

The specific services we are licensed and contracted to provide are defined as:

Case management-identifying issues, assessing bio-psycho-socially, goal planning, linking to services, monitoring delivery of services, and evaluating services and supports for enrolled members. Case management will be delivered as needed, up to three times per week. An individual requiring a higher level of support will be referred for additional services. Typical case management delivery occurs once per week, for an hour.

Daily living supports-designed to assist the individual in maintaining the highest level of independence possible. Without such supports the individual would not be able to remain stabilized and may require crisis intervention or hospitalization. Included in daily living supports are cueing, coaching, and modeling activities as appropriate relating to hygiene, medication compliance, housekeeping, laundry, nutrition, and appropriate self care. Individuals will receive daily living skills support as necessary, based on assessment and willingness to engage with the provider about such.

Skills development services-assisting clients with learning the skills necessary to access community resources, increasing and teaching independent living skills (how to use public transportation, how to budget, introduction to 12 step programming, how to manage stress and mental health symptoms, communication skills, and conflict resolution skills). Skills development will be delivered as needed, and will include supportive counseling services when a member is experiencing difficulty or a crisis. Generally speaking, supportive counseling is not therapy and is not designed to provide a level of care provided through a residential or intensive outpatient program. Skills development will also include utilization of natural supports (friends, peers, family) and other supportive services available in the members' surrounding community (support groups, warm lines, volunteer opportunities).

Clients who are enrolled into Community Support will have an individualized service plan (ISP) developed with them by their case manager. The ISP will identify short and long term goals, as well as duration of plan, a description of services and supports needed, documentation of the clients' unmet needs, and a review of such plan minimally every 90 days. In addition, a crisis plan will also be developed with the client that will identify specific strategies and steps to take when a perceived crisis arises.

The Community Support worker will also ensure other providers of care (if any) are engaged and following through with their commitments on behalf of the client, will make adjustments to the ISP as substantial changes in the clients' life occur, will advocate and act in the best interest of the client, and will terminate services at a mutually agreed upon time, unless a situation warrants otherwise.

Eligibility for Service:

1. Adult aged 18 or older
2. Have a qualifying mental illness/diagnosis or a co-occurring mental health and addiction issue (individuals who are considered class members are eligible for CI services based on class member status alone, and do not require a major mental illness)
3. Individual demonstrates without this level of care he/she will deteriorate to the point of requiring more intensive services
4. Scores a 17 or higher on LOCUS (staff will administer this assessment)
5. Not currently enrolled in CI with another provider-if you chose YCSPi to deliver your CI services, you will have to notify your previous provider of this change
6. Maine Care as a payer source (we do have some grant money to support individuals with no insurance)

7. Demonstrate a need for case management, supportive counseling, daily living skills, or skills development in some capacity

Desired Outcomes: depending upon your unique situation, the following are some desired outcomes we would hope to see:

1. Increased ability to manage personal difficulties on own
2. Increased ability to complete daily living tasks (ie cooking, doing laundry, house cleaning)
3. Consistency in taking prescribed medications
4. Reduction in symptoms of mental illness (crying, sleeping, hopelessness, hearing voices)
5. If there is a co-occurring SA issue, a reducing in the use of substances to complete abstinence
6. Integration of skills and education building with member to address mental illness or co-occurring disorders (why taking medications may be important, how using various coping skills can impact overall stability)
7. Increased usage of community based supports (AA, NA, support groups, peer support)
8. Self-awareness of how your illness manifests itself in you (anger, frustration, dishonesty)
9. Decreased interaction with crisis providers
10. Decreased need for hospitalization
11. Self-report of “feeling better” about multiple aspects of your life

Discharge Criteria: while not an inclusive list, the following are some reasons why your services can end:

1. You and your CI worker mutually agree you no longer need or are benefiting from CI services

2. You have decided you no longer want CI or YCSPi as a provider of CI and you terminate the relationship
3. You have attained all of your stated goals, with no new goals identified
4. It is determined that the level of care you need is higher or lower than what we offer-when this is the case, we will work with you and refer you to another service YCSPi offers or another provider
5. When you no longer meet the eligibility criteria (see above)
6. You lose the ability to pay for the service (when this occurs, we will do our best to taper you off of services and follow through with any work that has begun with your case manager)
7. You move out of our catchment area (we travel in York County, there are other providers of CI services in other areas of the State)
8. If you enroll into another service that conflicts with CI, or chose another provider to deliver your CI services (i.e. engage another Agency to provide the same service)
9. If you become violent or bring alcohol/drugs onto Agency property and your tenancy in our housing is jeopardized, it may result in termination of CI services, depending upon the nature of what happens
10. If you engage in illegal activity on any Agency property, and your tenancy in our housing is jeopardized, it may result in termination of CI services, depending upon the nature of what happens
11. If we are repeatedly unable to connect with you, we will assume you are no longer interested in services (missing multiple appointments, not showing up at scheduled times, not returning phone calls)

Next Steps:

1. A referral for CI will occur while you are in shelter to the CI team, or if not in shelter, through your inquiry about such, a referral can be made
2. A member of the CI team will meet with you and your current residential case manager within 3 days of the referral to review your progress and your current treatment plan
3. If you are determined by the CI team member to be eligible for CI, such service will be offered to you
4. There will be some basic paperwork to complete for CI, but most of it can come from information you have already given us
5. You will be given an appointment date for your next appointment, staff will “come to you” whether you are in your own apartment or residing in another location
6. Your ISP will be developed shortly thereafter, to identify what you are working on

