


# Supporting Homeless Services through Health Home Care Management

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Person Centered Housing  
Options

September 24<sup>th</sup>, 2019



# What happens 1<sup>st</sup>??

- Clients are referred to PCHO Care Management from various sources, most often PCHO Homeless Outreach team encounters someone who is homeless speaks with them about services they either have in place, or are in need of and completes a referral.
- Clients are also referred by either of the two local Health Homes, (GRHHN)-Greater Rochester Health Home Network, or (HHUNY) Health Home of Upstate New York. Typically, referrals received by these two Health Homes are from clients who are either interested in seeking assistance with housing or are homeless.



What comes next.....

- For PCHO, when a new client is enrolled into Health Homes, we take a VI-SPDAT (Vulnerability Index - Service Prioritization Decision Assistance Tool) to obtain a score and send it to the COC (Continuum of Care) to be placed on the prioritization list.
- PCHO also continues to explore other housing options (Ex: If the client is interested in applying to subsidized housing, the Care Manager starts that process as well.



Multi-Task!!!

- Simultaneously while working on housing, we are also working with the client to obtaining all necessary documentation that is needed for a move (Identification, Birth certificate, Social Security Card).
- If not already in place, Care Managers are also working to help get benefits such as temporary assistance established during this time.

Let the client drive!!



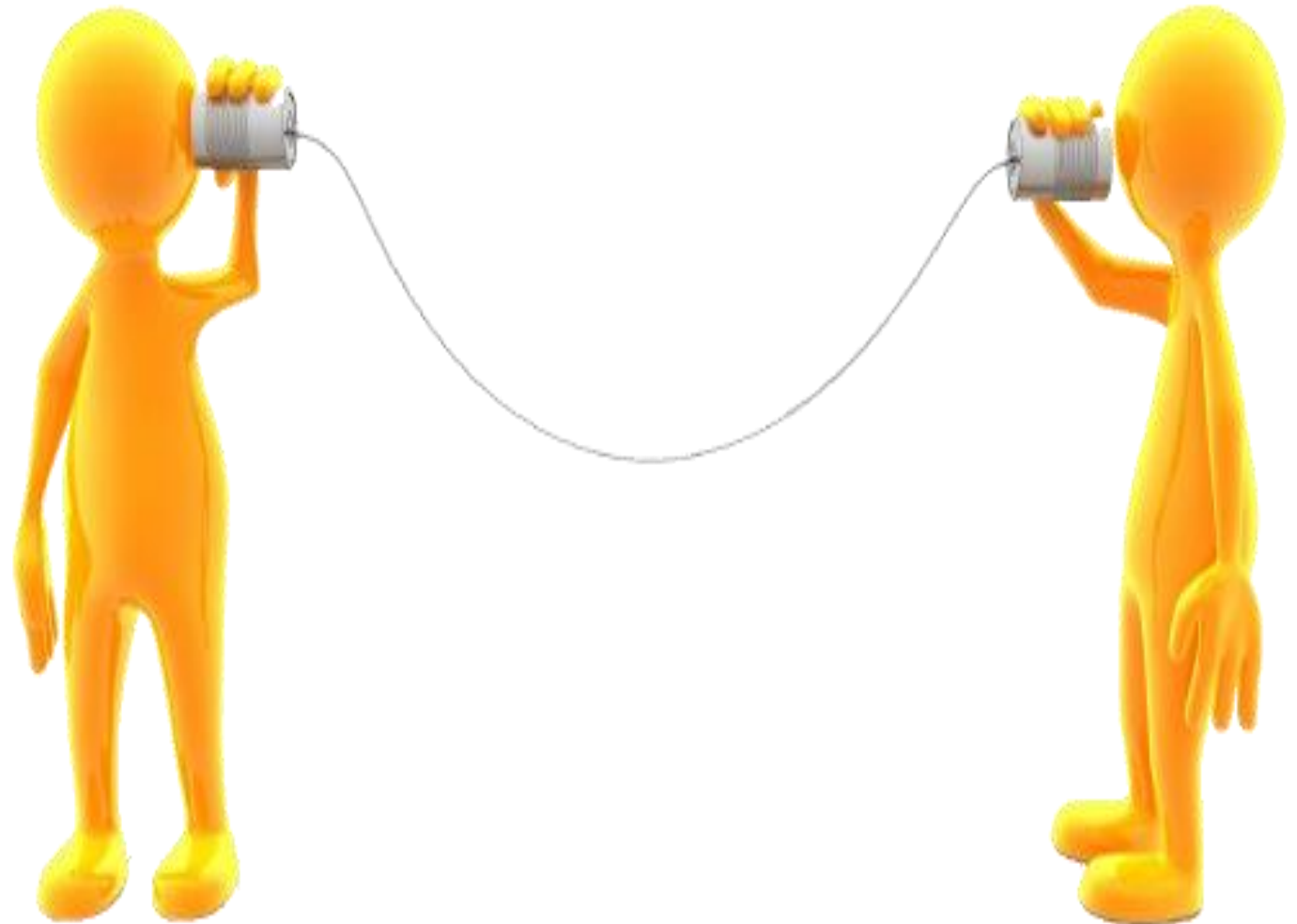
# STAY IN TOUCH

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Care Managers stay in regular contact with the client and client's providers and support the client's decision to move forward with additional health care support.

When the client is ready to pursue health care options, the Care Manager can work to find doctors and other health care specialist.

(Keep in mind that it may be important to obtain certain medical documentation for certain housing programs!)



Questions?

