Texas Community Services Block Grant
Case Management Manual

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Table of Contents

PURPOSE OF MANUAL

Purpose

The purpose of this manual is to outline guidelines for Community Service Block Grant (CSBG) case managers in Texas. Some of the items discussed in this manual are requirements but most are recommendations for provision of case management according to best practices. CSBG Case Management Forms are available for case managers to document services. It is recognized that some programs will develop their own forms and documentation systems and best practices for documentation are therefore identified throughout the manual.

It is hoped this manual is used for training of new CSBG case managers but also as an ongoing resource for case managers to refer to throughout service provision.

The manual was developed through the Texas Association of Community Action Agencies and a contract with Cossy Hough, LCSW.

OVERVIEW OF CASE MANAGEMENT

Case Management Expectations

Case Management is a service provided on an ongoing basis that includes individual assessment, service plan development, arranging for necessary services, follow-up, and ongoing monitoring of client's status and the services delivered.

Through the provision of case management, clients access the services needed through a network of social service providers in the community. Case management provides a mechanism for managing a service delivery system that is fragmented and complicated.

An effective case management system requires that case managers be aware of the full array of appropriate services available to a client.

The following are expectations of an adequate case management system:

- Persons who are most in need of case management services should be identified;
- Persons who are most in need of services and are willing to be full partners should receive first priority;
- Continuity of service should be established and maintained;
- The specific needed services for clients should be identified and coordinated;
- Needed community services should be developed so that clients have the greatest opportunity to receive the best service delivery;
- The personal strengths, interests and self-image of clients should be reinforced and enhanced.

Case management programs should also track client and community outcomes for services provided. A more in depth discussion of outcomes and benchmarks is included in the Service Plan and Quality Assurance portions of this manual.

Key Case Management Concepts

1) **CSBG case management is comprehensive and client - centered:**
The client's unique needs must drive the focus of the process. Case managers ask, "Who are you, where are you now, where do you want to go, and how should we work together to get you there?"

2) Clients should involve their household or significant others:
Encourage the client to involve his/her household or significant others in achieving goals in the Service Plan. For client goals to be met and for the household to achieve self-sufficiency, household members must be included in case management service provision. For additional information on inclusion of household members in services see Client and Household Involvement in this manual.

3) **The case manager and the client are partners:**
They work as partners by sharing responsibility for the achievement of the goals spelled out in the Service Plan (see Service Plan Development in this manual). A successful case manager fosters a client's ability to become more independent over time.

4) **There is mutual respect between clients and case managers:**
The client needs to be comfortable enough to share personal thoughts, dreams and frustrations. Case managers convey respect through their awareness of communications skills and styles, and they understand when a client needs assistance from a counselor or other service providers.

5) **The case manager and the system are accountable:**
For a client to trust and respect the case manager, and for effective coordination of services to succeed, the case manager must hold himself/herself and the network of community services accountable. Case managers should view timely follow-up with clients and community service providers as crucial.

6) **Case management involves creative problem solving:**
The case management system must be flexible enough to accommodate change when needed. Case managers need to be prepared to handle a wide variety of client/household needs as well as how to problem-solve when faced with barriers to goal attainment.

7) **Case management relies on a network of services and support:** The case manager must work within a network of community service providers, and should make sure that clients and service providers are kept informed of each other's activities. Case managers mediate between network members and intervene on behalf of the client when necessary.

8) **Case management requires partnership at the systems level:** Case management must be supported and maintained by a partnership among the case management staff of the various organizations that make up the network of community service providers. Establishing and maintaining relationships with community service providers and organizations will help meet client goals. For additional information on community involvement and partnerships see the Service Coordination and Advocacy portion of this manual.

General Documentation

Case managers must document all services provided to the client/household. This includes contacts with the client/household as well as contacts with community service providers and others in order to coordinate services and provide advocacy.

Some general guidelines for documentation include:

- **Make documentation objective**. Avoid language that judges the client or can be misinterpreted. Describe behavior instead of documenting subjective statements (For example: "The client was crying and said he hadn't been sleeping" instead of "The client was depressed.")
- **Documentation should tell a complete story.** If another case manager picks up the client record, he/she should be able to tell exactly what has and hasn't been done to assist the client. Documentation of services should be descriptive and in enough detail for others to be able to determine the sequence of events.
- **Documentation should be completed in a timely manner.** Everyone gets behind from time to time but the sooner client contacts are documented, the more complete the documentation will be. Don't go more than a couple of days without documenting services.
- **Documentation supports the goals of the case management program.** Documentation can say a lot about what work the program is doing and how clients are achieving goals. When case managers don't document comprehensively they are selling short the work they do.

It is a best practice for case managers to sign and date all completed documentation. Case managers are also encouraged to have clients sign a participation agreement in his/her preferred language. An agreement form can be found in the CSBG Case Management Forms.

Suggested forms for documentation of case management services are available as a supplement to this manual. CSBG programs can modify these forms to be responsive to the needs of their clients. Programs should establish a consistent documentation system among case managers within their agencies.

CLIENT PARTICIPATION IN SERVICES

Establishing a Relationship

Several studies in case management have shown that the relationship between a client and case manager can have a great impact on a client/household reaching their goals. Clients respond to regular, consistently scheduled follow-up as well as access to their case managers in times of crisis. The relationship starts with the first meeting with a client and establishment of rapport as well as an environment of trust.

Some ideas/tips for establishing a connection are:

- **Ask open-ended questions.** Closed ended questions can be important in gathering information but clients are more likely to open up when asked questions that can't be answered "yes" or "no" such as:
    - "What do you think about….?"
    - "How do you feel about…..?"
    - "What are some ideas you have…..?"
- **Explain case management services and confidentiality.** An explanation of services can let clients/household members know what to expect. Also, having a conversation about confidentiality, including when confidentiality would need to be broken (in case of danger to self or others, see more under Confidentiality and Abuse Reporting in this manual).
- **Show empathy.** There is a difference between sympathy and empathy. Making statements of empathy to the client show that the case manager is really listening and understands what he/she is saying. Some statements that show empathy are:
    - "That sounds really tough."
    - "You sounded (sad, angry, upset, happy, frustrated, etc…) when you said….."
    - "I wonder if you are feeling (feel word) about that."
    - "I am sorry that happened to you."
- **Avoid judgment**. Watch questions and comments that may lead the client to feel judged (for example: comments that question a client's abilities to find and keep a job or transition out of poverty). Judgmental comments can damage relationships between clients and case managers.
- **Ask clarifying questions when you need to.** Case managers shouldn't be fearful of asking questions to clarify the client's meaning or actions

with an issue or topic. Clarifying questions show the case manager is listening and invested in hearing what the client has to say.

- **Give opportunities for clients to ask questions.** Case managers can manage the pace of client conversations and assure clients understand what can sometimes be complex issues in case management by asking what questions the client has. Make these open-ended questions as well such as:
    - "What questions do you have?"
- **In general, don't underestimate the power of the process with clients.** Case management tends to focus on resources and outcomes but clients will be more invested when case managers show they are committed to the relationship.

Client and Household Involvement

In general, people are more motivated to participate in a process when they are involved with planning the process. Clients should be involved heavily in the case management process. Clients should be involved in setting goals, actions to follow-up and decisions about resources.

The concept of household involvement should be explored at the onset of services with clients/household members. Clients should be told when case management services are initiated that involvement of household members is an important part and vital to the success of case management services.

Clients will participate, in the most obvious way, in the goal setting process when the Service Plan is developed. Clients may be asked to take the lead in formulating and prioritizing goals. Case managers should let clients know what services are available and let the client take the lead from there.

Clients should be encouraged to take an active role in defining tasks to meet goals. Case managers will have tasks to accomplish, as well, but clarifying the client role is important. It is a learning process for clients to be able to access resources and services on their own.

It is equally important that clients be able to choose, when available, what services will best meet their needs. The case manager can define options for the client as far as resources and ask the client to make a choice.

The comfort and skill level of clients in active participation in case management services will vary greatly. Case managers should assess the level of involvement possible, taking into consideration factors such as the client's reading and education levels and language spoken.

Case managers should try and involve the household in provision of case management as much as possible. Often, the needs of households are complex and difficulties in household dynamics may impact their ability to move out of poverty. For example:

- A single parent may have a child with special needs and lack childcare
- A household may be supporting an elderly parent without any additional income

- A member of the household may be dealing with a substance abuse issue

Case managers need to assess the needs of household members and include all household members' needs on the Service Plan. If a household member is involved in attainment of a goal, that household member's role should also be included on the Service Plan.

COMPONENTS OF CASE MANAGEMENT

Pre-Assessment

Case management services are available to all persons eligible for services and who are willing to be full partners.

The Pre-Assessment is completed once staff has identified someone potentially eligible for case management services. The Pre-Assessment may provide the information necessary for the case manager and/or staff to screen interested individuals and determine the appropriateness of the provision of case management services. CSBG programs may also determine eligibility for case management prior to completion of the Pre-Assessment and use the Pre-Assessment to gather additional information.

Factors to consider in selection of clients for CSBG case management include:

- The household's level of poverty using the current US Poverty Guidelines (See Resources for guide)
- The need for case management assistance
- The potential for transition out of poverty, for example:
    - The potential for the client/household to change their employment status
    - The potential for greater stability for the client/household
    - The client/household's history in making commitments to long term changes
    - How goal oriented the client/household appears to be

It may be unclear, in some cases, whether a client/household can benefit from CSBG case management services. Case managers are encouraged to discuss these cases with other case managers within their agency and their supervisor in order to make an informed decision.

In completing the Pre-Assessment form, the case manager receives information from the client/household to determine their needs and the level of service needed.

A program should have a system for recording all client information, including the securing of factual information pertinent to the request/need. Programs may use the Pre-Assessment form, as included in the CSBG Case Management Forms, for documentation. This form is designed to be completed by the

client/household but may also be completed by program staff. The Pre-Assessment should be completed in the client's preferred language.

CSBG programs have the option of completing the Pre-Assessment and Integrated Assessment together and combining the documentation into one form.

Pre-Assessment documentation should include, at a minimum:

- Client and household demographics
- The household's poverty level
- Identification of the initial needs of the client/household
- What the client/household desires to receive from case management services

Integrated Assessment

The Integrated Assessment is an in-depth evaluation of all issues that impact the short and long term well being of the client and their household system. The Integrated Assessment is completed after the Pre-Assessment has been completed and the case manager and/or staff have determined that the individual would benefit from case management services and is willing to be a full partner in the process. CSBG programs also have the option of completing the Pre-Assessment and Integrated Assessment together and combining the documentation into one form.

The process is interactive, focusing on household members strengths, liabilities, opportunities, motivation, and ability to adequately care for themselves. The socio-economic status of the household, cultural influences, strengths, attitudes, and behaviors are explored. The result of completing the Integrated Assessment should be an overview of the household's functioning and needs as well as an outline of the client's level of willingness to participate in services. Completion of the Integrated Assessment leads into formation of goals and action items in the Service Plan (see Service Plan)

Case managers may use the Integrated Assessment form in the CSBG Case Management Forms for documentation of this element. Documentation should include, at minimum:

- Any barriers the client/household has to transition out of poverty.
- An assessment of the client/household's willingness to participate in services and goal setting
- Information about the household's financial and social functioning including relationships and dynamics between household members

If a client/household is still enrolled in case management after a year of services, it is recommended that a new Integrated Assessment be conducted. This should be done to assess the client/household progress in a comprehensive manner.

Service Plan

The Service Plan sets the direction for provision of case management services. After completing the Integrated Assessment, case managers should help clients take the identified needs and create goals and a plan of action.

Before a Service Plan can be developed, case managers should spend some time discussing goals in general with clients. Many people are not familiar with setting goals for themselves and then implementing a plan to reach those goals. Case managers can help by having an open discussion with clients about:

- The client/household's experiences with setting goals
- How the client feels about setting goals
- What will make achieving goals more realistic for the client/household

The case manager should start the goal establishment process by discussing the overall goal for provision of CSBG case management. Ultimately, clients/households will have a final goal of household income at or above 125% of the poverty level but clients will have varying goals to establish this self-sufficiency. It is important to establish what goals mean to the client/household. Some examples may be:

- To have enough income to consistently support the household
- To have stable housing and enough income to cover bills
- To have adequate income to start a savings account

After the overall goal is established, the client and case manager should mutually develop the details of the Service Plan. The Service Plan outlines:

- Goals to meet each need from the Integrated Assessment;
- A description of a course of action or list of steps for meeting each need; and
- A timeframe for goal attainment

Service Plans should contain goals that are objective and measurable. Goals should reflect the desired outcome for case management services. Goals should contain an expected completion date, as well. Clients and household

members should be involved in setting a priority for each goal in order to maximize investment in the case management process and avoid being overwhelmed by the need to complete too many goals at one time.

Example of measurable goals:

Client will obtain full time employment, making, at minimum, $10.00 per hour, by August 1st.

Client will receive Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) by March 25th.

Remember to report outcomes to reporting/funding sources. Tracking and reporting outcomes help to record program accomplishments. The Service Plan can be a way of tracking outcomes through measurement of client/household goal completion.

Once goals are established, case managers and clients should outline steps to achieve those goals. These steps should contain responsibilities of both the case manager and client/household so roles are clear. Case managers may use the Service Plan form in CSBG Case Management Forms for documentation. If this form is used, the case manager should use as many copies of the form necessary to cover all of the client's goals.

Documentation should include, at a minimum:

- Client goals
- Tasks to accomplish those goals
- Timeframes for goal accomplishment

Both the case manager and client should then sign the Service Plan. It is a best practice to assure the client receives a copy of any document he/she signs. If case management services extend beyond one year, case managers are encouraged to update the Service Plan to ensure it reflects current goals.

Follow-Up

Follow-up is the provision of continuing assistance that clients need in order to successfully meet the goals of their Service Plan. Follow-up is necessary to determine the client's progress and what adjustments to the Service Plan may be necessary. Follow-up is also important to the relationship between the case manager and client/household. As follow-up contacts with the client/household occur, a relationship of trust is established. It is this relationship that may have the most important impact on clients/households as they learn new skills and roles.

At minimum, monthly follow-up contacts should occur through the duration of case management provision. The case manager and client/household should set a schedule for how often follow-up contacts will occur. As these contacts are scheduled, the case manager needs to assure consistent, timely follow-up. Consistent follow-up will help establish trust with clients/household members. Time management is essential for case managers tracking and following multiple clients.

The progress and movement through the service delivery system of a person receiving case management services must be monitored by the case manager to determine:

- Client/household adherence to the mutually consensual Service Plan
- What services have been delivered;
- Whether the services were delivered as scheduled;
- If the services are adequate for the client/household's needs; and
- If advocacy is needed on the part of the case manager.

Case managers should also address what the client/household is learning about being able to access services on their own. **The more a client/household learns about how to seek and obtain services independently and advocate for themselves, the more self-reliant they will become. This self-reliance is the ultimate goal of case management services.**

The Service Plan should be reviewed during follow-up contacts and the following questions should be considered:

- Is the client/household getting the services required by the Service Plan?

- Did the services produce anticipated outcomes in terms of the stated goals and objectives?
- Are the services provided in a manner that is beneficial to the client?
- Are the Service Plan objectives appropriate to the client/household members' current needs and desires?
- Do the services maximize available resources?
- Are the services delivered in a culturally relevant and competent manner?
- What assistance does the client/household need from the case manager in order to be successful with their goals?

Follow-up contacts may be documented on the Follow-Up form found in the CSBG Case Management Forms. Documentation of follow-up contacts should include, at minimum:

- The date of the contact
- A review of what the client/household has accomplished
- What assistance the case manager provided during the contact

Case managers are encouraged to document goal completion dates on the Service Plan. This will allow case managers and agencies to more easily track client outcomes.

Service Coordination and Advocacy

Service coordination and advocacy are vital components of case management. Effective case management service provision goes beyond providing referrals and following up with the client/household. It involves coordination of services among service providers and stepping in to advocate for appropriate service provision when needed.

Service coordination refers to the linkage between the client/household and community resources. It is the efficient and appropriate use of available resources to meet the needs of the client/household. Referrals should be provided as appropriate to the needs of clients. Linkage should be established and maintained between case managers and community service providers, both publicly and privately funded, that serve clients/households.

Effective referrals always include follow-up with the client/household and may include coordination with community service providers when necessary. Sometimes it also becomes necessary to intervene on behalf of clients to promote coordination among community resources such as when a rental assistance agency needs to speak with a landlord. Every client is different and case managers should assess how much assistance the client will need as services progress.

It is recommended that detailed directories of services in the community be maintained and updated. At minimum, case managers should maintain their own current resource directories. For maximum effectiveness with client referrals, the directories should include information on:

- The type of client served;
- Eligibility requirements;
- Services provided; and
- Logistics on how to access services (address, phone, email address).

Some limited state and federal resources can be found in the Online Resources for Case Managers section of this manual. Updated directories will assure clients/household members get accurate referral information. Inaccurate information can be frustrating for clients and also serve as a barrier to services. Confidentiality of client records should be maintained in accordance with program standards/agreements. Before specific client information is

shared

between programs and providers, the client must agree to release the information for such purposes (see Confidentiality and Reporting of Abuse).

When clients/household members are having difficulties accessing services, case managers should advocate on their behalf. This often involves conversations with community service providers and other resources to promote appropriate client access. Advocacy should also occur when clients/household members are not treated or accommodated within state or federal law or guidelines such as the Americans With Disabilities Act.

Any service coordination or advocacy efforts should be documented in the case management record.

CSBG programs and case managers must maintain close relationships with community resource agencies and partners. Formal and informal relationships should be established with the agencies that most often serve and refer case management clients. Communities often have established coordinating meetings for agencies with similar purposes and client populations. One of the most successful coordination efforts in Texas has been through Community Resource Coordination Groups (CRCGs) that pull together community agencies to problem solve difficult client situations. More information can be found at: http://www.hhsc.state.tx.us/crcg/WhatAreCRCGS/Overview.html.

Relationships with community agencies can also help prevent duplication of services. Any time another case manager/care coordinator is involved with a client/household, the CSBG case manager must coordinate with the other case manager involved to assure duplicate services are not provided.

Case Management Closure

Each program must develop a procedure for closure of cases of clients/households in case management. Case management requires that services be terminated when the client no longer needs the services coordinated by case management. There may be other reasons for bringing a client's case to closure including:

- Client has reached self sufficiency;
- Client declines services;
- Client cannot be located; or
- A pattern of non-compliance on the part of the client.

Clients should be prepared for closures. It is ideal for the level of service to decrease gradually so that there is not an abrupt stop to services. Since the relationship between the client and case manager can lead to positive changes for the client/household, discussion about case closure and how termination of services is perceived by the client should be undertaken. Case managers are also encouraged to recognize closure and the transition out of poverty with small celebrations. Types of recognition may include certificates of case management completion, letters of congratulations or other creative recognitions.

During the closure process, information should be obtained on the client's satisfaction with the services provided. Programs are encouraged to implement a client satisfaction survey or interview to be implemented at either closure or the final follow-up contact. If clients can no longer be located for service provision, case managers are encouraged to send a letter to the client's last known address to inform him/her of the case closure. Each CSBG program should have a policy outlining how services will be handled if a client cannot be located. CSBG programs should also have a policy that addresses client appeals of denied services and grievances according to requirements outlined in the Texas Administrative Code.

Case managers may document closure of cases using the Closure form in the CSBG Case Management Forms. Closure documentation should include, at a minimum:

- The date of closure

- The reason for closure
- Acknowledgement that the client may still receive other agency services

When case management services are closed, clients/households can still receive additional services from a program for which they are eligible.

90-Day Follow-Up

Case managers should follow-up, once a case has been closed to ensure that the client is functioning well. These follow-up contacts should occur, at a minimum, monthly during the 90 days following the attainment of income at or above 125% of the poverty level. The client/household work status and income should be verified during each of these contacts as well as the household's poverty level (percent of poverty). This will help determine if the client/household has made a long-term change to transition out of poverty.

Follow-up can assist in reinforcing the client's achievements and helps the program track its outcomes. Case managers should inform clients to contact them if they have any changes to their level of functioning/self-sufficiency during this time.

Each contact in the 90 day follow-up period may be documented on the 90 Day Follow-Up form included in the CSBG Case Management Forms but should include documentation, at a minimum of:

- The date
- The household's verified monthly income (with a copy of a pay stub or other proof of income for each contact during this period)
- The household's poverty level status

If at any point in the 90-Day Follow-up period, the household's poverty level drops below 125% of the poverty level, the tracking for the 90-Day period should begin again. Households must demonstrate 90 consecutive days of income at or above 125% of poverty in order to have transitioned out of poverty.

CONFIDENTIALITY AND REPORTING OF ABUSE

Clients have the right to receive confidential services from case managers. What confidentiality means is that case managers will not discuss clients and their household members with others unless the client has given permission for the case manager to do this. Case managers should not disclose information about clients outside of what is absolutely necessary to coordinate services or consult with other professionals within the program about how to proceed with client services. The information clients and household members tell case managers is private and can be sensitive. The client's privacy needs to be protected.

Some tips on protecting confidentiality include:

- **Speaking with the client in as private a location as can be managed.** Sometimes confidentiality can be difficult to protect during home visits or meeting with clients in busy office settings. Case managers should use creativity in thinking about how best to meet with clients to assure conversations cannot be overheard.
- **Don't discuss client situations in areas where confidentiality cannot be maintained.** This includes office hallways, reception areas, restrooms restaurants and other public areas.
- **Protect client records.** Keep all documentation regarding clients in a secure area. Locking client records is the best way to assure others cannot access them.

Case managers must often talk with others involved with the client's Service Plan for the purposes of coordination and advocacy. Clients should be aware this will occur and should sign a release of information indicating their agreement for the coordination to take place.

The CSBG Case Management Forms has a Release of Information that may be used for clients whose case management services will be coordinated with other agencies. The client's signature must be included on a release of information in order to be utilized. The signed form should also be in the language of the client.

There are some exceptions to complete confidentiality without release. If a client or household discloses potential child abuse or neglect or abuse or neglect of someone who is elderly or disabled, this information must be reported to proper authorities regardless of the consent of the client/household.

Case managers are required to follow the Texas Family Code, Title 5, Subtitle E, Chapter 261, **"Investigation of report of child abuse or neglect."** This is Texas Law and not specifically addressed by the Texas Department of Housing and Community Affairs. The Texas Family Code includes the mandate to report suspected abuse or neglect by the professional within 48 hours of identification of the suspicion. It is not the case manager's responsibility to determine if actual abuse or neglect of a child or elderly or disabled person has occurred, it the case manager's responsibility to report suspected abuse or neglect. **Failure to report suspected abuse is against Texas Law.**

Reports can be made to The Texas Department of Family and Protective Services at:

1-800-252-5400 or www.txabusehotline.org

Both means of reporting are available 24 hours per day. Any report of potential abuse or neglect must be documented in the client's record.

Case managers also have the responsibility of **reporting to authorities, a person who indicates he/she is a danger to themselves or others.** If someone expresses desire to hurt himself or herself or someone else, this must be reported to local law enforcement. This report must also be documented.

Clients should be told about the limits of confidentiality when services begin. This way, expectations are clear and the client has had a chance to ask questions. Respect is also developed as clients receive education about the professional nature of case management services. Every case manager finds his/her voice around this issue, but **an example of what could be said follows:**

> "Before we get started I want to talk with you about something important. I want you to know that what you say to me will

remain confidential. Do you know what confidentiality means?....It means that what we say will be kept between us unless you have signed something that says I can talk with others about what we are working on. There is one important exception to this, if you tell me you have or plan to hurt yourself or someone else including a child, I will need to report this to the proper authorities. What questions do you have about this?"

HOME VISITS AND HOME VISIT SAFETY

Home visits are one of the best ways to assess clients and households. Case managers who conduct home visits are also meeting clients in their communities and showing their commitment to service provision. The relationship between the client and case manager can grow stronger though the home visits. Not all programs have, within their capacity, the ability to make home visits. Even an occasional home visit in specified circumstances (for instance when clients cannot be located or when a client lacks transportation) could make a case management program more effective for a client.

When making home visits, case managers need to be aware of safety issues. Some tips for safe home visits include:

- **Avoid making unannounced visits.** A letter or call prior to the visit may avoid a surprised client/household.
- **Call the home before you leave to let clients/household members know you are on your way.**
- **Let a co-worker know where you are going and when you plan to be back.** Ideally, programs should have a sign out system.
- **If you need to make a home visit to a household you don't know well, take a co-worker with you.**
- **Have directions and/or a map to the home.**
- **Once at the home, notice your surroundings.** Does anything seem unsafe? Unsecured dogs? Large groups of people in the yard? If you can, call the client to inquire.
- **Once inside the home, introduce yourself (unless you have already) and explain the purpose for your visit.**
- **Notice the location of the exit.**
- **If you notice illegal substances, weapons or the client or a household member seems impaired by drugs or alcohol,** you need to leave the home.
- **Bottom line:** Follow your instincts! If you feel unsafe you need to leave immediately.

The vast majority of home visits are completely safe. Case managers who incorporate home visits into their programs find them to be meaningful for clients and lead to stronger, more effective interventions.

QUALITY ASSURANCE

Each program should have a system for evaluating the quality of the services being provided. The goals of quality assurance are:

- To assure clients are receiving high quality services and access to the services they need.
- To assure as many clients/households as possible are transitioning out of poverty and the transition is sustainable.
- To assure client documentation is appropriate and in compliance with guidelines.
- To assure clients and household members are satisfied with the services being offered.

In order to implement a comprehensive quality assurance system, programs are encouraged to do the following:

- Identify outcomes that will indicate to the program what high quality services look like (Example: 70% of case management records included documentation of advocacy on the part of the case manager) and what goals the program has for client outcomes. Programs are encouraged to develop a small list of outcomes for tracking.
- Identify a benchmark or number of clients and households for transition out of poverty along with a benchmark time frame for the transition to occur. These benchmarks can be changed over time to set realistic goals for the program.
- Identify areas for review in documentation and develop a tool for review of those areas. File reviews can tell a program a lot about what is occurring. The file review tool could also include items to track outcomes once cases are closed. Someone who has training and expertise in the program should conduct actual file reviews.
- Develop and implement a client satisfaction survey. The survey should be, ideally, implemented at case closure or the 90-Day Follow-Up. The survey should be in the preferred language of the client. An example of a client satisfaction survey is included in the CSBG Case Management Forms.

CSBG programs should identify who is responsible for quality assurance activities and how often the activities will occur (monthly, quarterly, etc.).

To pull together a full picture of program process, quality assurance results should be reviewed as a whole at least once per year. Programs will be able to take a look at their accomplishments and plan for the coming year with the information gleaned from the results.

ONLINE RESOURCES FOR CASE MANAGERS

Below are some of the State and Federal resources that may help case managers do their job. This is not meant to be an exhaustive list and case managers need to become experts in the resources available in the community and most needed by their clients.

Texas Department of Housing and Community Affairs, Community Services Block Grant: http://www.tdhca.state.tx.us/community-services/guidance.htm

U.S. Department of Health and Human Services, Community Services Block Grant: http://www.acf.hhs.gov/programs/ocs/csbg/

Assistance for Elderly and Disabled:
http://www.dads.state.tx.us/services/index.cfm

CHIP and Children's Medicaid: http://www.chipmedicaid.org/en

Domestic Violence Resources:
http://www.womenslaw.org/gethelp_state_type.php?type_id=1646&state_code=TX or http://www.tcfv.org/service-directory

Early Childhood Education in Texas:
http://www.tea.state.tx.us/index2.aspx?id=2147495267&menu_id=2147483718 or http://cli.uth.tmc.edu/our-programs/program-overview/TX-head-start/thssco-map/map.htm

Medicaid Transportation:
http://www.hhsc.state.tx.us/QuickAnswers/index.shtml#Get_Ride

Texas Medicaid Information: http://www.hhsc.state.tx.us/Help/index.html

211: https://www.211texas.org/211/

Finding Mental Health Services: http://www.dshs.state.tx.us/mhsa-mh-help/

Rural Transportation in Texas:
http://www.dot.state.tx.us/drivers_vehicles/public_transit/contacts.htm?type=rural

SNAP (food stamps) Benefit Information:
http://www.hhsc.state.tx.us/Help/Food/FoodStamps/index.html

Social Security Disability Benefits: http://www.ssa.gov/pubs/10029.html

Special Education in Texas: http://ritter.tea.state.tx.us/special.ed/

Subsidized Child Care:
http://www.twc.state.tx.us/svcs/childcare/ccinfo.html

Subsidized Housing:
http://www.hud.gov/local/index.cfm?state=tx&topic=renting

Temporary Assistance for Needy Families:
http://www.hhsc.state.tx.us/Help/Financial/Temporary_Assistance.html

Texas Tenant Advisor: http://texastenant.org/

Texas Workforce Commission: http://www.twc.state.tx.us/

Vocational Rehabilitation: http://www.dars.state.tx.us/drs/vr.shtml

APPENDIX: SAMPLE FORMS

Case Management Pre-Assessment

I. DEMOGRAPHICS

Name: _____

Address: _____

City: _____ Zip Code: _____

Phone Number: _____ Other Phone: _____

Date of Birth: _____ Gross Income: _____

II. HOUSEHOLD INFORMATION

Marital Status (Circle One): Married Divorced

Separated Widowed

How many children do you have (circle one): None 1 2 3 4 5 6 7 8

More than 8

What type of housing do you live in (circle one)?

Rent Own Public Assisted

How many bedrooms are in your home? _____

How much do you pay for housing per month? _____

III. EDUCATION

Did you graduate high school or do you have GED? Yes No

Have you taken any college classes? Yes No

If you have taken college classes, what topics have you studied?

_____

_____

_____

Have you taken classes in a vocational school? Yes No

If you have taken classes in a vocational school, what type of classes did you take?

_____

_____

_____

IV. EMPLOYMENT

What is your job situation (circle all that apply)?

Full Time Job

Part Time Job

Do not have a job but have had a job in the last 30 days

Receiving unemployment

Receiving child support

Receiving TANF

Receiving disability checks or SSI

Retired and receiving benefits

Other: _____

Are you healthy enough to work? Yes No

List current employer (if applicable):

_____

_____

_____

Have you served in the military? Yes No

If you have children, are they in school? Yes No

If you have children, do you have childcare? Yes No

V. TRANSPORTATION

Do you have a car? Yes No

If you do have a car, is it in good condition? Yes No

If you do have a car, is your insurance and registration current? Yes No

Do you use the bus? Yes No

Do you have enough money to pay for transportation (either car or bus)?

Yes No

VI. HEALTH

Do you have health insurance? Yes No

If you do have health insurance, what type do you have?

_____

_____

Do all members of your household have health insurance? Yes No

Where do you go for health care?

_____

_____

_____

Do you have enough food in your household for all members to have three meals a day?

Yes No

VII. ASSISTANCE NEEDED

What do you need assistance with (circle all that apply)?

Food

Utility Bills

Weatherization

Rent/Mortgage

Job Assistance

Household Items:

Other:

What led you to seek help today?

_____

_____

_____

_____

_____

_____

Signature: Date:

For Office Use

Case Management Eligible? Yes No

Poverty Level (Percent):

Reviewed By:

Date:

Participation Agreement

Client Name: _____ DOB: _____

I, _____ (name of client), agree that I would like to participate in Case Management Services. I understand that I need to be an active participant in services in order to achieve my goals. I also understand that members of my household will be active participants in Case Management Services. I agree to meet at least monthly with my case manager.

Signed:_____

Print Name: _____

Date: _____

Release of Information

Client Name: _____DOB: _____

I give permission to _____ (name of agency) to share any information necessary with other individuals or organizations in order to provide case management services and secure resources on my behalf. I understand that information will only be shared when necessary to meet the requirements of my established service plan. I authorize _____ (name of agency) to share my educational and employment records with individuals and organizations as needed.

Signed:_____

Print Name: _____

Date: _____

Integrated Assessment

I. DEMOGRAPHICS

Client Name: _____

Case Manager: _____

Date: _____

II. PRESENTING PROBLEM

Describe the presenting problem that caused the client to seek services:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

III. ASSESSMENT AREAS

<u>Circle or indicate household status</u>. Add comments when needed.

Housing

Homeless or Pending Eviction
Spends more than 20% of income on housing
Affordable Housing, rental
Affordable Housing, Own

Comments:

_____

_____

Utilities

One or more utilities off or due for cut off
Spends 15% or more of income on utility cost
Usually pays utility bills on time
Affordable bills, less than 10% of income

Comments:

_____

_____

Employment

Unemployed; without work history
Unemployed; has work history or Working Part Time
Working full time for minimum wage or working part time (attending school) OR permanently disabled
Working full time, income at or above needs

Comments:

_____

_____

Education

Reading, writing, basics skills absent
Has some education but needs English as a second language OR limited reading, writing and math skills
High School Diploma or GED
Post High School Education

Comments:

_____

_____

Transportation

No access to transportation
No license and/or insurance but drives or depends on others OR no access to public transportation
License but no vehicle or unreliable vehicle. Occasional access to public transportation
Access to public transportation or vehicle, all transportation needs met

Comments:

_____

_____

Health

No health coverage for adults or children
Insure for some members of household
All members covered with subsidized insurance
Private insurance covers household members

Comments:

_____

_____

Income

No income, not receiving public benefits
Receiving public benefits or child support which is inadequate for expenses OR income inadequate for living expenses
Income adequate for basic living expenses, Needs budgeting skills
Income adequate for basic living and discretionary spending

Comments:

_____

_____

Mental Health

Current mental health issues, negative behaviors or substance abuse, Intervention needed
Previous referral for mental health services without follow through, No current issues
Actively involved in mental health or substance abuse services
No counseling, parenting classes, mental health or substance abuse needs

Comments:

_____

_____

Child Care

No child care
Relies on family and friends for child care
Subsidized child care
Children are in an affordable, private child care program OR no children

Comments:

_____

_____

Nutrition

Unable to afford food, no access to public programs or food pantries OR not able to cook
Supplements food with public benefits and access to food pantries OR access to Meals-on-Wheels
Able to afford basic food items without access to public benefits or food pantries, Eats at least one balanced meal per day
Able to afford a wide range of food choices and regularly eats from all food groups

Comments:

_____

_____

IV. STRENGTHS

What does the client think he/she is good at?

_____

_____

_____

_____

_____

_____

What success has the client had in the past in getting his/her needs met?

_____

_____

_____

_____

_____

_____

If the client could wake up tomorrow and all his/her problems are gone, what would that look like?

_____

_____

_____

_____

_____

_____

V. GOAL SETTING

What has been the client's experience with forming and meeting goals in the past?

_____

_____

_____

_____

_____

_____

How does the client feel about setting short and long-term goals?

_____

_____

_____

_____

_____

_____

What are the client's personal goals for his/her life and career?

_____

_____

_____

_____

_____

_____

VI. BARRIERS

What does the client perceive as the primary barriers to achieving his/her goals?

_____

_____

_____

_____

_____

_____

How has the client handled these barriers in the past?

_____

_____

_____

_____

_____

_____

VII. IMPRESSIONS

What are the case manager's perceptions of the motivation and opportunities the client has?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VIII. NEEDS TO BE ADDRESSED

List Needs to be Addressed:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Case Manager Signature: _____

Case Management Service Plan

Client Name: _____ DOB: _____

Overall Goal at the Completion of Case Management: _____

_____

List at least one goal for every need identified in the Integrated Assessment. Use as many pages as necessary.

Goal: _____

Steps to achieve goal:

_____

_____

_____

_____

Expected Completion Date of Goal: _____Date of Goal Completion: _____

Goal: _____

Steps to achieve goal:

_____

_____

_____

_____

Expected Completion Date of Goal: _____Date of Goal Completion: _____

Case Management Service Plan
Signature page

I agree to participate in the Service Plan goals as we have outlined to the best of my abilities. I consent to my case manager contacting others service providers in order to coordinate the tasks in this plan.

Client Signature: _____

Date: _____

Case Manager Signature: _____

Case Management Follow Up Documentation

Client Name: _____

Date: _____

Meeting Notes:

_____

_____

_____

_____

_____

_____

Case Manager Signature: _____

Date: _____

Meeting Notes:

_____

_____

_____

_____

_____

_____

Case Manager Signature: _____

Case Management Closure

Client Name: _____

Date: _____

Reason for Closure (circle):

Goals met

Unable to locate client

Transition out of Poverty

Client no longer desires services

Other:

Comments:

_____

_____

_____

_____

_____

Case Manager Signature: _____

90 Day Follow Up

Client Name: _____

30 DAY FOLLOW UP

Date: _____ Income: _____

Poverty Level According to Household Size (Percent): _____

Proof of Income Collected?

Yes No

60 DAY FOLLOW UP

Date: _____ Income: _____

Poverty Level According to Household Size (Percent): _____

Proof of Income Collected?

Yes No

90 DAY FOLLOW UP

Date: _____ Income: _____

Poverty Level According to Household Size (Percent): _____

Proof of Income Collected?

Yes No

Transition out of Poverty? Yes No

Case Manager Signature: _____

Case Management Client Satisfaction Survey

Please take a few minutes to answer these questions about the case management services you received from: _____ (case manager name).

Answering these questions will help improve our services. Thank you.

Circle your response:

My case manager explained case management to me.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

My case manager helped me find services that I needed.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

I am better able to find services I need since I received case management services.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

I am better able to provide for myself and household because of case management services.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

I would recommend case management services for a friend or household member.

Strongly Agree Agree Not Sure Disagree Strongly Disagree

Date: _____