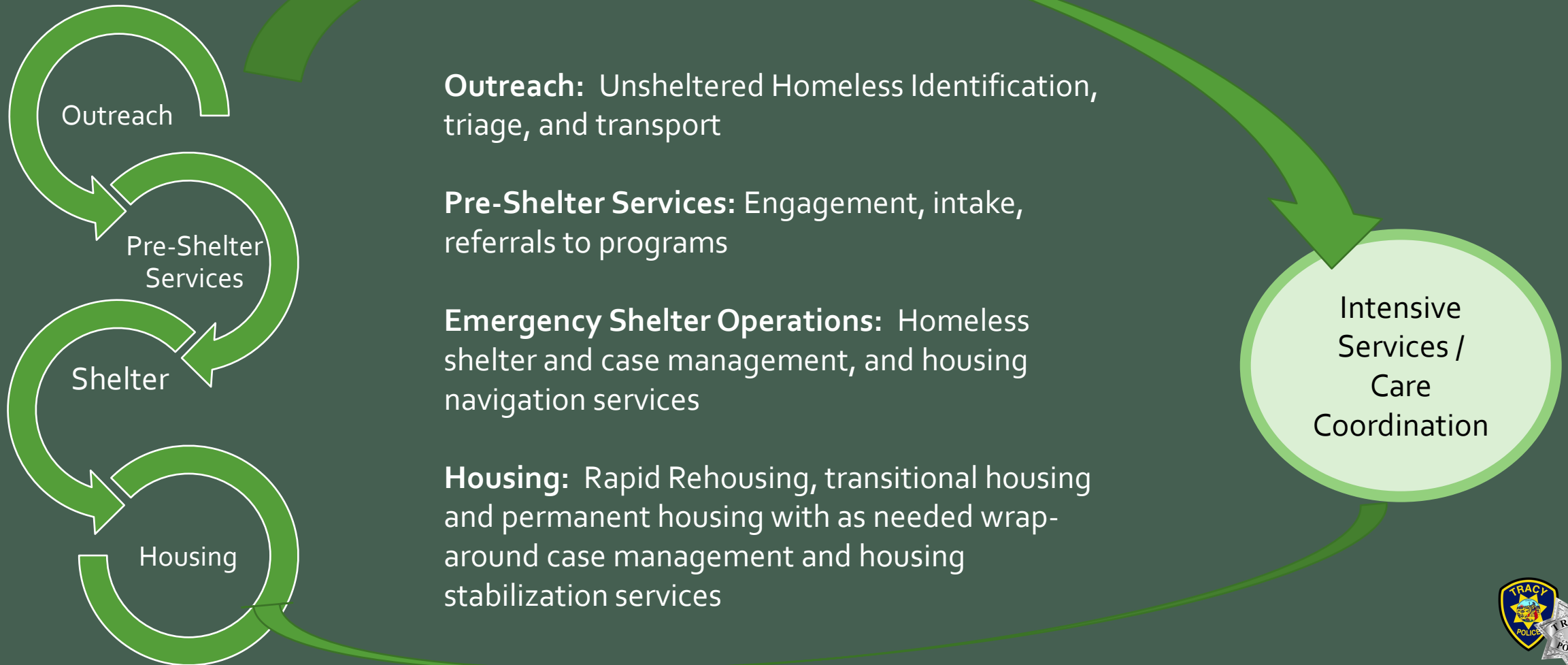




TRACY POLICE DEPARTMENT COMMUNITY SERVICES DIVISION

INTEGRATED RESPONSE TO PERSONS EXPERIENCING HOMELESSNESS

UNSHELTERED HOMELESS RESPONSE



Populations of Focus

Who is responsible for different types of clients?

City of Tracy Homeless Engagement Teams

TCCC: Unsheltered homeless individuals who are generally able to successfully self-manage and meet their own basic needs.

WPC/BHS: homeless individuals with complex health or behavioral health needs who are not successfully self-managing or meeting basic needs.

Familiar Faces



Diversion: Short-term problem resolution and linkage to services for those at imminent risk of homelessness.

Top 20 / By name list: Unsheltered individuals who are most reluctant to engage, with high levels of nuisance behaviors.

Situation Response: One-time de-escalation or abatement response. (Encountered via walking patrol or as dispatched by TPD)

Shelter / Transitional Housing



Tracy Shelter by City Net

- Single adults
- Adult couples
- People with Pets
- People with Disabilities / Mobility issues



Other Programs

- McHenry House (Families)
- Chest of Hope (DV)
- Women's Center (Youth)
- Ready to Work (Re-entry)
- BHS (Recovery)

Prevention Approach

Diversion: Early interventions to prevent displacement and avert homelessness

Early Interventions:
e.g. Emergency re-housing and stabilization assistance for individuals or families displaced by eviction, flood, fire or other type of crisis.

Prevention/ De-escalation:
e.g. Dispute resolution between shared household members that could result in loss of housing.

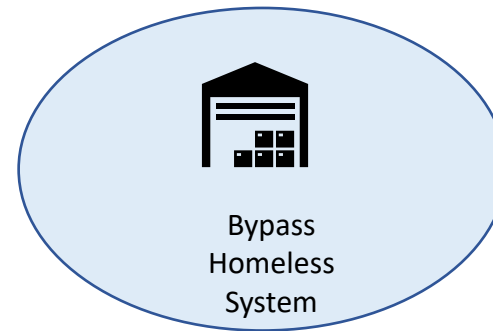
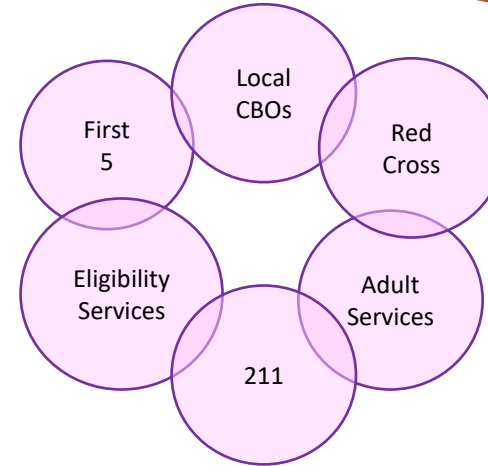
Relocations:
e.g. Assist individuals that need to immediately leave a living situation find a new place to stay while looking for a permanent home.

Youth Response:
e.g. All youth under age 21 and unaccompanied minors will receive early and enhanced interventions upon identification.

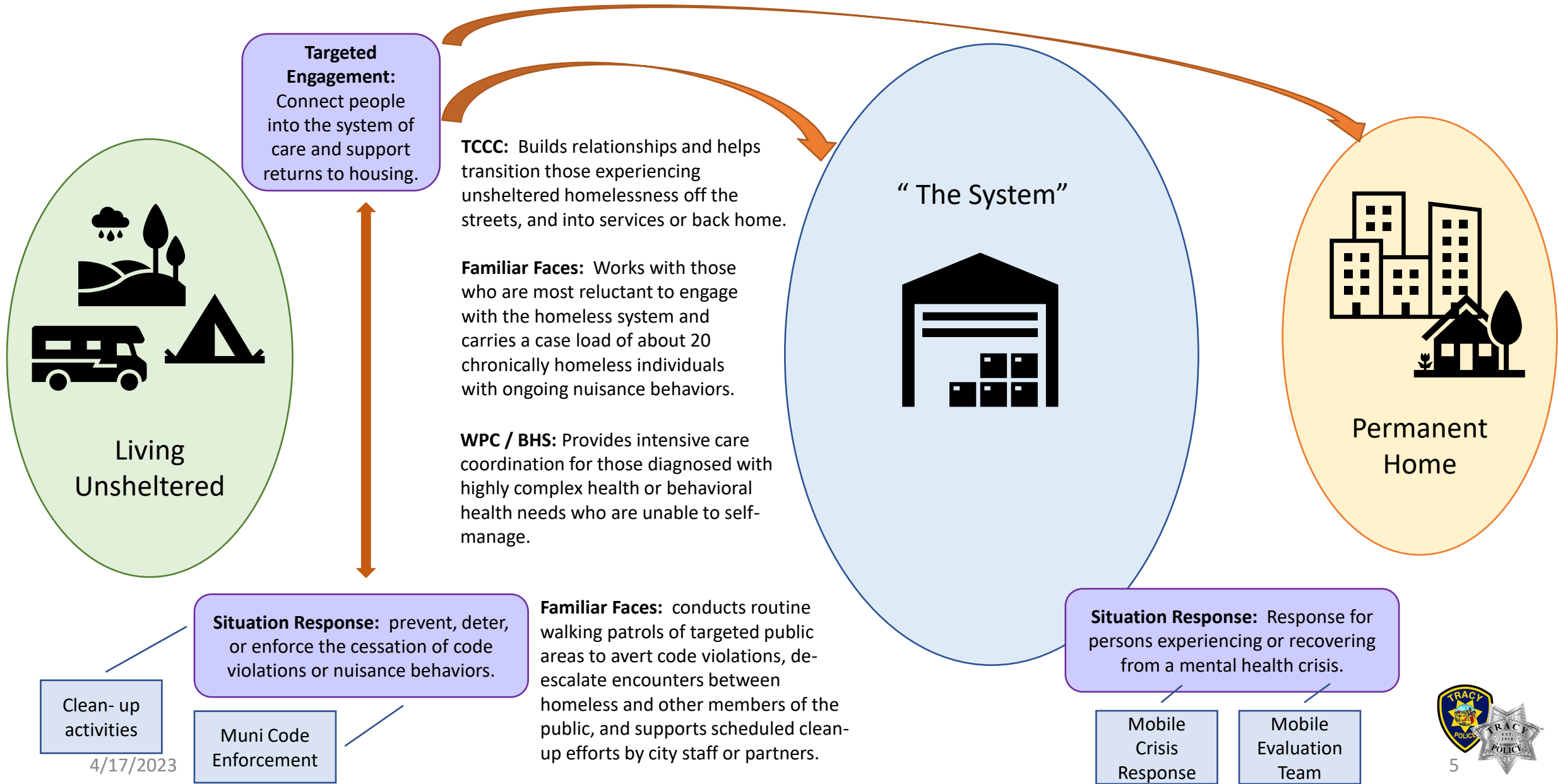
Familiar Faces: Receives referrals for early intervention services to address the needs of individuals/families at-risk of homelessness or who are very recently displaced or evicted.

The goal is to immediately stabilize the living situation and prevent an entry into the formal homelessness system.

Coordination will occur with the Human Services Agency and other community-based services and supports.



Street Outreach and Engagement



4/17/2023

Coordinated Care Teams

80 / 20 Approach

80% of clients are managed through city-coordinated homeless response services.

20% of clients are managed through county-coordinated specialty services, including Whole Person Care and Behavioral Health Services.

- Homeless & eligible for SMI & SUD services
- Homeless & with complex health care needs and inability to successfully self-manage
- Homeless & complex need and transitioning from incarceration or institution

	Enroll to Services	Case Management	Housing Navigation	Care Coordination
TCCC	TCCC conducts most initial outreach, enrolls in system, OR refers to: FF or WPC	If Feasible	Rarely	TCCC, FF, & City Net: Refer clients with complex needs to WPC for further coordination ↓
FF		Top-20 Clients	Top-20 Clients	
City Net		If incomplete for all Shelter Guests	All Other Shelter Clients	
WPC / BHS		Eligible Clients	Eligible Clients	Eligible Clients

Enrollment to Services:

- Basic client assessment
- Enrolled in HMIS
- Communications
 - Phone / e-mail
 - Mailing address
- Triage & Case Plan
 - Referrals to services
 - Routine check-ins

Case Management:

- Documents obtained
 - Legal ID
 - SS card
 - Birth certificate
- Eligibility Program Applications
 - Food stamps
 - Cash aid
 - Medi-Cal
- Wellness Supports
 - Social skills groups
 - Recovery services

80%

Of clients will need some case management and housing navigation assistance.

20%

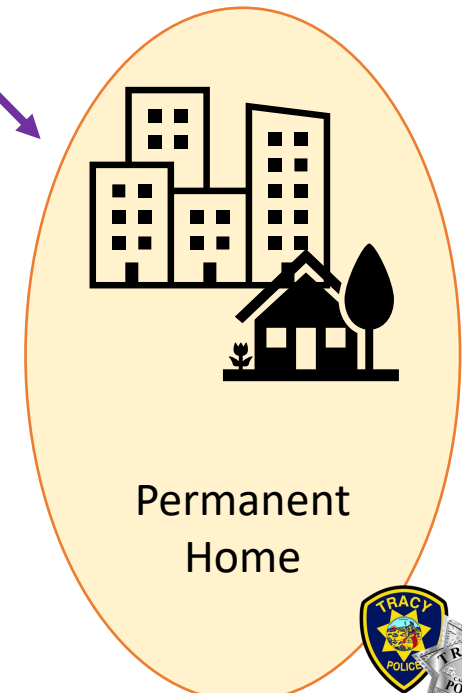
Of clients will require very intensive care coordination due to an inability to self-manage complex health or behavioral health issues.

Intensive Care Coordination:

- Develop comprehensive care team and meet regularly to review client progress.
- Schedule all appointments, transport and accompany client to meetings for benefit, health, or other program enrollments.
- Engage into primary and behavioral health care services, develop care plan, manage appointments to prevent no-shows, and assure daily care and wellness.
- Work with homeless court or collaborative court programs to resolve outstanding criminal justice concerns.
- Identify and transition to permanent supportive housing, as eligible with long-term wrap-around support services.

Housing Navigation:

- VI-SPDAT complete
- Enrolled in CES
- Application for housing vouchers (HA-CSJ)
- Landlord Readiness
 - Bank Account
 - Employment search / income stabilization
 - Prop 47 Record Clearance
- Rental Search and application assistance
 - Landlord negotiations
 - Landlord incentives (security deposits, etc.)
- Moving Assistance
 - Basic household set up



Permanent Home