographics
- Clinical justification
- Recommended housing level
- Risk factors

B. Attach required documentation:

- Assessment summary
- Release of information (ROI)
- Income verification (if applicable)

C. Submission and Tracking

All housing placement requests must be formally submitted to the designated approval authority and appropriately tracked to ensure accountability and timely review.

1. The clinician or case manager shall submit the completed housing placement documentation to the designated approval authority (Supervisor or Program Lead) for review and approval.
2. All submissions must be recorded in the agency's internal tracking system or log.
3. Staff shall ensure that submission status is monitored and updated as needed until a final determination is made.



APPROVAL & PLACEMENT COORDINATION (ADMINISTRATIVE)

Responsible Staff: Supervisor / Housing Coordinator

PROCEDURE

- Review request for completeness and appropriateness
- Approve, deny, or request additional information
- Coordinate placement with housing provider
- For placement at a MMHA house, the clients sign the

MMHSA House Rules Form and you must fill out the rental agreement: *Chowchilla : P street*

TRANSITIONING THE CLIENT FROM ONE PLACEMENT INTO ANOTHER USE THE:

- *Housing transition form*

Include the: Client Agreement, *Housing support plan form* and Housing stabilization form

For Casa Grande placement process flow review Casa Housing doc. and Casa Grande Invoice.

This is when a client is at housing and they need supplemental assistance.

- Schedule client intake/entry date
- Notify referring staff of placement outcome

For site contact and applications please referenceAppendix-A.

Transitional Rent

The transitional rent program provides rental assistance through Medi-Cal Community Supports for clients who meet the homeless criteria and housing navigation requirements. Contingent upon client's eligibility, this program aims to helps reduce financial barriers to obtaining and maintaining permanent housing while supporting the client's transition to independent living.

Transitional Rent cannot be utilized for temporary or short-term housing:
Transitional Rent must be used for permanent housing with a minimum of at least one year lease agreement. The client must demonstrate that they have sufficient ongoing income and the ability to assume responsibility for the monthly rent beginning in the seventh month once Transitional Rent assistance ends.

If approved, Transitional Rent may assist with the security deposit and up to six months of rent. Please note that MCDBHS does not determine eligibility of a unit. The property managers of the apartment/housing complex determine if a client meets the eligibility criteria of a unit.

Referral & Documentation Process

Before a Transitional Rent referral can be submitted, the following must be obtained:

1. The Housing Referral Form must be completed in its entirety.

2. The Housing Support Plan must be completed in its entirety in collaboration with the client, assigned case manager, and the Housing Case Manager.

3. The client must have an approved applicant/approval letter for the permanent housing unit.

4. A lease agreement for a minimum term of one year must be obtained.

5. Once all required documentation is complete, the full referral packet is submitted to the Housing Coordinator. Please see the Housing referral process

6. The Housing Coordinator will review the documentation and submit the completed package to the contracted vendor for final processing and approval.

INVOICE PROCESS FOR HOUSING (ADMINISTRATIVE)

Responsible Staff: Assigned Staff + Fiscal Team

Procedure

1. Receive placement confirmation from housing provider
2. Verify: Dates of service, approved rate and client eligibility
3. Process invoice according to county *fiscal guidelines*
4. Submit for payment approval
5. Maintain documentation for audit compliance

Who does it...	What needs to be done...
Clinical	1. Case manager/ Clinician identify needs
Clinical	2. Case manager complete/submits form to supervisor/division manager
Clinical	3. Division manager emails to BHS.accounts.payable
Fiscal	4. Fiscal staff prepares and submits to Fiscal Manager
Fiscal	5. Fiscal Manager approves
Fiscal	6. Fiscal staff enters into FE
Fiscal	7. Once approved, Fiscal Staff picks up check
Fiscal	8. Fiscal staff contacts clinical staff to advise check is ready for pick up
Clinical	9. Supervisor/Division Manager – picks up check or arrange for delivery
Clinical	10. Check is delivered to property manager by case manager/clinician
Clinical	Property manager will sign the receipt and the receipt will be provided back to fiscal. If the payment request is for rent BHS requisition and FSP Housing Assistance Rent invoice also needs to be documented and turned in together to fiscal (if FSP funds are used)
Clinical	6-month review of any assistance that is to be repeated more than once. This is to confirm that the client is still approved by Clinical and Housing to receive the repeated/ongoing assistance

HOUSING EXIT PLAN (CLINICAL)

The purpose of this guide is to ensure that all transitions from housing are conducted in a safe, structured, and clinically appropriate manner. Emphasis is placed on advance planning, continuity of care, and the promotion of long-term housing stability.

Responsible Party: Clinician and/or Case Manager

The assigned Clinician and/or Case Manager is responsible for developing a Housing Exit Plan in collaboration with the client. This process shall include identifying the client's next housing destination, arranging for ongoing treatment and supportive services, and assessing both formal and informal support systems that will assist the client following discharge.

As part of this process, the Housing Stabilization Plan shall be reviewed and updated to reflect the client's transition goals and post-exit needs. The Clinician and/or Case Manager shall also ensure that appropriate referrals are made to relevant community resources and service providers to support a successful transition.

Client Agreement

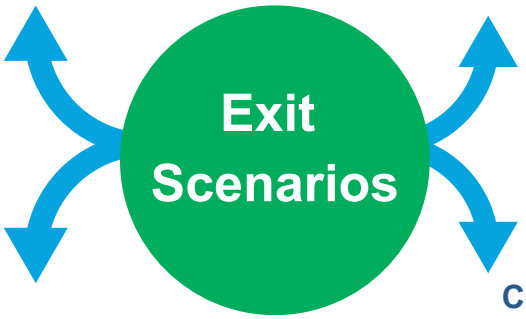
Clients are expected to acknowledge and adhere to program requirements, agree to all discharge and transition conditions, and actively participate in the housing exit planning process. Engagement in planning is essential to ensure that transitions are appropriate, coordinated, and supportive of the client's ongoing stability.

Voluntary Exit

- Client chooses to leave program
- Document decision and attempts to engage
- Provide referrals and resources

Involuntary Discharge

- Due to non-compliance, safety issues, or rule violations
- Follow due process:
  - Document incidents
  - Supervisor review
  - Provide notice (when applicable)



Successful Completion

- Client transitions to permanent or independent housing
- Provide follow-up support plan
- Close case with documentation

Crisis/Unplanned Exit

- Ensure immediate safety
- Coordinate with crisis services if needed
- Document the incident thoroughly

Documentation Requirements: Exit summary – Updated housing plan – Discharge reason – Referrals provided – Follow-up recommendations

ADMINISTRATIVE VS. CLINICAL RESPONSIBILITIES

Clinical Focus	Adminstrative Focus
• Assessment and eligibility determination • Treatment planning and stabilization goals • Client engagement and readiness • Exit planning and follow-up care	• Form processing and tracking • Approval workflows • Coordination with housing providers • Fiscal/invoice processing • Compliance and recordkeeping

Quality Assurance and Compliance
All program procedures shall be implemented in alignment with applicable Madera County Behavioral Health BHSA Housing guidelines. Documentation and client records must be maintained in a complete, accurate, and timely manner to ensure that all files remain audit-ready at all times.

Regular case reviews shall be conducted to support compliance and program integrity. These reviews are intended to verify the appropriateness of housing placements, ensure that documentation is completed within required timeframes, and confirm fiscal accuracy in all related records and reporting.

Continuous Improvement
The program is committed to ongoing quality improvement through regular evaluation of policies, procedures, and service delivery practices. Staff feedback shall be actively solicited and utilized to refine workflows and improve overall efficiency and effectiveness.
As new scenarios or service needs emerge, additional procedures and workflow processes may be developed to address gaps or enhance service delivery. Supervisory staff shall conduct periodic reviews of all procedures and update them as necessary to ensure continued relevance, compliance, and alignment with best practices.

Please see Appendix C for a more detailed overview.



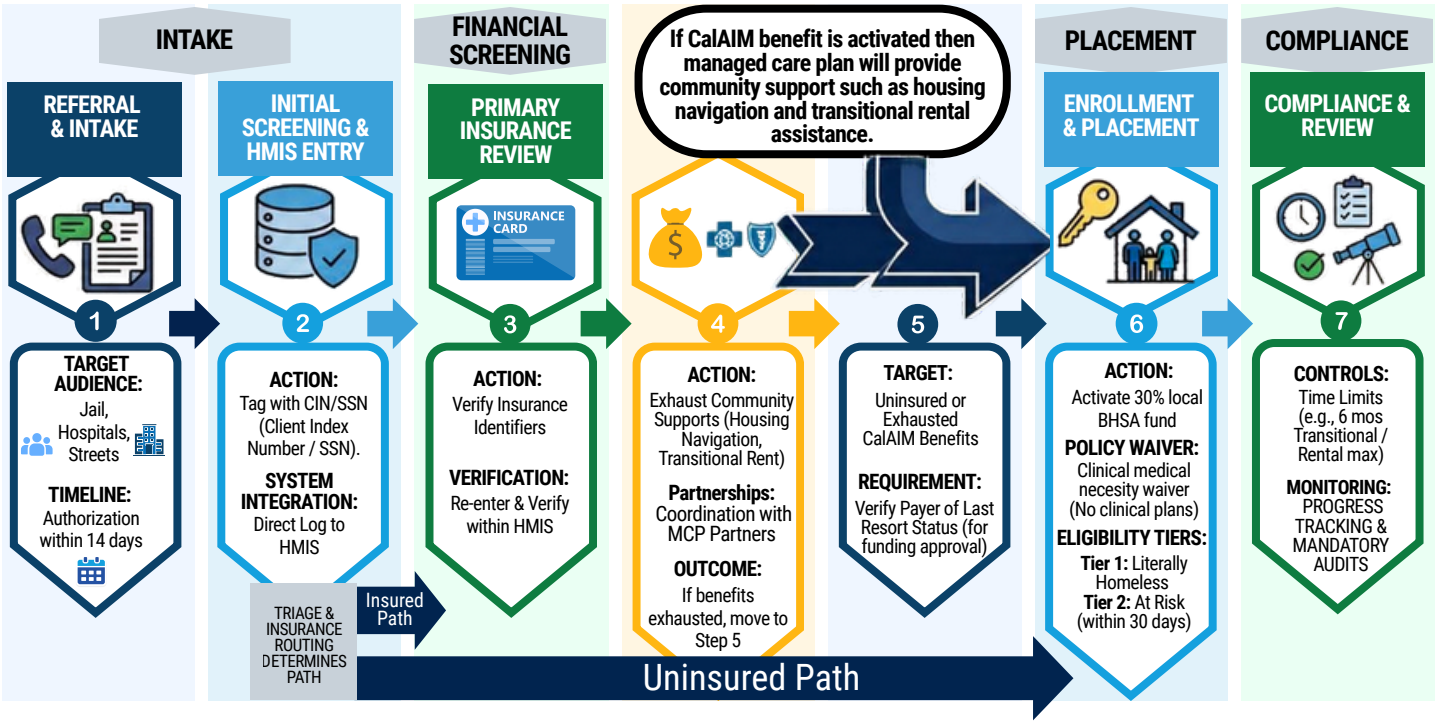
Funding and Resource Alignment

CROSSWALK: WORKFLOW, FUNDING AND DOCUMENTATION

This section establishes a fully integrated fiscal framework that aligns funding sources, program workflows **(as outlined in Section 5)**, and documentation systems **(described in Section 7)** to support coordinated and accountable service delivery. The framework is designed to ensure seamless integration across Behavioral Health and Housing systems, promote accurate billing and reimbursement practices, and maintain alignment among HMIS, CES, and clinical documentation requirements. In addition, it provides the structure necessary to ensure compliance with all applicable regulatory and funding requirements, including the Behavioral Health Services Act (BHSA), Medi-Cal through CalAIM, U.S. Department of Housing and Urban Development (HUD) and Continuum of Care (CoC) standards.



HOUSING INTERVENTIONS WORKFLOW



Workflow Overview

The diagram outlines a standardized, five-phase process containing seven structured steps to transition individuals from initial contact to stable housing. The workflow branches based on a client's insurance and benefit status to maximize funding resources.

The Five Core Phases

Intake (Steps 1 & 2)
Focus: Engaging the target audience (individuals from jail, hospitals, or streets) and initiating authorization within 14 days.
Action: Clients are tagged with identifiers (CIN/SSN) and logged directly into the HMIS (Homeless Management Information System). A triage assessment determines whether they follow the Insured Path or Uninsured Path.

Financial Screening (Step 3)
Focus: Verifying coverage for clients on the Insured Path.
Action: Staff review primary insurance and re-enter/verify credentials within HMIS to leverage active healthcare benefits.

Benefit Activation & Exhaustion (Steps 4 & 5)
Focus: Utilizing and exhausting CalAIM benefits.
Action: Activated managed care plans provide community support (housing navigation, transitional rent). If these specialized healthcare benefits are exhausted, or if the client is uninsured, they transition to Step 5 to verify "Payer of Last Resort" status.

Placement (Step 6)
Focus: Enrollment and physical housing placement.
Action: Activates a 30% local BHSA fund using a clinical medical necessity waiver. Placement prioritizing is managed via two eligibility tiers: Tier 1 (Literally Homeless) and Tier 2 (At Risk within 30 days).

Compliance (Step 7)
Focus: Long-term oversight and program integrity.
Action: Enforces strict controls, including time limits (e.g., 6-month maximums for transitional or rental assistance) alongside continuous progress tracking and mandatory audits.

Program Operations

This section establishes the standardized operational procedures for Madera County Behavioral Health housing programs and services. The procedures outlined are designed to ensure compliance with the Behavioral Health Services Act (BHSA), CalAIM Managed Care documentation requirements, Coordinated Entry System (CES) standards, and Homeless Management Information System (HMIS) integration best practices. The guidance provided supports consistent implementation of clinical and housing service documentation, accurate HMIS data entry and tracking, Medi-Cal and CalAIM compliance, and BHSA housing program reporting requirements. Under BHSA, counties are responsible for delivering integrated behavioral health and housing services that promote housing stability while maintaining strong standards for reporting, coordination, accountability, and quality oversight.

QUICK SUMMARY TABLE

Term	Meaning	Role in Housing System
CoC	Continuum of Care	Regional body coordinating homelessness services and HUD funding.
CES	Coordinated Entry System	Standardized process for assessing and prioritizing people for housing.
HMIS	Homeless Management Inforamtion System	Data system used by CoCs to track services and outcomes.



REQUIRED REPORTING MECHANISMS

Core Documentation Set (Mandatory). Each client file must include:

Housing Referral Form

Purpose: Initiate housing navigation and referral

Required Fields	Staff Responsible
• Client demographics • Homeless status verification • Behavioral health diagnosis (if applicable) • Referral source • Priority indicators	• Case Manager • Housing Navigator

Intake Screening

Purpose: Establish eligibility and service need

Clinical Components	
• Presenting problem • Risk flags (suicide, substance use, medical) • Insurance / Medi-Cal status • Initial level of care	Madera County requires intake → scheduled assessment for services

Risk Assessment

Purpose: Determine immediate safety and prioritization

Required Tools (examples)	Policy
• Suicide Risk Assessment • ASAM (SUD) • Crisis evaluation	• Must be completed the **same day** for high-risk clients • Drives prioritization in the **CES (Coordinated Entry System), a standardized process used to connect people experiencing homelessness with the most appropriate housing and services. and treatment**

Release of Information (ROI)

Purpose: Legal compliance for data sharing

Requirements	Includes
Signed before: • **HMIS** entry • **CES** participation • Partner **referrals**	• **HIPAA** compliance • 42 CFR Part 2 (**SUD** data)

HMIS Entries, Tracking, Monitoring and Reporting

The Homeless Management Information System (HMIS) is the primary data system used to document housing services and track outcomes for individuals experiencing homelessness. HMIS supports federal reporting requirements and Continuum of Care (CoC) coordination efforts. A Continuum of Care is a local or regional network of organizations, including government agencies, housing providers, shelters, outreach teams, and community-based organizations, that work together to address homelessness through a coordinated system of care. The U.S. Department of Housing and Urban Development (HUD) established the CoC framework to improve service coordination.

All housing-related services and activities must be entered into HMIS within 24 to 72 hours of service delivery and maintained according to established data quality standards. Required documentation includes **client enrollment information, services provided, housing status updates, and exit destination information.** Accurate and timely HMIS data entry is essential for BHSA housing coordination, program oversight, and tracking of client outcomes.

Program performance is monitored through ongoing tracking, monitoring, and reporting activities to ensure compliance with managed care and housing program requirements. Key performance indicators include the length of time between referral and housing placement, client engagement rates, retention in care, and housing stability outcomes. These measures help evaluate program effectiveness, identify opportunities for improvement, and demonstrate the impact of housing and behavioral health services on client success.

CONTRACTS (MANAGED CARE + PROVIDERS)

Madera County Behavioral Health uses contracts and provider agreements to ensure housing and behavioral health services are delivered according to program requirements. These agreements outline includes: scope of services, documentation standards, billing requirements, and provider agreements. Contract oversight helps ensure services are authorized, properly documented, and eligible for reimbursement.

Transitional rent assistance and housing support services funded through the Behavioral Health Services Act (BHSA) must be carefully documented and tracked. Required records include lease agreements, payment logs, eligibility verification, and the length of time tracking. Maintaining accurate records helps ensure compliance with BHSA requirements and supports effective program monitoring and reporting.

MANAGED CARE (CALAIM) DOCUMENTATION REQUIREMENTS

Core Managed Care Components

Medical Necessity Documentation

- Diagnosis (DSM-5)
- Functional impairment
- Service justification

Treatment Plan Requirements

- Client-centered goals
- Measurable outcomes
- Housing stability goals (BHSA integration)

Progress Notes (CRITICAL) Must include:

- Service provided
- Duration
- Intervention type
- Client response

Authorization, Utilization Review and Care Coordination

Authorization and utilization review processes help ensure that clients receive the appropriate level of housing and behavioral health services. This includes obtaining initial service authorizations, completing continued stay reviews to determine ongoing need, and supporting discharge planning to ensure a smooth transition when services end.

Care coordination is a key component of both the Behavioral Health Services Act (BHSA) and CalAIM. Staff are responsible for working closely with housing providers, behavioral health teams, healthcare partners, and community organizations to support client success. All referrals, follow-up activities, and coordination efforts should be documented to ensure continuity of care and effective communication across systems.

BHSA HOUSING PROGRAM COMPONENTS

The Behavioral Health Services Act (BHSA) supports a variety of housing-related services designed to help individuals with behavioral health needs obtain and maintain stable housing. These services work together to address barriers to housing, strengthen community partnerships, and provide coordinated support throughout the housing process.

Housing Navigation Services

Housing navigation services assist clients in locating, securing, and maintaining housing. Staff work directly with clients to identify available housing opportunities, complete housing applications, and coordinate move-in activities. These services help clients successfully navigate what can often be a complex housing system.



Landlord Engagement

Landlord Engagement activities focus on expanding available housing opportunities by recruiting landlords, negotiating lease agreements, and maintaining positive partnerships. These ongoing relationships help increase housing inventory and create additional placement opportunities for clients.

Participation Assistance

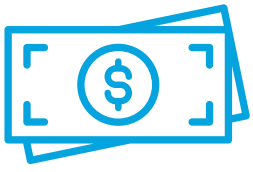
Participation Assistance helps remove barriers that may prevent individuals from obtaining housing. Depending on the client's needs, assistance may include transportation support, help obtaining required documents, or payment of application fees. These services help ensure clients can fully participate in the housing process and move more quickly toward housing stability.



Transportation Assistance

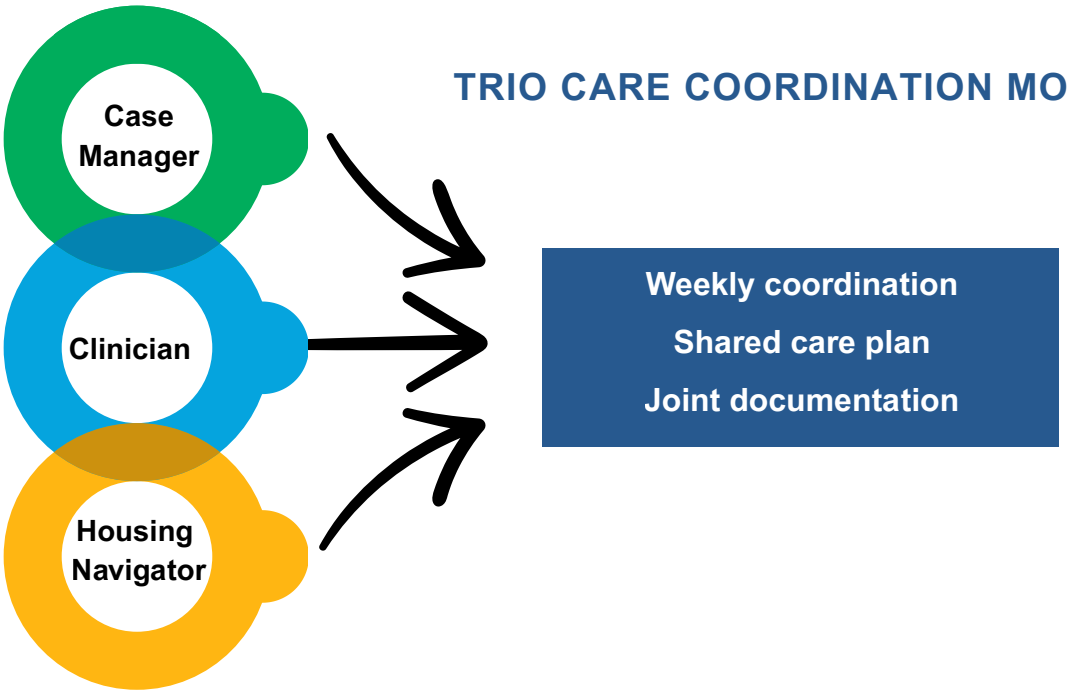


Document Collection and Support



Housing Application Fees

TRIO CARE COORDINATION MODEL



INTEGRATED DATA FLOW (IMPORTANT)

The integrated data flow represents the coordinated sequence that ensures clients move smoothly through each stage of care, housing support, and reporting systems. Each step is connected through required data systems so that services remain consistent.

INTAKE → HMIS ENTRY → CES → HOUSING → TREATMENT → REPORTING

This workflow begins at Intake, where individuals enter the system and are assessed for immediate needs and eligibility. Information collected is then entered into the HMIS, which is the primary data system for tracking client services and housing status.

From there, clients are placed into the CES, which prioritizes and matches individuals to housing resources based on vulnerability and need. Once matched, clients move into housing placements, where stabilization efforts begin.

After housing placement, individuals may be connected to treatment services, including behavioral health, substance use treatment. Finally, all service activities are compiled into reporting systems, which support program evaluation, funding compliance, and performance.

Required Integration:

To ensure continuity of care and accurate reporting, multiple systems must communicate with one another in real time or through regular data sharing processes:

Clinical EHR ↔ HMIS
CES ↔ Case Management
Managed Care ↔ Billing

HOUSING REFERRAL PROCESS

PURPOSE

To establish a clear, standardized workflow for submitting, tracking, and documenting universal housing referrals for homeless clients within Madera County Department of Behavioral Health Services (MCDBHS).

Housing Referral Process Steps

1. **Universal Housing Referral Requirement**
   All homeless clients in search of housing (including affordable housing options for individuals who have income) must have a completed universal housing referral packet.

2. **Submission to Supervisor**
   The universal housing referral packet must be completed in full and submitted directly to the Designated Supervisor.

3. **Document Management & Upload**
   The Designated Supervisor will scan the finalized packet and upload it securely into the Housing Referral BOX.
   Exception: Staff operating out of the 7th Street facility may hand-deliver the physical packet.

4. **Team Notification & Smart Care Messaging**
   The Designated Staff or Supervisor will send a secure message via Smart Care Messaging to both the Clinical Team and the Housing Team (housing Case manager and program assistant)
   The message must include the client's name and a confirmation that the housing packet has been successfully scanned and uploaded into the BOX for official processing.

5. **Medical Records Charting**
   The Designated Staff or Supervisor will forward the original physical housing packet to Medical Records to be scanned into the client's official electronic chart.

Housing Program and Flag Removal Procedures

Supervisor Approval Required

Treatment teams must receive formal approval from their supervisor prior to the removal of any housing programs or associated tracking flags.

Submission for Removal

Once supervisor approval is secured, all official requests to remove housing programs and flags from a client's profile must be sent directly to Medical Records for final processing.

Communication, Escalation, & Staffing Framework

The Madera County Department of Behavioral Health Services housing infrastructure is structured into two separate operational components: Clinical and Administrative. Staff must utilize the distinct communication matrices and escalation hierarchies outlined below based on the nature of the issue.

Component	Clinical
Primary Scope of Responsibility	Crisis management, behavioral issues, law enforcement, and safety concerns
Urgency Level	Urgent / Emergency
Permitted Communication Channels	Desk phone, cell phone, Microsoft Teams, and email.

Component	Administrative
Primary Scope of Responsibility	Housing inquiries, new referrals, and referral tracking
Urgency Level	Non-Urgent
Permitted Communication Channels	Desk phone, Microsoft Teams, and email.

Escalation chains

Clinical Escalation Chain

For immediate safety concerns, emergencies, or behavioral management, contact the client's assigned treatment team in the following sequential order:

1. **Case Manager**
2. **Clinician**
3. **Clinical Supervisor**
4. **Division Manager**
5. **Deputy Director (Clinical - Last Resort)**

Administrative Escalation Chain

For routing housing documentation, tracking queues, or handling general placement inquiries, contact the administrative housing staff in the following sequential order:

1. **Housing Case Manager**
2. **Housing Coordinator**
3. **Program Manager**
4. **Deputy Director (Housing Administrator)**
5. **Assistant Director (Operational- Last Resort)**

Conferencing and Ongoing Collaboration Schedule

To maintain a seamless workflow between the clinical and administrative branches, staff will adhere to the following data coordination and conferencing standards:

Multidisciplinary Team (MDT) & Case Conferencing Meetings

Frequency: Conducted on a weekly or bi-weekly basis at a minimum.

Participants: Includes Behavioral Health Clinicians, Housing Navigators, Case Managers, CES/HMIS Data Staff, and relevant community partners.

Objective: Review open housing referrals, match clients to available vacancies, coordinate care across systems, and update the Housing Stabilization Form.

Data Log Requirements

Clinical Progress:

Clinicians and Case Managers must document clinical adjustments, treatment goals, and housing readiness within the client's Electronic Health Record (EHR).

System Entry:

Housing Coordinators and HMIS Staff are responsible for tracking landlord engagement, application statuses, and entering placements into the Centralized Housing Queue and HMIS within 24 to 72 hours of activity.

Special Considerations & Ongoing Care

Attached Referrals:

If you are concurrently including a Madera Rescue Mission or Casa Grande referral, it must be physically or digitally attached to the main universal housing packet before submission.

Continuous Collaboration:

Following this initial referral process, there will be ongoing collaboration and consultation with the BHS Housing Team and relevant external agencies to address the client's specific needs and assist them through their housing placement journey.

MDT Scheduling & Discussion Topics

- Weekly Case Conferencing supplies names for the MDT.
- Clients may be selected there or for an initial 30 / 60 / 90-day review.
- The Housing Coordinator and Housing Case Manager coordinate with BHS Treatment and MRM.
- Names and viewing order are set Monday before the Wednesday MDT.
- MDTs meet Wednesday, 8:30–10:30 a.m.; six clients allow 20 minutes each.
- MRM and BHS plan topics: behaviors, decompensation, medical or medication needs, housing, and exit plan.

QUALITY ASSURANCE & COMPLIANCE

Quality Assurance and Compliance activities are essential to ensuring program integrity, service quality, and regulatory adherence. All housing and supportive services programs shall participate in ongoing monitoring activities, including monthly chart audits, HMIS data quality reviews, and managed care documentation assessments.

These reviews help ensure that client records are complete, accurate, and compliant with established standards of care while supporting continuous quality improvement efforts. Program staff are responsible for maintaining timely and accurate documentation and addressing any deficiencies identified through monitoring activities.

Ongoing Monitoring Activities

Ongoing monitoring helps ensure client records are complete, accurate, and compliant with established standards of care while supporting continuous quality improvement efforts.

1 2 3 4 5

Compliance Frameworks

All housing programs must operate in compliance with applicable federal, state, and local requirements, including HIPAA privacy and confidentiality regulations, Medi-Cal and CalAIM documentation standards, and Behavioral Health Services Act (BHSA) reporting requirements.

HIPAA	Medi-Cal	CalAIM	BHSA

Program Requirements

Programs are required to complete all documentation within established timelines

1. Enter housing-related data into HMIS
2. Maintain managed care-compliant clinical records
3. Participate in the CES and coordinated housing efforts
4. Track and report program outcomes as required per BHSA
5. Programs are required to complete all documentation within established timelines

Adherence to these requirements ensures accountability, supports funding compliance, and promotes coordinated, client-centered service delivery across the continuum of care.

Appendix A

Resources

Forms and Resources

Housing Support Plan Template for/or Transitional Rent
Housing Stability Plan
Universal BHS Housing Referral Form
Lease Agreement Violation Notice
Emergency-Temporary Housing Referral
BHSA Programming-Housing Initiatives.docx
SUD Housing - Madera County Housing Team
SUD Housing - Fresno/Madera Continuum of Care
SUD Housing - AWIMC
SUD Housing - Madera Rescue Mission
SUD Housing - Self-Help Enterprises
SUD Housing - CAP MC
SUD Housing - HUD Exchange-HMIS
SUD Housing - RH Community Builders

Site Contacts and Applications

River Grove
Maple Meadow
MMHSA House Rules 11.19.18
MMHSA Rental Agreement Chowchilla
MMHSA Rental Agreement P. Street
Temporary Rental Assistance Agreement

Appendix B

ASAM Levels of Care

Early Intervention (ASAM 0.5)

Targeted at youth under 21 years of age at risk of SUD.

Outpatient (ASAM 1.0)

Up to 9 hours/week for adults; 6 hours/week for youth. Includes counseling, medication services and Medication Assisted Treatment (MAT).

Intensive Outpatient (ASAM 2.1)

9–19 hours/week for adults; 6–19 hours/week for youth.

Withdrawal Management (ASAM 1-WM, 3.2-WM)

Urgent, short-term stabilization services.

Residential (ASAM 3.1–3.5)

Non-institutional 24-hour programming. Length of stay determined by clinical need.

Opioid Treatment (OTP/NTP)

Requires a 2-year addiction history and documented treatment failures for maintenance. Includes direct medication administration

Appendix C

Housing consists of two components: Clinical and Administrative.

Clinical

FOR EMERGENCIES

The assigned treatment team should be contacted for any issues regarding crisis, behaviors, law enforcement, and exiting the housing facility.

You may utilize this chain of communication by calling the desk phone, cell phone, Teams message, and email.

CLINICAL ESCALATION PATH

1. Case Manager
2. Clinician
3. Clinical Supervisor
4. Division Manager
5. Last Resort Clinical Deputy Director

This side is for urgent matters.
Clinical is more likely to have emergencies.

Administrative

FOR NON-URGENT MATTERS

The Housing Coordinator and Housing Case Manager will receive phone calls inquiring on housing, new referrals or status of referrals.

You may utilize this chain of communication by calling the desk phone, Teams message, and email.

ADMINISTRATIVE ESCALATION PATH

1. Housing Coordinator
2. Housing Case Manager
3. Program Manager
4. Deputy Director-Housing Operation
5. Last Resort Assistant Director

This side is non-urgent.
Administrative matters are not urgent in nature.

Housing Referral Process Flow

A step-by-step guide for staff to process housing referrals for homeless clients seeking housing or affordable housing placements.

START • HOMELESS CLIENT IN SEARCH OF HOUSING OR AFFORDABLE HOUSING SOLUTION

1 Complete the Universal Housing Referral

Complete the Universal Housing Referral in full and submit to supervisor.

Optional: Attach Madera Rescue Mission / Casa Grande referral if applicable.

2 Submit the referral packet

Submit referral packet to Designated Supervisor.

3 Scan and upload the packet

Designated Supervisor scans and uploads packet into Housing Referral BOX.

Note: If at 7th Street, may hand deliver instead.

4 Send the Smart Care message

Sent by: Designated staff or supervisor
Purpose: Scanned into the client chart
To: Clinical team & Housing team (Michelle Camarillo & Felicia Ramirez)
Include: Client's name & confirmation that packet is uploaded to the BOX for processing.

5 Give the original packet to Medical Records

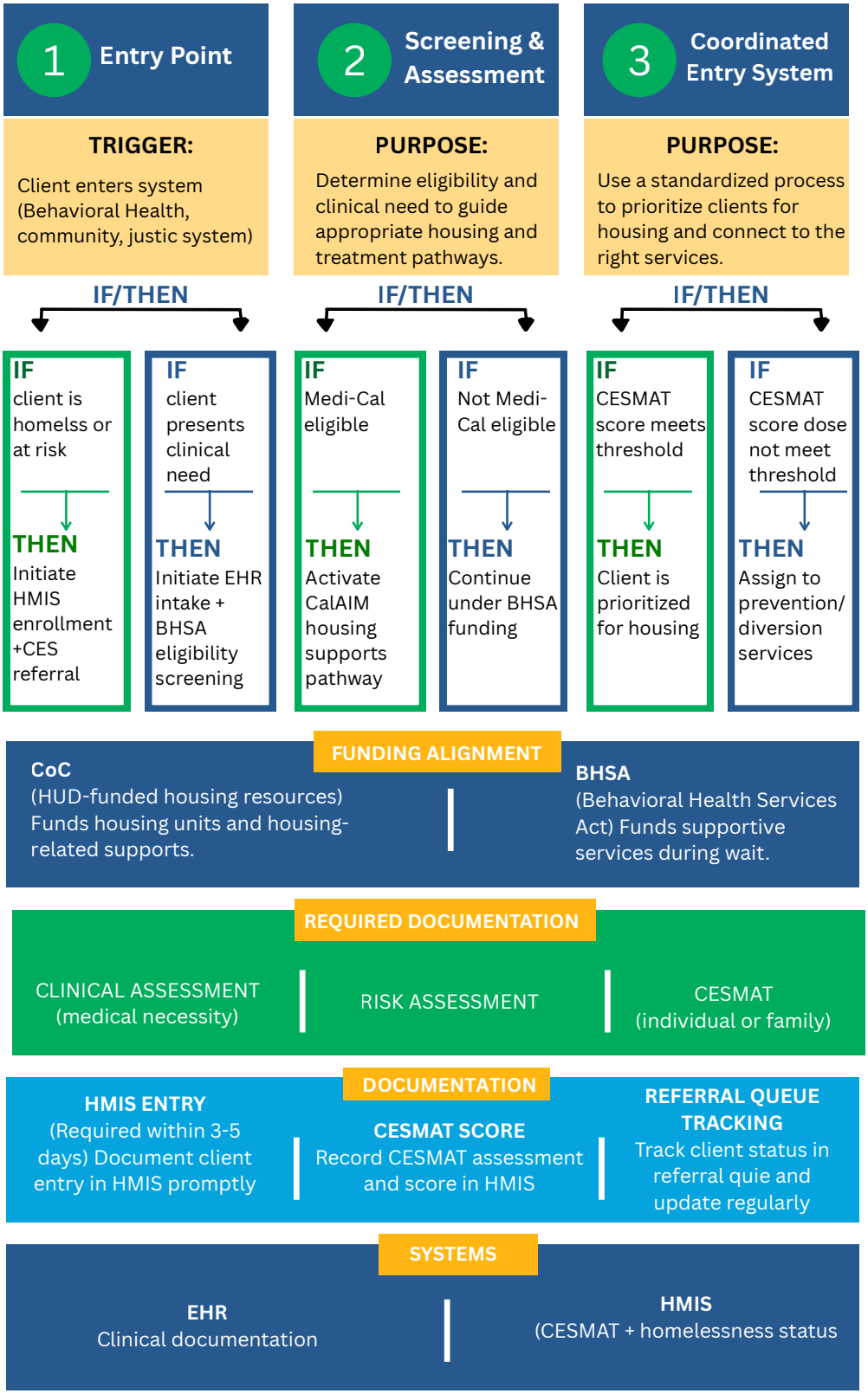
Designated staff or supervisor will give original housing packet to Medical Records for scanning into the client chart.

ONGOING COLLABORATION

After this initial process there will be ongoing collaboration and consultation with BHS Housing team and other agencies as it pertains to client's needs to assist with the housing.

Appendix D

Detailed Crosswalk: Workflow, Funding and documentation



4 STEP 4: REFERRAL & CASE CONFERENCING

PURPOSE:

Coordinate and align services across partners to ensure clients are connected to the right housing support.

IF /THEN

IF
Housing match identified

THEN

Proceed to housing referral submission

Outcome:

Client referred to appropriate housing resource

IF
Multiple needs identified

THEN

Escalate to case conferencing

Outcome:

Collaberative plan developed with partners and client

Funding Alignment

CoC
Funds housing placement and housing related resources.

BHSA
Funds case coordination and supportive services.

Medi-Cal
Supports billable case management (If applicable).

Documentation

HOUSING REFERRAL FORM
Complete and submit referral to housing provider.

CASE CONFERENCING NOTES
Document case conference discussion, decisions, and assigned action steps.

SERVICE COORDINATION NOTES
Record coordination actvities, referrals, and follow up with partners.

5 STEP 5: HOUSING NAVIGATION

PURPOSE:

Help clients find and secure housing by providing hands-on navigation and landlord engagement.

IF /THEN

IF
Client has Medi-Cal

THEN
Bill CalAIM Housing navigation

CALAIM
Housing Navigation (Medi-Cal)

IF
Client does not have Medi-Cal

THEN
Use BHSA funding for housing navigation

BHSA
Housing Navigation (BHSA Funding)

SERVICES

UNIT SEARCH
Identify and locate available housing options.

LANDLOARD ENGAGEMENT
Build relationships and address landlord concerns.

APPLICATION ASSISTANCE
Help clients complete housing applications and required documentation.

Documentation (Section 7)

PROGRESS NOTES (TIME-BASED)
Document tpm spent ant activities ralief to housing navigation.

HOUSING PLAN
Document client goals, housing preferences, barriers, and planned actions.

LANDLORD CONTACT LOGS
Record landlord outreach, responses, and follow-up activities.

6 STEP 6: HOUSING PLACEMENT

IF /THEN

IF
Unit is CoC funded

→ **THEN**
Follow FMCoC HUD Requirements

IF
unit is local/BHSA-supported

→ **THEN**
Follow county policy

FUNDING

CoC/EHS → Rental Assistance

BHSA → Support Services

Local Funds → Diposits (if need)

DOCUMENTATION

- **Housing Placement Forms**
- **Lease Documentation**
- **Inspection Records**
- **(CalHFA compliance if applicable)**

SYSTEMS

HMIS → Placement Entry

Admin File → Lease/Inspection Documents

The goal of Step 6 is to place households in safe, suitable, and affordable housing with the appropriate financial support and documentation.

7 STEP 7: Tenancy Sustaining Services

IF /THEN

IF
Medi-Cal eligible

→ **THEN**
Bill CalAIM Tenancy Services

IF
Not

→ **THEN**
Use BHSA

SERVICES

- Case Management
- Crisis Intervention
- Retention Support

DOCUMENTATION

- Progress Notes
- Service Logs
- Housing Stability Tracking

The goal of Step 7 is to support tenants in maintaining stable housing through ongoing services and documentation.

8 STEP 8: EXIT / TRANSITION

IF /THEN

IF
Client Stabilize

THEN
Transition to level of care

IF
Client exits housing

THEN
Document reason and outcome

DOCUMENTATION

DISCHARGE SUMMARY
Summary of services, progress, and reason for exit

HMIS EXIT RECORD
Record exit date,destination, and reason

OUTCOME TRACKING
Track housing stability and client outcomes over time

The goal of Step 8 is to ensure a sucussful transition, document outcomes, and support long term stability.

STEPS 6-8: HOUSING PLACEMENT, TENANCY SERVICES, & EXIT / TRANSITION

STEP 6: HOUSING PLACEMENT

IF Unit is CoC funded → **THEN** Follow FMCoC HUD Requirements

IF unit is local/BHSA-supported → **THEN** Follow county policy

FUNDING

- **CoC/EHS** → Rental Assistance
- **BHSA** → Support Services
- **Local Funds** → Diposits (if need)

DOCUMENTATION

- Housing Placement Forms
- Lease Documentation
- Inspection Records
- (CalHFA compliance if applicable)

SYSTEMS

- **HMIS** → Placement Entry
- **Admin File** → Lease/Inspection Documents

The goal of Step 6 is to place households in safe, suitable, and affordable housing with the appropriate financial support and documentation.

STEP 7: TENANCY SUSTAINING SERVICES

IF Medi-Cal eligible → **THEN** Bill CalAIM Tenancy Services

IF Not → **THEN** Use BHSA

SERVICES

- Case Management
- Crisis Intervention
- Retention Support

DOCUMENTATION

- Progress Notes
- Service Logs
- Housing Stability Tracking

The goal of Step 7 is to support tennants in maintaining stable housing through ongoing services and documentation.

STEP 8: EXIT / TRANSITION

IF Client Stabilize → **THEN** Transition to level of care

IF Client exits housing → **THEN** Document reason and outcome

DOCUMENTATION

- **DISCHARGE SUMMARY** — Summary of services, progress, and reason for exit
- **HMIS EXIT RECORD** — Record exit date,destination, and reason
- **OUTCOME TRACKING** — Track housing stability and client outcomes over time

The goal of Step 8 is to ensure a sucussful transition, document outcomes, and support long term stability.