STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

Nicole Tousignant

BULLETIN NO.: 22-14

FROM: Nicole Tousignant, Economic Benefits Director
Economic Services Division

DATE: 04/07/2022

SUBJECT: Reach Up Services Procedures

CHANGES ADOPTED EFFECTIVE 04/07/2022

INSTRUCTIONS

__X__ **Maintain Manual - See instructions below.**
____ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____**
____ **Information or Instructions - Retain Until _____**

MANUAL REFERENCE(S):

P-2300

Reach Up Services Procedures P-2310, P-2310A, P2310B and P-2371 are new Procedures.
Reach Up Services Procedure P-2352 updated and changed to P-2380.

New procedures have been created about using the goal achievement process and making referrals to the MOMS program.
The Case manager supervisory case review procedure has been updated to better reflect goal achievement also.

Manual Maintenance

Significant changes are highlighted in gray.

Reach Up Procedures

Remove		Insert	
		P-2310	(22-14)
		P-2310A	(22-14)
		P-2310B	(22-14)
		P-2371	(22-14)
P-2352	(19-18)	P-2380	(22-14)

2310 GOAL ACHIEVEMENT (22-14)

Reach Up's mission is to join families on their journey to overcome obstacles, explore opportunities, improve their finances and reach their goals. Helping participants determine what goals they would like to focus on and how they may accomplish those goals is done using the goal achievement process, specifically GPDR-R.

- **G**oal
- **P**lan
- **D**o
- **R**eview
- **R**evise

Language to get started

Use some of the following language to help explain the Reach Up program and introduce GPDR-R.

During an initial meeting with a family

- Description of Reach Up: Reach Up is a program that joins families on their journey to overcome obstacles, explore opportunities, improve their finances and reach their goals.

- Dual purpose: We want to help you meet your immediate needs so you can regain your economic footing and provide for your children, but we also are here to help you think ahead so that we can help you and your family permanently improve your circumstances.

- Starting point: We understand that everyone is at a different place in their path to improving their finances. We can take it one step at a time. What is one thing going on right now that you feel you would most like to change to help you improve things for you and your children? Stepping Stones is a tool we use to start a conversation about what is meaningful to you. We also have worksheets we can use together for you to write down steps you'd like to take. (Then use GPDR-R to work through this goal.)

Setting goals

Utilizing the life areas outlined on the Stepping Stones tool, participants will indicate what area is most important to them at the time and set a goal. For more information about Stepping Stones see procedure 2310A.

Language matters and if the terms "goal" and "plan" feel too formal, consider changing how the process is talked about. The goal achievement process and GPDR-R is designed to help someone move into intentional self-regulation, and out of automatic self-regulation—that is, rather than just being reactive and responding to the "crisis of the day," this is a way to be proactive and thoughtful about what they're going to do.

Ask questions like: "What is one change you could make in the next day/week that would make a difference for your current circumstances?" By giving the participant the chance to realize some "small wins" in a row, this can build their self-efficacy, which can help a participant make bigger, more meaningful progress in their life.

Personal goals versus goals to improve finances

Sometimes, goals will be personal goals instead of goals related to improving their finances (employment education, training, SSI). These personal goals can help a participant get started, build some self-efficacy, and then make progress toward employment.

Help participants recognize the connection between their personal goals and their goals to improve their finances. Taking steps towards personal goals, may help a participant get and keep a job in the future. When somebody is setting a personal goal, like child well-being or personal health, help them reflect on how their personal well-being in this area is going to set them up for success elsewhere in life.

Case manager role in determining goals

As participants work to identify their goals, use motivational interviewing skills to draw out the participant's motivations and help them discover the answers for themselves.

If the participant is interested in focusing on some type of education or career goal, pull in the employment, training and education specialist (ETES) to brainstorm and help participants consider their career goals and explore other opportunities. For example, a volunteer opportunity may make sense for a participant who does not yet feel ready to take part in job search but is interested in exploring their career goals while at the same time gaining some experience and building general workplace skills.

If a participant's goal does not seem to be attainable in their current situation, help the participant clarify the goal. For example, if a participant wants to be a marine biologist in Vermont, and there are not any marine biology jobs in the area, find out what about being a marine biologist appeals to them. Is it possible that they don't even want to live in Vermont, so is it realistic? Or

perhaps it is biology in general, or being outside, or being near the ocean? This conversation helps clarify the goal. Then work backwards to help them figure out the steps they need to take to reach their goal.

Goal storming

If participants are struggling to identify a goal, a fillable goal storming sheet may be useful.

Activating motivation

The goal achievement process, GPDRR and Stepping Stones are meant to provide the participant with space to articulate what is most important and motivational to them and where they want to start. During this process, it is important to be sensitive to the participant's readiness for change.

"Moving" participants from pre-contemplation or contemplation into preparation and action steps, should be movement that is *driven* by them and *facilitated* by the case manager. Rather than moving someone into action on an action step they are not ready for change in, nudge them toward action on goals which they have articulated they are committed to and ready to pursue.

Stepping Stones nudges participants more intentionally than a traditional "assessment." Do not push participants toward preparation and action steps to pursue goals they have not themselves identified and committed themselves to. A plan without motivation is not going to happen.

However, it is okay to help participants see connections between certain obstacles (such as lack of transportation and ID), and their current goals.

Documenting goal achievement

Make sure to document conversations around goal identification in case notes. Save copies of tools used (Stepping Stones and goal sheets) in the participant's electronic case file.

Creating a plan

Utilize goal sheets such as My Action Plan and My Goal Success Plan to help participants come up with specific and detailed plans for how they will accomplish their goal. Offer a copy of Participant Guide to Using GPDR-R, which provides tips about each step in the GPDR-R process.

Identifying other supports to hold participants accountable

Ask the participant to identify family or friends who may be able to help check in with them and make sure they have followed through on their plan.

If other supports cannot be located:

- Treat this as an opportunity to reaffirm and emphasize support for the participant, both as a safe space to reflect on what is getting in their way of goal progress and what they're learning as they pursue their goals.

- Encourage the participant by affirming the belief that they can make positive changes in their life, one step at a time.

- Recommend options for building up their social support network. If opportunities exist within the district office (workshops, peer support groups, etc.), or if there are other good resources in the community, feel free to suggest or recommend those as options to consider.

Identifying resources needed to accomplish goal

As participants set goals, invite them to consider what resources are required for those goals:

- Program resources – support services, coaching, checking in, incentives;

- The participant's own resources – family, social connections, income/savings; or

- Inaccessible or unavailable resources at that moment– a college degree requirement, space for a business, savings.

This exercise of identifying required resources helps the participant consider whether this is the right goal at the right time for them. It also helps them realize obstacles that they could address to reach their goal.

Do the plan

Allow the participant time to try out the plan. Schedule check ins as needed, and then follow up with reviewing and revising how it went.

Review and revise

At the next scheduled meeting, review what happened. What went well and what did not work? If the plan did not work, what got in the way and how could it be planned for differently? Is it still the right goal?

Changing goals

There is no hard-and-fast rule around the number of times someone can or should change their goal within a given period. With that said, if a participant wants to change their goal three successive times (that is, each time over the course of three consecutive meetings), this suggests that they may not be truly committed to the goals they've previously set.

Ask open-ended questions to help them reflect what they have learned when identifying the past few goals—that is, why did they set those goals in the first place and what specifically has led them to change their goal? It may be appropriate to hold them accountable to being honest and authentic about their goal.

Holding participants accountable does not mean moving directly to conciliation, sanction or closure. Always make sure each step of the goal achievement process is thoroughly reviewed and revised as needed. See procedure 2310B when participants continue to not follow through.

Remind the participant that it is okay to change or abandon a goal—after all, that is what happens sometimes. The main thing is that the participant is making a good faith effort to pursue their goals and when they encounter a challenge or obstacle, they are willing to review and revise their plan. The road to goal success involves failures, u-turns, and several hard lessons; part of facilitating that journey with and for participants is being willing to give more control over to them to prioritize the process for themselves.

Case Manager Support

The Reach Up Case Management Page on SharePoint is full of GPDR-R related resources, including goal sheets, sample goal plans, and other resources.

The Goal, Plan, Do, Review and Revise (GPDR/R) Manual is an executive function-informed goal achievement framework for use in human service programs developed under the lead of LaDonna Pavetti, Vice President for Family Income Support at the Center on Budget and Policy Priorities.

The Your Money, Your Goals toolkit was created by the Consumer Financial Protection Bureau (CFPB). The toolkit is a collection of important financial empowerment information and tools you can choose from based on the needs and goals of the people you work with.

2310 GOAL ACHIEVEMENT (Continued)

P-2310A Stepping Stones and Goal Achievement (22-14)

The purpose of using Stepping Stones is to engage participants in a meaningful way that helps them move forward, improve their financial situation, and eventually move off of Reach Up. Stepping Stones is a tool that helps start a conversation with participants about what is personally meaningful to them, and helps participants set goals which build on their own internal, or intrinsic, motivation.

Stepping Stones is trauma informed, because it empowers participants, offers choice, and does not require them to divulge more information than they are comfortable sharing. It also focuses on participants' strengths and possibilities for the future.

Introducing Stepping Stones to participants

The Stepping Stones process should be used with everyone who receives Reach Up, including minor parents and mandatory youth.

How often to use Stepping Stones

Stepping Stones should be used with every new participant a case manager works with, and then at a minimum every 6 months. Each participant will be very different, and some participants may want to use Stepping Stones more often. Stepping Stones should be used to help participants identify their goals and move forward.

Three ways to use Stepping Stones

Initially, as a springboard into goal setting:

- Focus on the life areas along the left-hand side of the page.

Periodically, to reflect on and visualize goal progress (Goal Plan Do Review Revise--GPDRR):

- Focus on the life areas within which the participant has been pursuing goals.
- Invite the participant to indicate where they see themselves (using the bubbles).

- When one goal is accomplished, bring out Stepping Stones to explore what's next.

- If someone is struggling to reach their goal, use Stepping Stones to investigate if another life area is requiring the participant's attention instead.

Regularly, to prime and structure meetings:

- Once the participant is familiar with Stepping Stones, send a copy to them before a meeting, or invite them to fill it out before the meeting begins, or right at the beginning.

- Use their bubble ratings to gauge any changes.

- Use their answers to other questions on the form to focus the discussion accordingly.

Using Stepping Stones with participants

If participants are meeting their goals with their current plan, leave the plan as is, and use the tool to build on their existing goals.

If Stepping Stones has not yet been used with an existing participant, be transparent about the fact that the Reach Up program is trying out a new approach and tool. Mention that Stepping Stones is a different way of "doing assessment" and that the focus is more intentionally on goals.

Use the introduction as an opportunity for the participant to:

- Step back and think about the different areas of life, even though they may have been working on a variety of goals (many of these same areas) over the past few months or years; and

- Be reflective on what has worked versus what has not worked in the past.

This introduction may avoid the disjointedness of simply switching to a new tool without context or some way of bridging the conversation.

Use of Stepping Stones with participants in crisis

When a participant attends a meeting and self identifies as being in crisis, it makes sense to not start with Stepping Stones, because the participant needs to focus on one particular issue. In the moment, focus on helping them take one small step forward—something they can do today, tomorrow, or this week—such

as taking a shower tonight, or having some place to sleep. Don't let the Stepping Stones tool get in the way of meeting those urgent needs.

After the crisis has been addressed, it can be helpful to come back to Stepping Stones to reflect on the participant's life as a whole. Circling back around to think about other life areas can help the participant think beyond the crisis.

Resisting the urge to gather all information up front

In general, avoid leading a conversation with questions about topics such as housing, transportation, or criminal history to name a few, for the mere reason of collecting information. Instead, these topics should come up either because the participant feels that they are important and wants to discuss them (jumping off of the Stepping Stones tool), or because they relate to a challenge or obstacle to the participant's goal.

For example, it may be appropriate to discuss criminal history if the participant's goal relates to applying for a job where criminal history will pose a challenge to their plan to get that job. Rather than leading with a question about criminal history, ask an open-ended question along the lines of: "So, as we think about your plan to apply for this job, are there any aspects of your previous experience that you think help or hinder your chances? How might you address these strengths or challenges as you apply and interview?"

Discovering hidden obstacles

Sometimes while using the Stepping Stones process, obstacles the participant were grappling with surface, such as lack of consistent transportation, or fear of using child care. Explore with the participant what they might do to reduce or eliminate that obstacle if it is getting in the way of their goal.

If a participant does not want to address the obstacle that is getting in the way of their goal, this is a valid tension, and it is important to name it and recognize it.

In some circumstances, this means allowing the conversation to lead to topics that do not seem most important (for example, the participant wants to focus on physical health when their housing situation is in crisis).

A good facilitator will do the following:

- Use open-ended questions to draw out the "why" and the "how" of the participant's goal;

- Redirect the conversation back to the participant's goal or area of focus if they begin to discuss other issues or matters by reemphasizing what you

heard their goal to be and checking to make sure that is still what they want to focus on; and

- If the participant would like to focus on something else, confirm that as well.

At its core, this approach is about starting where the participant is at and where their motivation lies, and then pursuing goals from there. Other life circumstances and issues will undoubtedly arise in the pursuit of those goals; as they do, it's important to facilitate the participant's reflection about whether those other areas/circumstances merit their attention now—that is, if the participant is focused on a goal related to education, but in the process of doing so, they learn that their housing is really getting in the way, that may be an opportunity for them to step back and consider focusing on their housing to get to that education goal.

Discrepancy between Stepping Stones and case manager insight

If a participant indicates a life area is "fine" on the Stepping Stones tool, but prior conversations or events have shown the area may not be fine, respect the participant's desire to not address the obstacle at that moment. However, enter it as an "interfere" on the Family Support Matrix (FSM) and document the entry in case notes. (See the Reach Up Services procedure P-2305 Assessment for more information about the FSM.)

The Stepping Stones process puts more control in the hand of the participant. They are the ones that need to make the decision about what to prioritize and work on. If they do not see those other areas as obstacles or important things to focus on, let it go. In walking them through the process, they may come to realize the importance of these other issues, but it will be their own self-awareness, rather than telling them what to focus on and what to do.

While it can seem valuable to direct the participant to focus on certain priorities, that does not necessarily build their capacity or skills. This results in fixing things for them, which may land them right back in the same situation again.

Case Manager Support

Until a finalized version is made into an official ESD form, the Stepping Stones tool can be found here on SharePoint.

Stepping Stones tool and the case management file

The Stepping Stones tool should be printed in color.

If the Stepping Stones tool is completed, either on paper or electronically, it should be kept in the first brad of the file and documented in case notes. If the

tool is not written on, then the tool does not need to be kept; just document the process in case notes.

The tool should be placed in the first brad. If documentation is gathered to support the participant's goal refer to the RU CM file retention schedule to determine the best place for the document.

Documenting the use of Stepping Stones

Participant and case manager should decide if they complete the tool or discuss the tool without actually writing anything on paper or completing it electronically. The case manager should document the process in case notes.

If the "paperwork" of Stepping Stones is getting in the way of an authentic conversation with the participant, set it aside for the moment. Stepping Stones is not primarily a tool for documentation. It is meant to facilitate an increase in self-awareness and self-reflection on the part of the participant, with the case manager in dialogue.

At the end of a session, consider briefly using the paper/electronic version of the tool to somehow reflect on the conversation that was had—even if that is simply marking the domain discussed, or filling in one or two of the bubbles. The focus should be on goal-pursuit; Stepping Stones is a springboard into goal pursuit, and a way to reflect on starting points and progress along the way.

Entering Stepping Stones goals on FDPs

If a participant's goal does not align with current activities in ACCESS, use an activity in ACCESS that most closely matches the participant's goal. Indicate in case notes the reason for selecting the specific activity.

If unsure of the correct activity to choose, review the case with the Reach Up Supervisor. If additional support is needed, send an email to AOPS.

Balancing the use of Stepping Stones among the caseload

Stepping Stones does not automatically increase the amount of time spent with a participant. Not every participant is going to be "intensive" – requiring long meetings on a weekly basis. Considering the caseload as a whole, there will be participants who do not need such consistent touch points.

The Stepping Stones tool is more targeted and may allow the conversation to be more focused, in a way that at least does not add time, and might even take less time. For example, "Last time we talked, you identified transportation as the area you would like to focus on. Is that still the case?"

If documenting each life area in case notes, just update the area that changed when reviewing with a participant. “Reviewed Stepping Stones tool over the phone with participant. Housing: now listed as strength. Transportation: identified as needs help. All else is the same.”

2310 GOAL ACHIEVEMENT (Continued)

P-2310B Accountability through the Goal Achievement process (22-14)

What to do when participants do not follow through

Prior to implementing a conciliation or sanction, have a discussion with the participant to discuss why they are not meeting their goal and see if they would like to change their plan. This is the review and revise part of the goal achievement process and GPDR-R. Engage the participant in a conversation to help them realize where the plan is breaking down, and revise. Build in accountability and timelines in this process. Make sure to document in case notes the use of motivational interviewing and the goal achievement process.

Moving to Conciliation/Sanction/Closure

If the participant is still not engaging, moving forward with conciliation, sanction or closure might be appropriate in the following times:

- If the participant is completely unwilling to engage, will not contact you or show up for an appointment.

- If participant refuses to come up with a goal, motivational interviewing has been used to determine a goal, and the participant still refuses to come up with a goal.

- If participant creates goal and plan but does not "do" (ex. Meet with employment specialist) and continues to say that is their goal and does not want to change their goal. But then does not do the "do."

Changing a goal while conciliated or sanctioned

If after a thorough attempt to review and revise, a participant ends up conciliated or sanctioned and then wants to change their goal to resolve the non-participation, go with the new goal on the conciliation resolution or sanction cure. Likely the wrong goal was identified—something the participant did not really care about—that led to the conciliation or sanction in the first place.

The key is to help the participant move forward and focus on what is motivating them right now. Do not immediately resolve the conciliation or release the sanction. Their new goal becomes the way they make progress and demonstrate commitment, which then can resolve the conciliation or cure their sanction.

P-2371 VT MOMS PARTNERSHIP PROCEDURES (22-14)

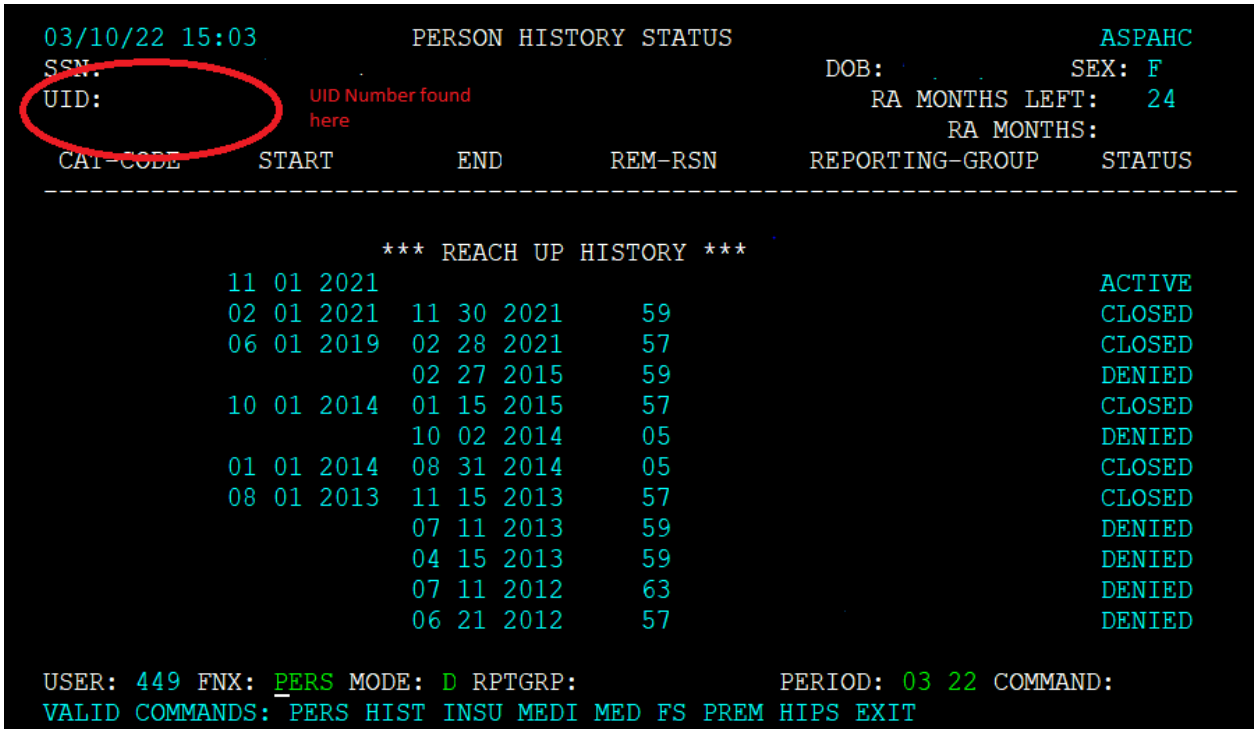
VT MOMS is an 8-week stress management group offered to mothers who would like support with relaxation tips, balancing responsibilities with fun, problem solving tips, communication strategies and more. VT MOMS is led by a community Mental Health Ambassador and VT MOMS Clinician and is offered on a rotating basis throughout the year. Classes are 90 minutes long and will be held over zoom and/or in person.

Who is eligible to apply?

- Be at least 18 or older and identify as a woman
- Be pregnant or the primary caregiver of a child under 18
- Be experiencing emotional challenges
- Be participating in Reach Up, Reach First, Reach Ahead, or the Post-Secondary Education program, or have participated in Reach Up in the last 2 years. Or are receiving the Child Only grant

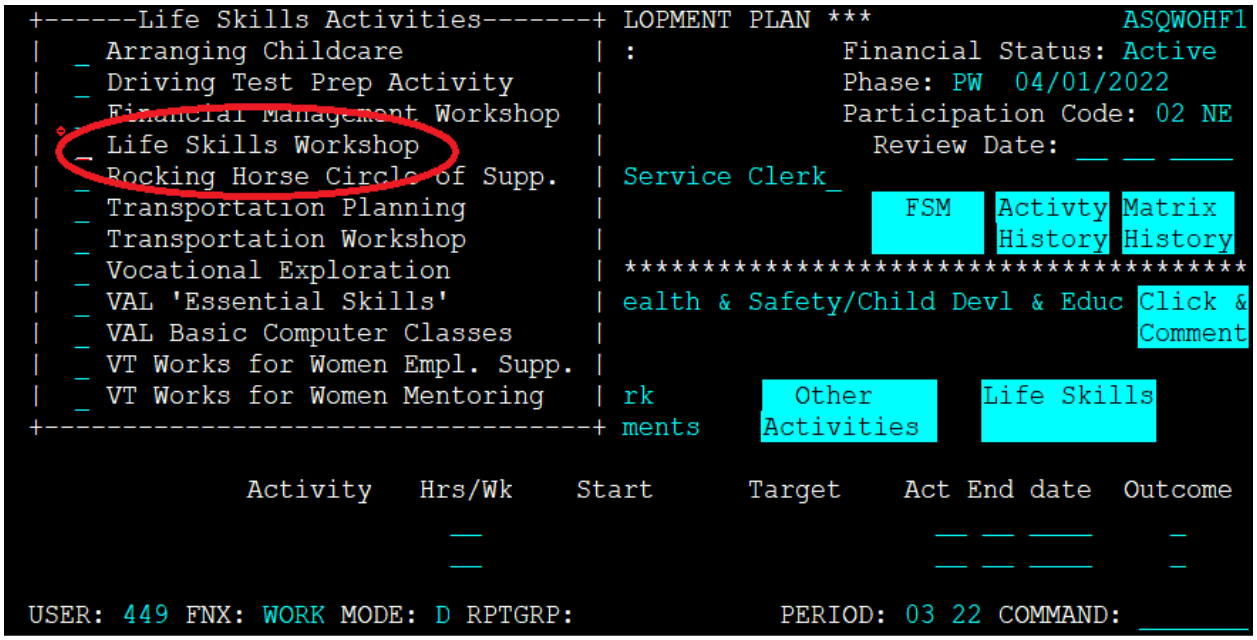
Referral Process

- Complete the VT MOMS referral form found here (attach link)
- Submit referrals to **VTMoms@howardcenter.org**
- The referral form asks for information about the participant including their UID number. To find the number, please check ACCESS under PERS/D/HIST. The participant's UID number will be listed on the top left corner of ACCESS. See screenshot below.



Family Development Plan and Support Services

- VT MOMS should be added as "life skills workshop" in ACCESS on the work panel for participants Family Development Plan. Please also use the GPDR/R process and tools if the participant would like this as a primary goal and could benefit from breaking the process down in smaller steps. The screenshot below shows where to find life skills workshop on work panel in ACCESS.



- Attendance should be verified and entered into ACCESS by the 12th of each following month. The class is counted for 2 hours of attendance weekly unless otherwise specified. Attendance form 625AR can be found here Vermont Department for Children and Families (sharepoint.com) File attendance verification in Brad 5 in the electronic case file.

- If eligible for Reach Up ICAN set flag in ACCESS "Y".

- Review and offer support service assistance as appropriate following matrix guidelines to support with acquiring laptop if needed, transportation help, childcare authorization, incentives, etc…

P-2380 Reach Up Supervisory Case Reviews (22-14)

Supervisory case reviews (SCRs) are completed by Reach Up Supervisors and used as a tool to promote best practice among Reach Up Case Managers.

Selecting Cases for Review

Each Reach Up Supervisor selects number of cases asked for by Central Office.

Reviews must be completed by the last business day of the month each month.

Choose different case manager (including contracted case managers)'s cases to review each month until everyone has had a case reviewed and continue in this manner.

Cases should be chosen by the supervisor from every selected case manager. If possible, select a case that Reach Up AOPs has completed a case review of in the last 4-6 months to review what case specific work has been done around "Next Steps." If a case review has not been done in last 4-6 months, review the general "Next Steps" from the last AOPs case review, and note if efforts have been made to address the steps.

Observing meeting or interaction

Once a case has been selected, find out when the next scheduled meeting is to be held between the case manager and the participant. Attempt to join the meeting either in person, virtually, or by joining a three-way call.

Tracking SCRs

Log the review on the "Supervisory Case Review Tracking Sheet" located on the shared drive in the SCR folder (Y:\AHS ALL SHARE\ESD\SCR).

Scan or save the original document to the share drive.

Role of the Operations Director

District Operations Directors will choose 3 of the case reviews that the Reach Up Supervisor has completed to review and log that on the "Supervisory Case Review Tracking Sheet".

Use of Form 242CR-RU

Form 242CR-RU is completed by the Reach Up Supervisor for each Supervisory Case Review.

Identifying information

Date completed: Actual date the supervisor is completing the SCR.

Month of review: Should be same month as the date completed. Best practice is to review 4-6 months back in the case, or as long as the case manager has held the case if shorter than 4-6 months.

Date of Most Recent AOPS Review: Check when last AOPs case review was completed in district, and if case manager had one completed.

Case Review Recommendations/Next Steps: At the end of each AOPs case review there should be some specific next steps identified for the case manager to work on.

Date of observed meeting: If able to observe a meeting between the case manager and the participant, indicate date observed.

Assessment

Appointment scheduled within 30 days from the time the case manager was assigned the case: Only needs to be answered if case opened in the past 12 months.

UNCOPE/PHQ2 (604SUPP): Review case notes for documentation of when PHQ and UNCOPE were completed or reference to them already being in the file, participant already in treatment, etc. Should be completed during initial appointment or within 30 days of the initial appointment if not appropriate at first meeting. If no mention in case notes, case manager should complete. Can be rescreened if changes in participant's life warrant rescreen. Concerns should be followed up with referrals.

Stepping Stones tool used in first 30 - 60 days and documented: Stepping Stones should be referred to in case notes. Copies of the tool should be available in most cases (especially for the initial use).

Stepping Stones tool used minimum of every 6 months (can be used more frequently depending on participant) and documented: Same note as above.

FSM (Family Support Matrix) is current (check "assessment updated" date): Case notes indicate when the FSM is updated and should match "assessment

updated" date. Case notes should provide reasoning behind why certain domains are considered Strength, Neutral or Interfere based on the case manager perspective.

GPDR/R

Ongoing documentation of goal-setting tools (Stepping Stones, "Potholes and Detours," GPDR/R worksheets – indicate in comments which ones were used): Goal sheets should be referred to in case notes. Copies of goal sheets should be available in most cases.

Longer term goal for improving finances (employment, training, education, SSI, etc.) identified: Identify the long term goal.

Goal (shorter term goals identified): Identify the shorter-term goals (activities). May be one or more. Indicate up to two on SCR.

Plan – Specific tasks identified, preferably physically written by participant, accountability written into plan (who will check in and when), possible potholes explored: Note what parts of the plan are completed for each shorter-term goal identified. Suggest ways the plan could be made more specific.

Do-- Evidence of action or engagement toward the goal: Consider if the right amount of time was allowed to complete the plan.

Review – Is the goal still important to the participant, what worked/did not work in the plan? Case notes should indicate if the goal review process was completed, and what was the result. Point out when this step is missed.

Revise – What should be updated? The goal, the plan?: If a goal or plan is not accomplished, point out how it might have been revised.

FDP - Exploring Opportunities

Signed and dated (including initial FDP if opened within the last 12 months): Matches date signed in ACCESS. Allow for electronic signatures or indicate verbal agreement. Case notes should indicate if FDP is only available in Notices.

Current: Includes at least one current activity.

Matches documented goal planning conversations in case notes: Activities include tasks and are written with strength-based language. When possible, goals use existing ACCESS activities, with specifics spelled out in the tasks. Refers to goal sheets when appropriate.

Hand-written FDP matches ACCESS: Activity name, dates and hours.

Participation code: Indicate code.

Activities Align with Participation code:

Activities are up-to-date and reflect participant progression: Goals and activities build on each other.

Scheduled/verified hours entered: Timesheets are entered by the 12th of the following month. Participants are held accountable for late timesheets when appropriate. Hours are entered correctly.

Overcoming Obstacles

Initiated support services conversation with participant: Noted in case notes.

In the last 6 months appropriate use of support services, including incentives were provided: Ensure support service discussions are in case notes and indicate when approved or denied. Include what supports were provided and any suggestions for other supports.

Support services documented in case notes and file if additional documentation is needed: Estimates, receipts, etc.

Appropriate planning for transportation: Have discussed GNG, R2G, and transportation goal(s), and noted in case notes.

Appropriate planning for housing: Have discussed rental subsidies, rental assistance, and long term housing goal(s), and noted in case notes.

Contact with Participant—Increasing Connections

Evidence of key Reach Up frameworks (strength-based practice, family-centered practice, behavioral economics, financial empowerment): Case notes reflect case manager's knowledge of and use of key frameworks and best practices in conversations and actions with participant.

2Gen Approach (childcare discussed, authorization offered, school performance discussed, higher education opportunities shared): Consider if it is easy to know who the children are in the family based on case notes.

Frequency of contact meets intensity of need: Minimum of monthly contact with case manager, more as situation requires. Text messaging and email utilized when available.

Home/community meetings offered: Offered and participant preferences documented.

Appropriate referrals to support goals (employment and training, education, SU/MH): Case notes provide clear identification of services providers and next steps. Include what referrals were made and any suggestions for other referrals.

Offered and arranged 3-way meeting at time of referral with partners, such as with ES, SSS, or MH/SU CM.

Add any notes from observed meeting/interaction between case manager and participant: This is a space to enter any observations the supervisor made while sitting in on the case manager meeting with the participant.

Electronic Case File Management

Electronic file is organized by brads: General set up of electronic case files follows procedure.

Necessary documents are saved to the electronic file in the appropriate brads: Consider if any type of document is missing from the file.

Documents are saved with the proper naming convention- date, document type, participant initials: Example—10.21.21 TPS MB or 10.21.21 GNG Transportation Points MB.

Case notes are up to date with no big gaps in time, objectively document meeting content and participant progress, and entries include type of contact and next appointment: Entered for each contact with participant.

Appropriate Releases of Information: Releases obtained for all appropriate referrals and other community partners.

Conciliations, sanctions and 60-month closures

Efforts to engage participant prior to Good Cause, conciliation, sanction/closure are pursued:

Good Cause: Pursued and documented, if good cause is found conciliation/sanction is removed.

Conciliation forms: Resolution matches reason for conciliation.

Sanction forms: Reasons letter is available.

Form 606 completed, signed and dated:

Sanction entered into ACCESS:

ACCESS

TODOs in ACCESS are up to date: Check for specific case and for entire caseload.

CATN notes used appropriately: Consider if anything is missing that should be CATNed.

Wrap Up

Next Steps/Due Date section of the spreadsheet. Issues in need of follow up are noted. For example, reference to UNCOPE or PHQ2 was not in case notes. This should be highlighted as a next step with a due date for the Reach Up Supervisor to follow up on.