Provider Training:
CAS Assessor
Training Series

Intro to HMIS

Coordinated Access System

August 2025

Intro to HMIS

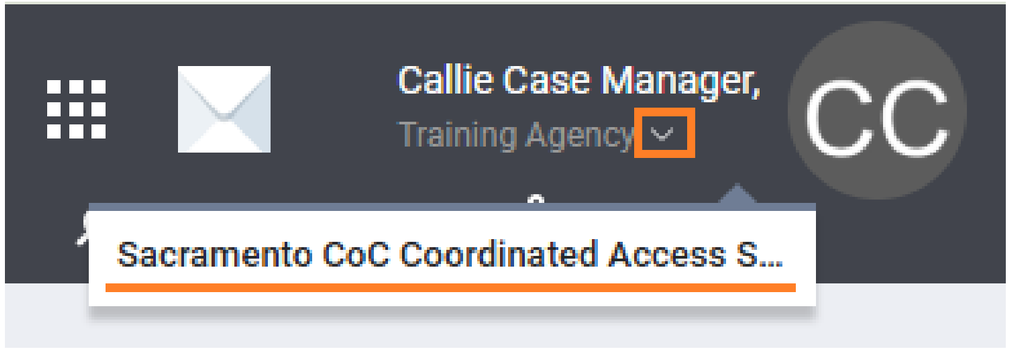
Learn about **The CAS Agency** and the work you will do within this HMIS agency.

Know how and when to complete several different CAS related assessments.

Identify CAS and HMIS resources available to you to help you in your work..

The Sacramento Continuum of Care (CoC) CAS Agency

Sacramento CoC CAS Agency

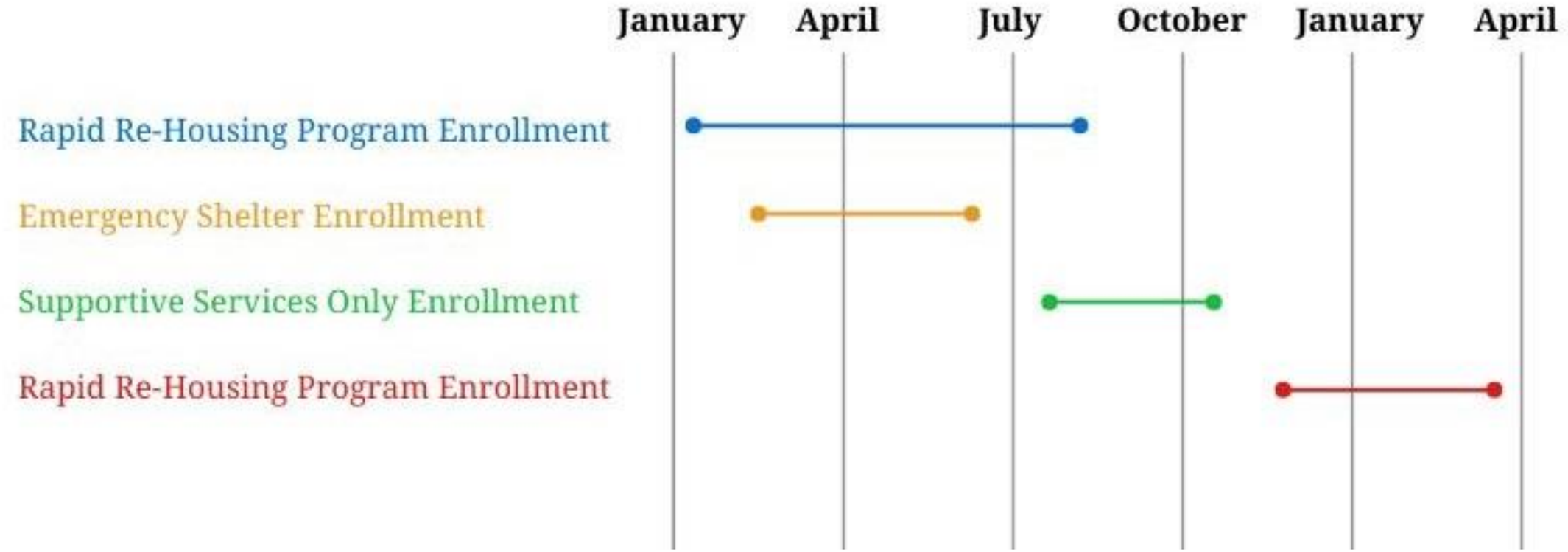


All HMIS user accounts work in their employer's HMIS agency. As a CAS Assessor, you will be granted access to the Sacramento CoC CE Agency.

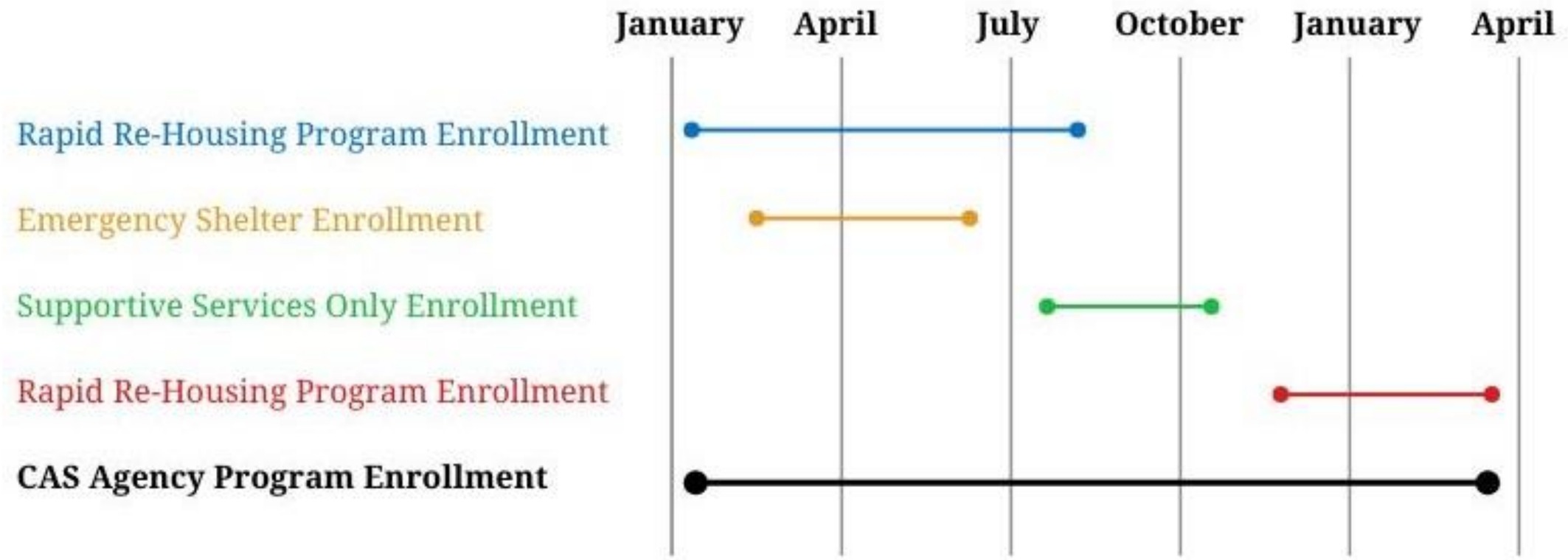
In the CAS Agency, you will collaborate with SSF CAS teams, the staff at 211, and CAS Assessors in dozens of other organizations to coordinate the work you are doing with your clients.

Every client who receives assistance through the CAS system will be enrolled in the CAS: Coordinated Access System Program – CE. As a CAS Assessor, you will need to either enroll your client in this program or work within your client's existing enrollment to complete any CAS related work.

Client Record without a CAS Agency Program



Client Record with a CAS Agency Program



Assessments and Coordinated Entry Events

The Assessments

The Current Living Situation

The Crisis Assessment

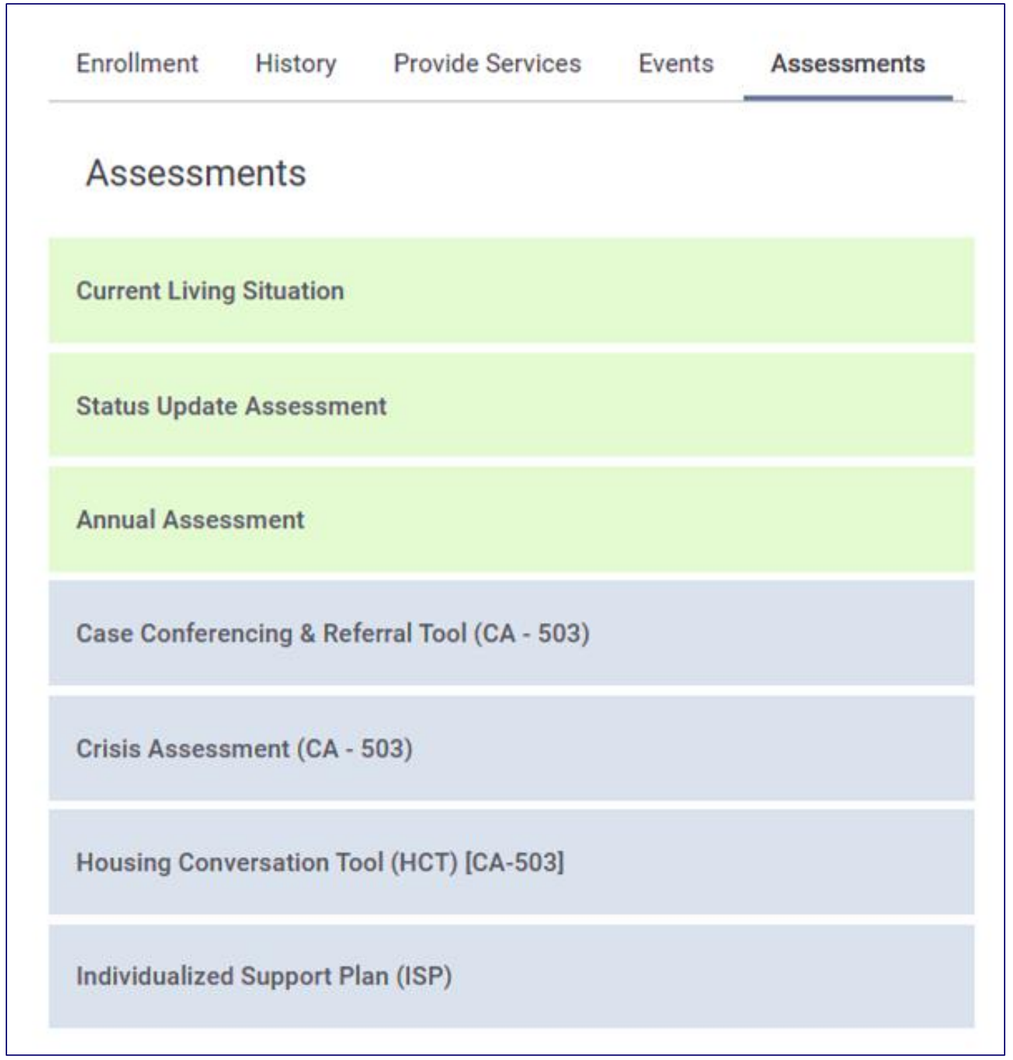
The Housing Conversation Tool

The Individualized Support Plan

The CAS Related Assessments

The assessments with the green background were designed to document changes in the client's circumstances over time.

The assessments with the blue background are more complex. Most of the assessments listed here are CAS Assessments, which were created to facilitate the client's journey towards permanent housing. CAS Assessments can only be accessed and completed in a program within the new CAS Agency.



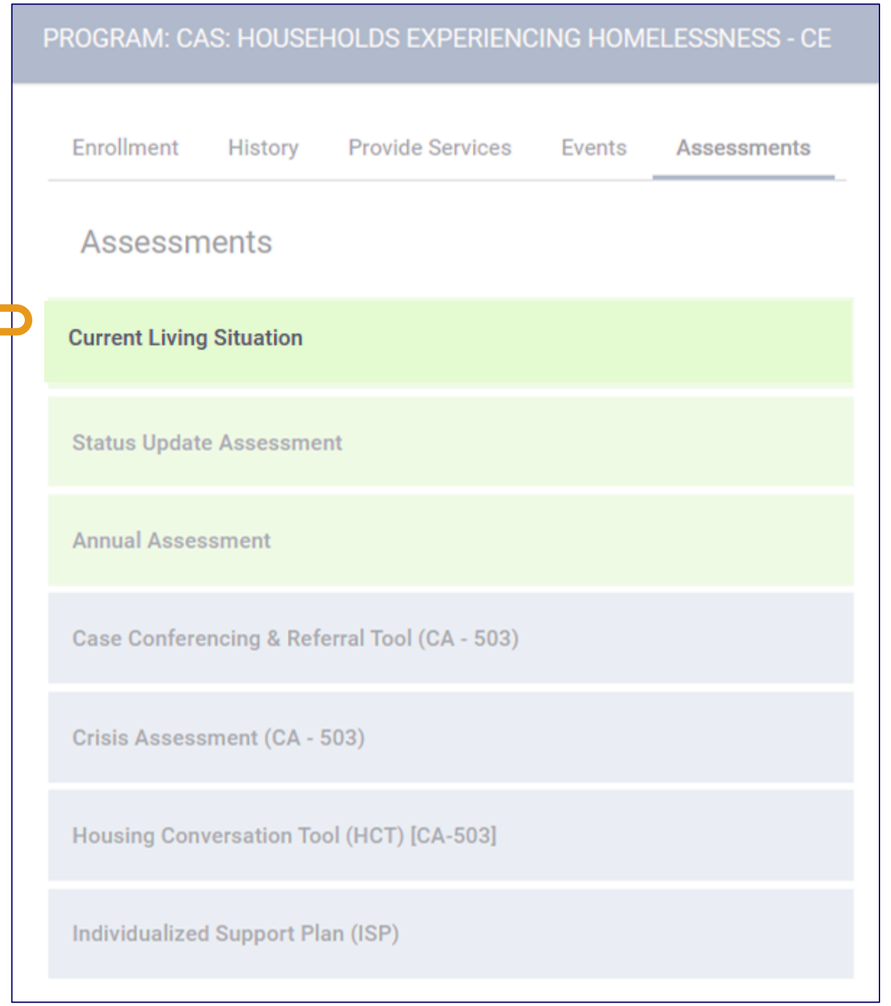
The Current Living Situation Assessment (CLS)

The CLS is an assessment that captures your clients present location.

This short assessment allows us to track the physical location of clients.

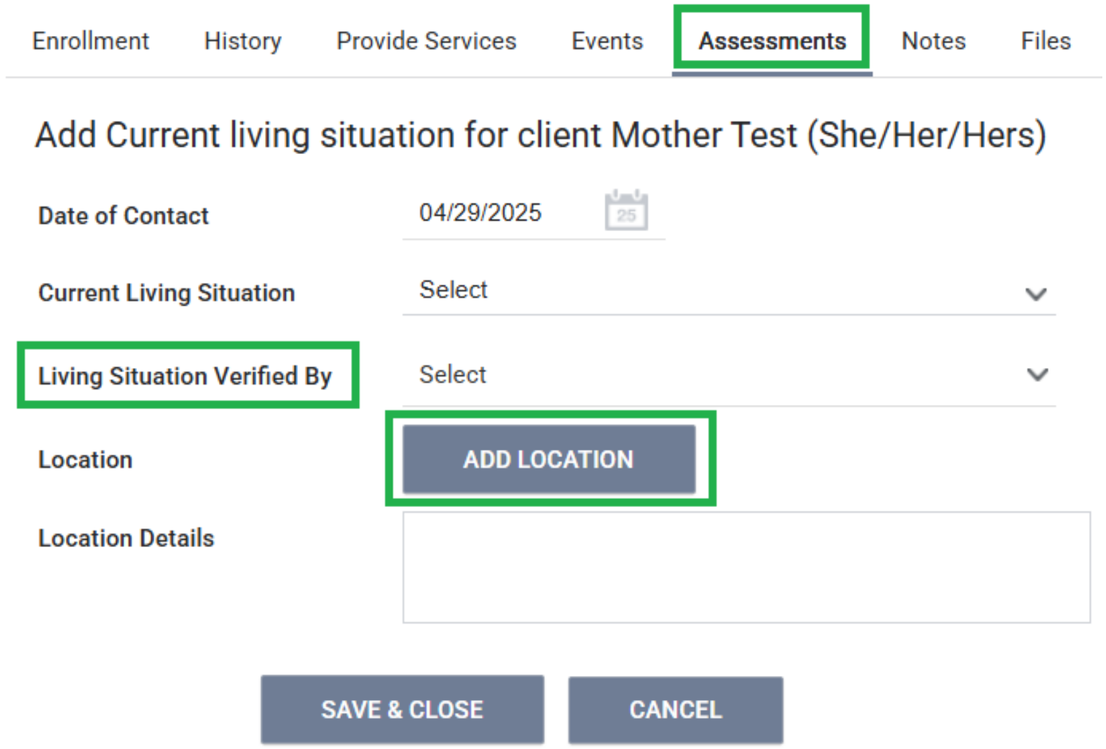
CAS Assessor should fill out a new CLS...

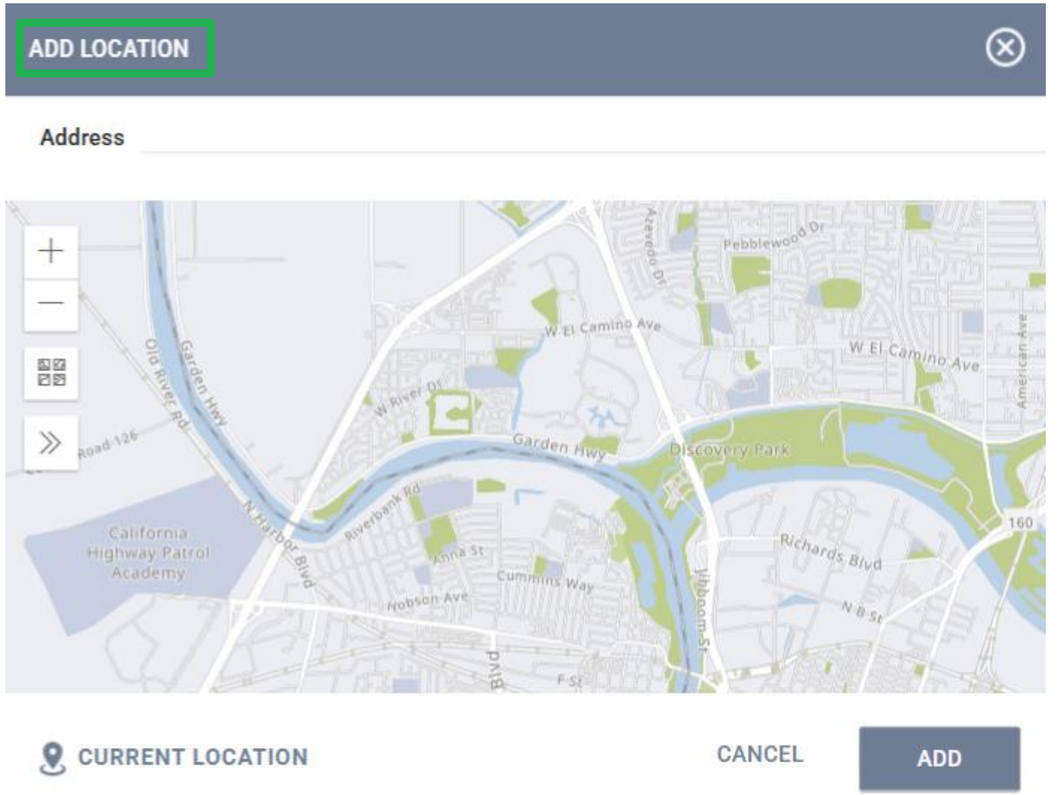
- ...when the client is first enrolled in a program.
- ...when you complete ANY CAS Assessment.
- ...when a CE Event is logged for the client.
- ...if the client's living situation changes.
- ...if the previous CLS is over 30 days old.



Job Aid: Current Living Situation (CLS)Assessment

Completing a CLS Assessment





The CLS confirms homelessness status and can be an eligibility factor for some shelter and housing opportunities.

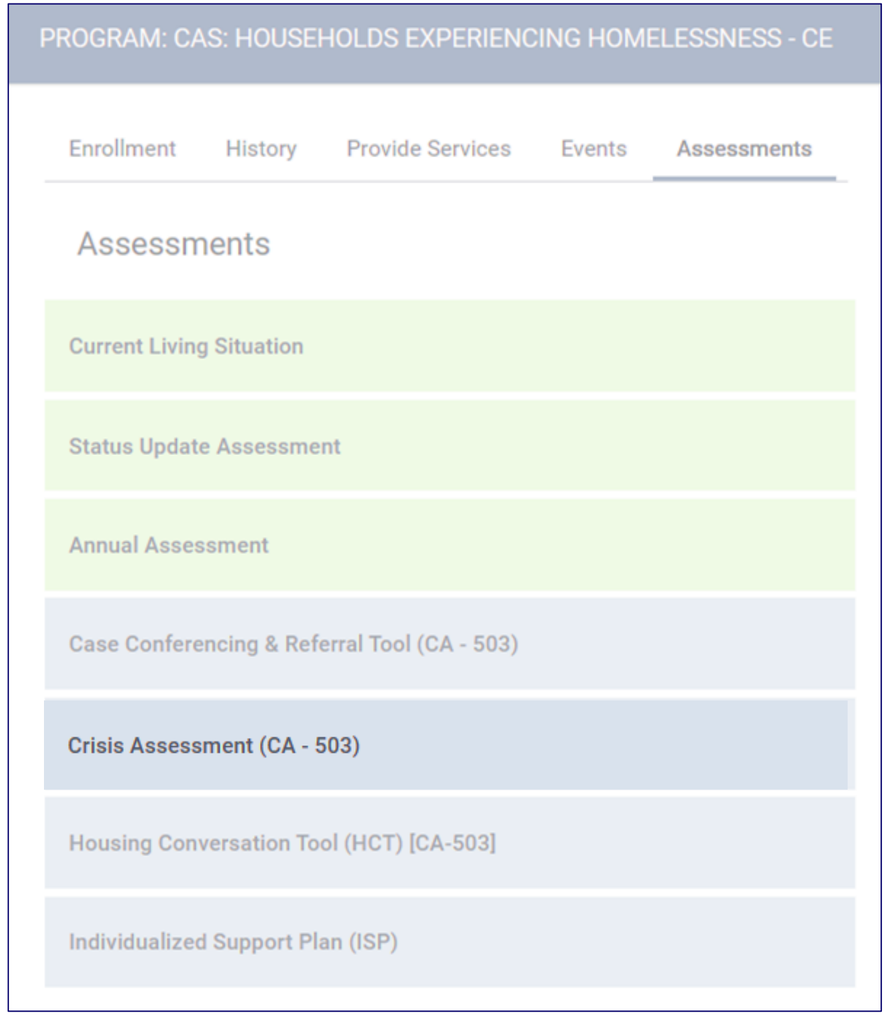
The Crisis Assessment

CAS Assessors will complete a Crisis Assessment **when their clients needs a referral for shelter**

The Crisis Assessment should also be **used to determine PSAP eligibility** and refer a client to **Case Management programs.**

- This one assessment for…
  - …all households experiencing homelessness.
  - …all households at-risk of homelessness.
  - …all households with minor children.
  - …all households with only adults.

Job Aid: Completing the Crisis Assessment



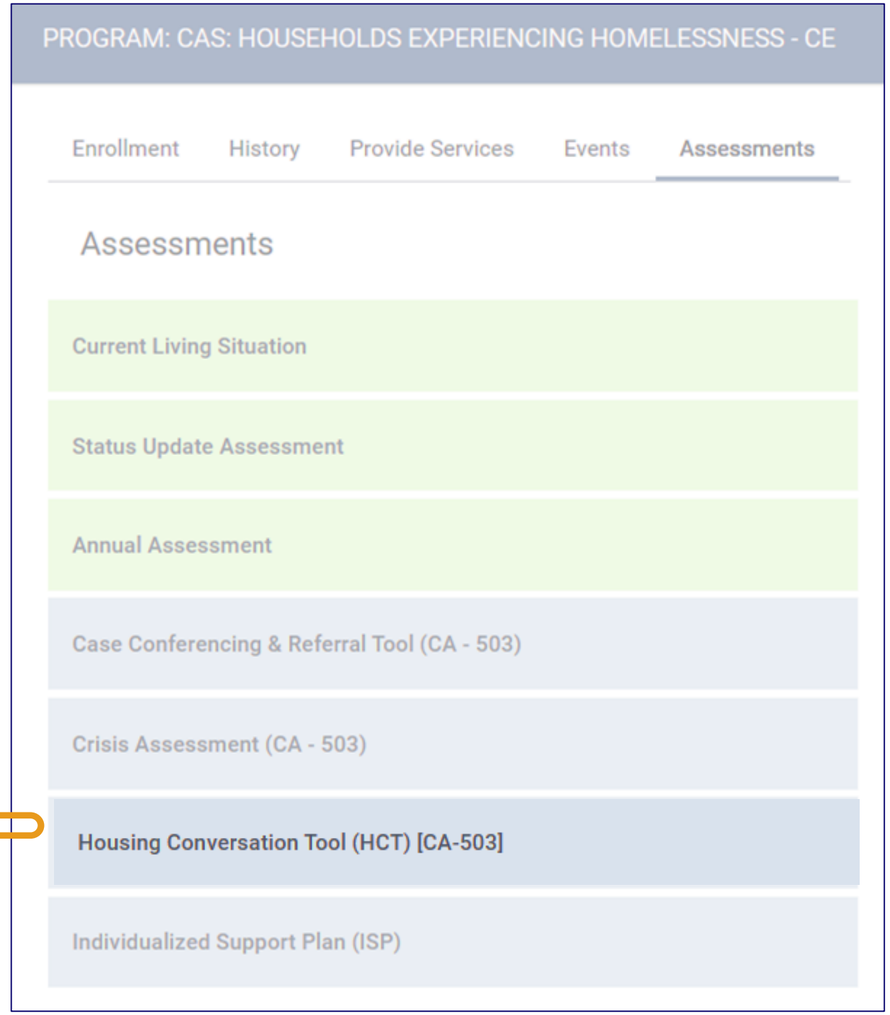
The Housing Conversation Tool (HCT)

CAS Assessors will complete the HCT to **refer households for housing.**

The HCT has been designed to integrate the questions from the VI-SPDAT assessments, Foster Youth to Independence (FYI) and the LEAP Assessments.

Upon the completion of the HCT, the accompanying Coordinated Entry Event must be logged.

Job Aid: Housing Conversation Tool (HCT) Assessment



The Individualized Support Plan (ISP)

The ISP is a plan created in collaboration with the client to meet their housing goals with identified barriers, steps, and a timeline.

It is a living document, updated as their situation changes.

The ISP **needs to be completed or updated every time** a CAS Assessor completes an HCT with their client.

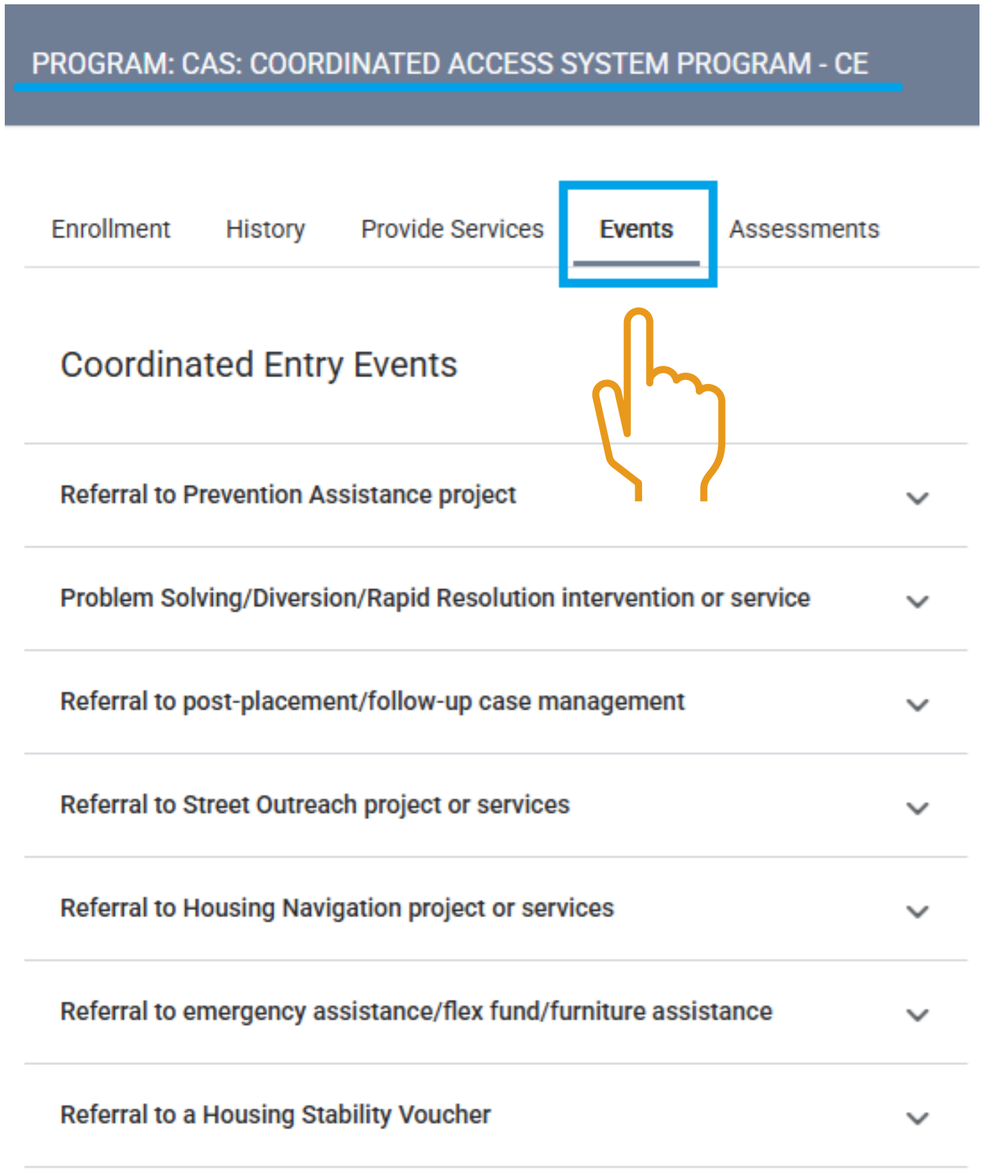
Coordinated Entry Events

Coordinated Entry Events are specialized services that are used to track major milestones along the client's journey to permanent housing.

As mentioned previously, it is important that a CE Event is logged after the completion or update of the HCT and/or ISP.

Additionally, CAS Assessors should be logging CE Events related to "warm handoff" referrals to other community programs.

Job Aid: Coordinated Entry (CE) Events – CAS Assessors

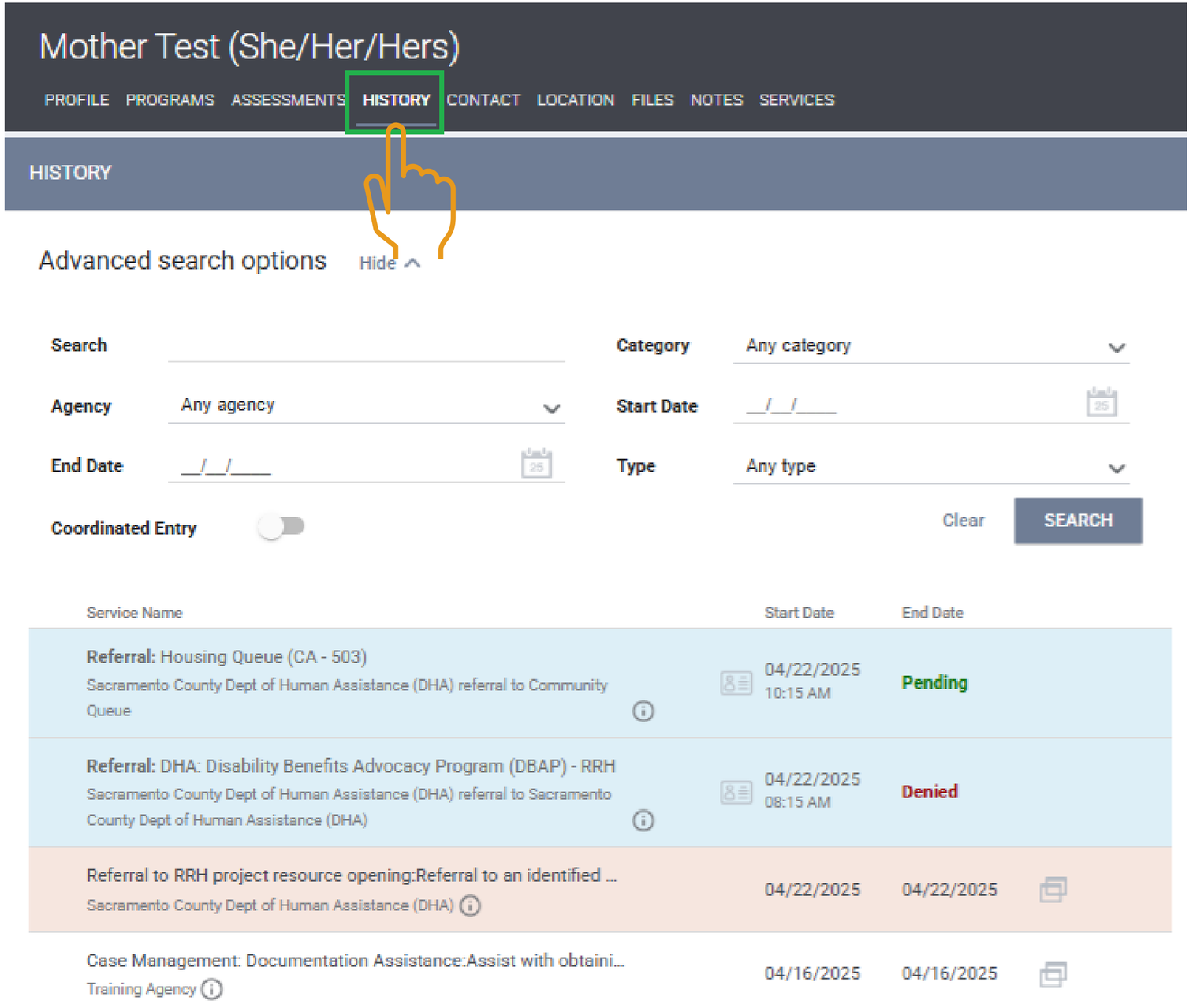


History Tab

The Global History tab lists all the client's enrollments, services, assessments, referrals, reservations, and CE events from all program enrollments, both past and present.

Entries show some basic information. You can reach the service, assessment, or enrollment directly by clicking on it.

Using the search feature, you can filter for dates, types, and categories to help you find what you are looking for.



Pop quiz: Drop it in the chat!

True or False:

1. It is okay to skip completing the location when entering in the details for the Current Living Situation Assessment.

2. You are responsible for asking the questions exactly as they are written on all the assessments.

3. To see **all** the client's enrollment, assessment, and service history in HMIS, visit the Assessment Tab on the Global Task Bar.

Support and Training Resources

HMIS Job Aids

Job Aids ***are short PDFs with step-by-step directions*** designed to provide ***self-directed training and resources*** for improved data quality.

The HMIS team designed several job aids specifically for the CAS Assessor Training, which live on the **HMIS Job Aids Website Page**.

Coordinated Access System Related Job Aids

- Completing the Crisis Assessment *NEW
- Housing Conversation Tool (HCT) Assessment *NEW
- Send a Completed Assessment to the Community Queue *NEW
- Current Living Situation (CLS) Assessment *NEW
- Coordinated Entry (CE) Events – CAS Assessors *NEW
- Coordinated Entry (CE) Events – 211 Referral Specialists *NEW
- Coordinated Entry (CE) Events – SSF Referral Specialists *NEW
- Using the Case Conference Tool
- Understanding Shelter Assessment Score Summaries
- Move Between Agencies in HMIS
- Process Referrals From the Community Queue
- Process Referrals for CAS Shelter Providers ONLY

CAS Assessor Best Practice Guide

- Comprehensive manual and best practice guide for CAS Assessors using the **Housing Conversation Tool (HCT)**
- Covers information in more detail than this training.
- Intended to be a resource, especially for new staff and includes a service decision matrix and post assessment examples.

ssf-sacramento-housing-conversation-tool-best-practice-guide.pdf

Which team can help me best?

Coordinated Access Department

The CAS teams are responsible for facilitating the streamlined system that matches homeless clients to housing and service options.

Examples questions our CAS staff can assist you with:

- **What CAS Assessments should I complete?**
- **How and when will my client get a referral?**
- **Why did my client receive the score that they did?**
- **How do I complete it correctly?**

HMIS System Administrators

The HMIS team is responsible for maintaining our Homeless Management Information System (HMIS) and providing technical support to all HMIS users.

Example questions our HMIS staff can assist you with:

- **Where are the CAS Assessments?**
- **How do I enroll clients in the CAS Program?**
- **How do I complete a Current Living Situation (CLS)?**
- **Where do I go to log a CE Event?**

CAS Open Office Hours Email Info

CAS Housing Referral
Referrals@sacstepsforward.org

CAS Shelter Referral and CAN
CAS@sacstepsforward.org

CAS Survivor Access System
SCAS@sacstepsforward.org

HMIS Open Office Hours Email Info

HMIS Technical Support
HMIS@sacstepsforward.org

HMIS Newsletter Feedback
HMISnewsletter@sacstepsforward.org

Q&A

Do you have any unanswered questions about HMIS or assessments?

We will return shortly.

Provider Training:

CAS Assessor
Training Series

Intro to Individualized Support Planning (ISP)

Coordinated Access System

AUGUST 2025

Intro to Individualized Support Planning (ISP) Learning Agenda

Understand **how to interpret CAS assessment results** and develop client-centered Individualized Support Plan (**ISP)**.

Learn how to discuss housing/service options **using human centered and trauma informed practices** with clients.

Demonstrate how to elevate Extremely Vulnerable Households **(EVH)** for immediate assistance.

CHAT

How many of you use the Individualized Support Plan function after completing the Housing Conversation Tool Assessment?

Developing the Individualized Support Plan (ISP)

Individualized Support Plan (ISP) & Housing Conversation Tool

- ✓ All CAS Assessors must complete the ISP **after finishing the HCT**
- ✓ HCT will help inform the development of the ISP with Trauma Informed Care practices.
- ✓ Development of ISP should be led by client
- ✓ ISP is not static and can be updated,
- ✓ Doc-readiness updates should be shared via the Case Conferencing and Referral Tool

Housing Goal # 1	
Housing Goal #1	
Start Date	
Barriers/Problems	
Steps (Measurable)	
Timeline (Days to Complete)	
Goals Status	Choose an item.
Notes for Housing Goal	

"Why do we have to do this?" - Purpose of the ISP

Why Develop the ISP?

The ISP helps support the HCT, providing supplementation for continuation of care

How does the ISP Support Resolving Homelessness?

Assists in assembling collaboration of care across providers & support teams

When to Utilize the ISP?

The ISP should be utilized during case management as well as when facilitating warm hand-offs

ISP Key Components

HCT INTERPRETATION AND DIRECTION

Indicate client's preferred housing program type (eligibility + needs)

CLIENT LED PROCESS

Trauma informed practices

ASSEMBLING A SUPPORT TEAM

Case Management
Housing Navigation
Healthcare including behavioral health

HOUSING FOCUSED SMART GOALS

Specific
Measurable
Achievable
Relevant
Time-Bound

Trauma-Informed Care Approach

Trauma-Informed Care is a manner of interacting with clients with the assumption that they have experienced trauma. This ensures that every interaction is rooted in humanity, emphasizing safety, empathy, and respect while fostering a supportive and healing environment using the six pillars below.

- Safety
- Trustworthiness
  Transparency
- Peer
  Support
- Collaboration
- Empowerment
- Cultural
  Humility

ISP Example – Jane Doe

GOAL #1: Secure Permanent Housing

Date: August 27, 2025 | **Case Worker**: John Smith

- ❑ **Specific**: Jane will apply for and secure a permanent housing unit within the next 90 days.
- ❑ **Measurable:** Jane will complete at least three housing applications and schedule at least two viewings per week.
- ❑ **Achievable**: Jane will work with a Housing Navigator to identify suitable housing options and complete applications.
- ❑ **Relevant**: Finding permanent housing is crucial for Jane's stability and long-term well-being.
- ❑ **Time-Bound**: Jane will achieve this goal within 90 days.

Action Steps

- ❑ **Week 1-2**: Meet with Housing Navigator to review available options and prepare application documents.
- ❑ **Week 3-4**: Submit applications for identified housing units.
- ❑ **Week 5-6**: Attend housing viewings and follow up on applications.
- ❑ **Week 7-8**: Review and respond to housing offer(s).
- ❑ **Week 9-12**: Finalize lease agreement and move into permanent housing.

ISP Example – Jane Doe

Goal #2: Address Healthcare Needs

- ❑ **Specific**: Jane will establish a regular health care plan and address any immediate medical needs.
- ❑ **Measurable**: Jane will schedule and attend at least one health care appointment per month.
- ❑ **Achievable**: Jane will connect with the Healthcare Plan Team to access necessary services.
- ❑ **Relevant**: Addressing health needs is vital for Jane's overall stability and ability to maintain housing.
- ❑ **Time-Bound**: Jane will have a health care plan in place within 60 days.

Action Steps

- ❑ **Week 1-2**: Meet with Healthcare Plan Team to evaluate health needs and create a care plan.
- ❑ **Week 3-4**: Schedule necessary medical appointments.
- ❑ **Week 5-8**: Attend scheduled appointments and follow up with care providers as needed.
- ❑ **Week 9-12**: Review and adjust health care plan based on feedback from providers.

Please note the ISP examples for goal 2 & 3 are optional examples to support skill development. The main focus for using the **ISP is to secure permanent housing**.

ISP Example – Jane Doe

Goal #3: Improve Financial Stability

- ❑ **Specific**: Jane will create a budget and work towards increasing her income through employment or benefits.
- ❑ **Measurable**: Jane will develop a budget and apply for at least two job opportunities or income-support programs.
- ❑ **Achievable**: Jane will receive assistance from a Financial Coach and Job Placement Specialist.
- ❑ **Relevant**: Financial stability is essential for maintaining housing and meeting other needs.
- ❑ **Time-Bound**: Jane will achieve this goal within 120 days.

Action Steps

- ❑ **Week 1-2**: Work with Financial Coach to create a budget and set financial goals.
- ❑ **Week 3-4**: Update resume and apply for job opportunities.
- ❑ **Week 5-8**: Attend job interviews and explore additional income-support programs.
- ❑ **Week 9-12**: Secure employment or benefits and adjust budget as needed.

Please note the ISP examples for goal 2 & 3 are optional examples to support skill development. The main focus for using the **ISP is to secure permanent housing.**

Extremely Vulnerable Households (EVH)

Extremely Vulnerable Households (EVH) Policy

Extremely Vulnerable Households (EVH) policy immediately prioritizes households for the next available and appropriate shelter unit. EVH clients will be prioritized for housing supports.

EVH is defined as:

- Individuals scoring 6+ on HCT or Crisis Assessment
- Families scoring 10+ on HCT or Crisis Assessment

Key Aspects

- EVH can be escalated for immediate supports, including **shelter and case management** during first engagement
- EVH clients should be assisted with completing and uploading doc-ready requirements
- Creates alignment between shelter and housing prioritization – clients prioritized for shelter are prioritized for housing and vice versa

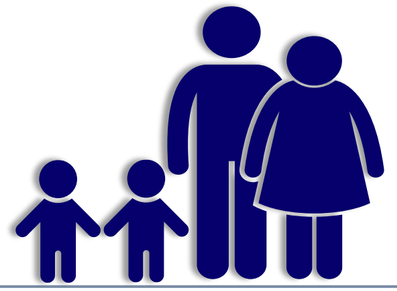
Factors of Extremely Vulnerable Households

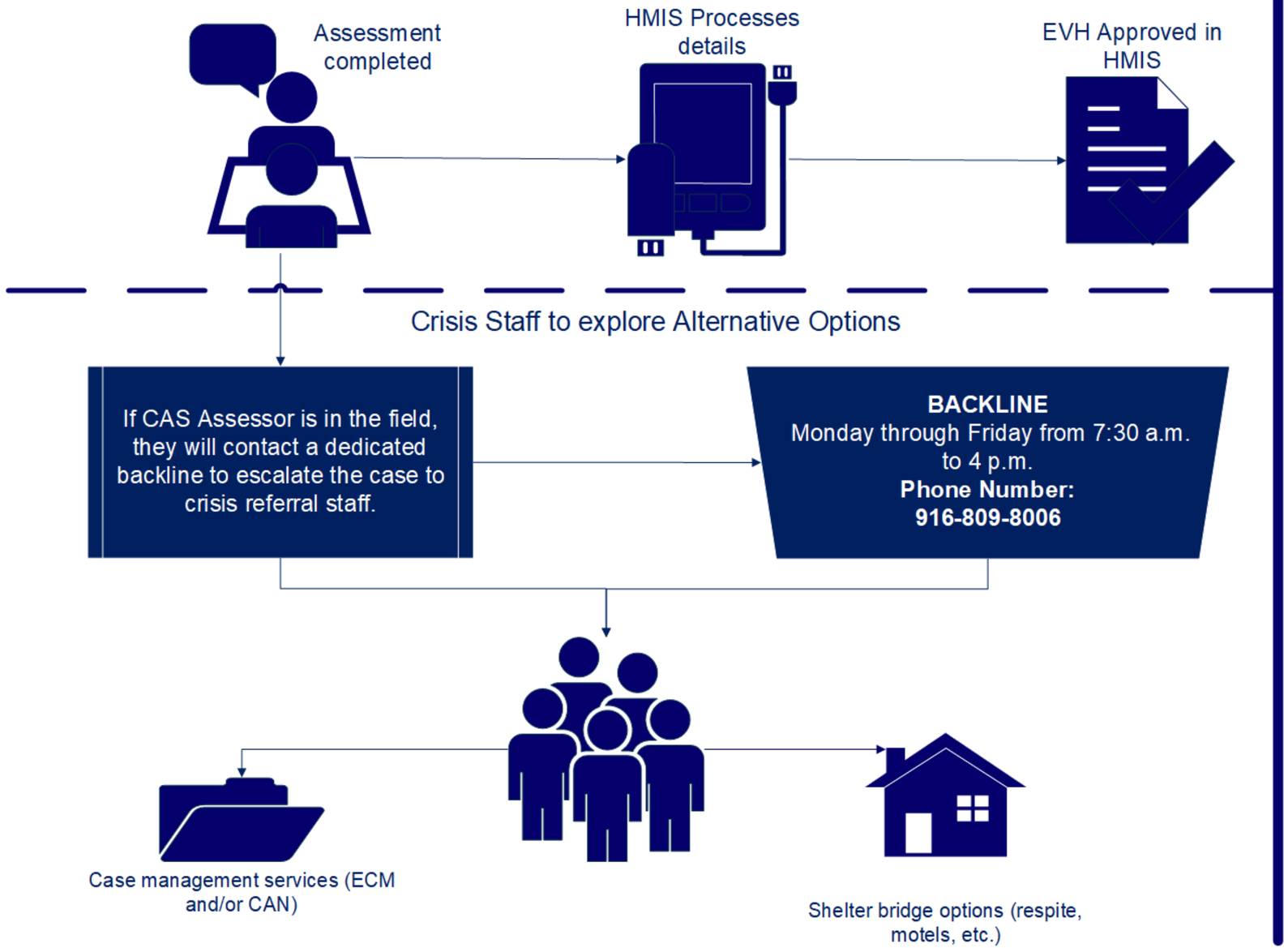
Singles

- Escaping DV, etc.
- Pregnant
- Disabling condition
- Senior (over 55)
- Recent mental health crisis
- Recent physical health crisis
- Sleeping in a tent or outdoors
- Continually homeless for over a year

Families

- Multiple Children
- At least one child under the age of 5
- Single-Parent Household
- Presence of multiple other factors noted in the "All “column





Crisis staff will review the client's eligibility and determine if a same-day shelter referral can be made.

If client is unable to be placed into an emergency shelter, the crisis referral staff will explore alternative options until a shelter intake appointment can take place.

Once client is connected to an emergency shelter, case management staff will support with getting client "doc-ready" for CoC housing options

EVH clients will be prioritized for CoC Housing options such as Rapid Re-Housing and Permanent Supportive Housing.

Q&A

Do you have any unanswered questions about the ISP process or tools?

Stay in the Know

Sign up to receive Provider Training updates
Subscribe to the SSF monthly newsletter
Follow us on social media

Visit us at sacramentostepsforward.org

Thank You

Please complete the exit survey!

SACRAMENTO
STEPS FORWARD

Coordinated Access System

May 2025