City of San José Children and Youth Services Master Plan

DRAFT

City of San José System of Care
No Wrong Door Service Delivery Handbook and Resource Guide

Creating Opportunity Pathways for Children and Youth through the City of San José System of Care with a No Wrong Door Service Delivery Model

Additional formatting and editing will be done to document upon City Council approval.

A Message from the Deputy City Manager, City of San José

At the heart of every community is the desire to ensure that children, youth, and families have access to the support they need to thrive. Imagine walking through any door, in any building, and finding exactly the help you're looking for. That's the vision behind the City of San José System of Care with a No Wrong Door (NWD) Service Delivery—a system designed to eliminate barriers and create seamless connections to services, no matter where someone starts their journey.

The No Wrong Door Service Delivery approach is built on the belief that access to support should be easy, efficient, and centered on the unique needs of each individual. It's more than a pathway—it's a promise. A promise that no matter where someone turns for help, they will find a service provider within a system that is ready to respond with the right resources, compassionate care and coordinated services.

Achieving this vision requires more than good intentions. It demands collaboration, co-design and a commitment to continuous improvement. Together, by identifying and addressing systemic barriers, we can create a network where every door is the right door.

This handbook is a key resource for frontline staff, service providers, supervisors, and community partners who are instrumental in bringing the City of San José System of Care NWD model to life. It offers guidance to ensure consistent implementation across all pilot locations and serves as a tool to support the work you do every day.

Thank you for your dedication and partnership. Your role is vital in shaping a system that truly meets the needs of our communities, ensuring that every child, youth, and family receives the support they deserve—no matter which door they choose.

Angel Rios, Jr.,
Deputy City Manager
City of San José

About the No Wrong Door Service Delivery Model

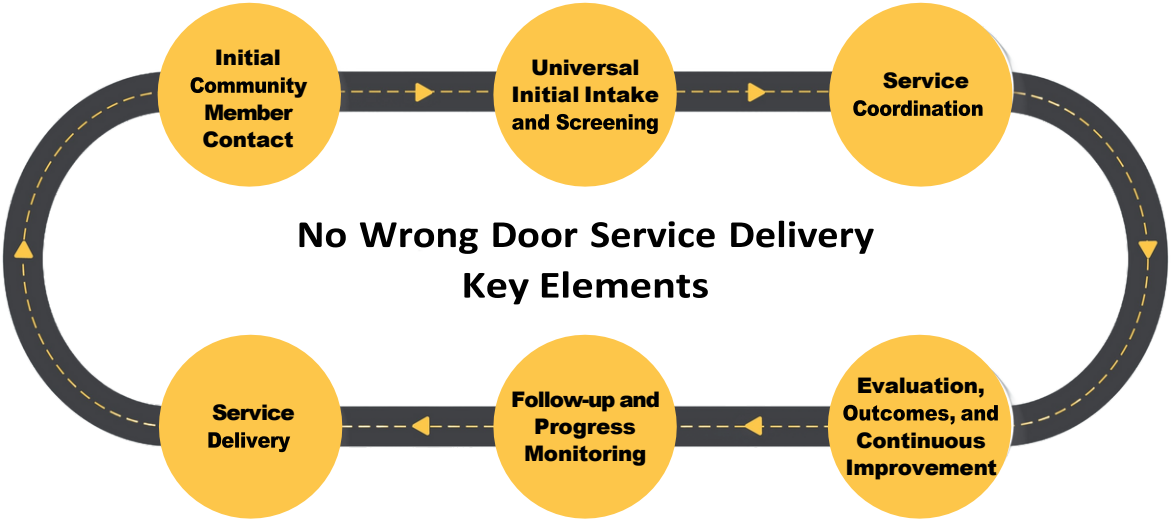
Imagine walking into any door in a massive building, and no matter which door you choose, you find exactly what you need. That is the essence of the City of San José System of Care No Wrong Door with a (NWD) service delivery model—a seamless approach to delivering services where every entry point leads to the right support.

The **No Wrong Door Service Delivery model (NWDSDM)** is a person-centered, coordinated approach designed to simplify access to services and supports, ensuring individuals can receive assistance no matter where they first seek help. A NWD service delivery model has multiple access points, meaning any person can seek services from any participating agency, organization or provider that is part of the NWD and be directed to the right resources without being turned away or sent elsewhere.

Access points can include community-based organizations, government offices, healthcare providers, community centers, libraries, or online platforms. The NWDSDM also uses a streamlined process, including universal intake, screening, assessment, and referral procedures across agencies to reduce duplication of efforts, especially for the person seeking help to avoid retelling their story, see Figure 1.

A strong NWDSDM that integrates a focus on a community pathway ensures services are tailored to the individual's unique needs, goals, and preferences. The community pathway also ensures there is a strong emphasis on empowering individuals to make informed choices and maintain control over their care and support.

Figure 1: No Wrong Door Service Delivery Model Key Elements



City of San José System of Care

No Wrong Door Service Delivery Model Handbook Details:

- **NWDSDM**: A model developed to ensure seamless, person-centered services across access points.
- **Entry Points and Demonstration Sites**: An introduction to the key entry points and demonstration sites where the NWDSDM is tested and refined.
- **Service Delivery**: A step-by-step guide to how individuals are connected to the right services through intake, assessment, and personalized care planning.
- **Service Coordination**: An overview of how multiple agencies and providers work together to deliver comprehensive, integrated support for individuals and families.
- **Continuous Improvement**: A look at how data and feedback are used to refine services, ensuring services remain effective and responsive to community needs.

This Handbook Provides:

Guided by the values of accessibility, equity, and collaboration, the NWDSDM is designed to ensure every individual receives the support they need when and where they need it.

- **Clarity**: Clear insights to support understanding of the NWDSDM model.
- **Consistency**: A unified guide to the model's components, processes, and procedures.
- **Support**: A practical resource for navigating challenges and questions during implementation.
- **Purpose**: To ensure all pilot locations understand and consistently implement the NWD approach.
- **Audience**: Frontline staff, service providers, supervisors and community partners involved in the implementation.

This handbook is a living document, intended to be updated periodically to reflect on going community input and feedback and collaborative learning. Familiarizing yourself with its contents supports our collective knowledge and shared success.

CITY OF SAN JOSE SYSTEM OF CARE

The City of San José System of Care is a coordinated network of services and supports designed to promote well-being, equity and belonging.

At its core, the service pathway entry begins with a welcoming and supportive environment that fosters a culture of care and inclusion.

City of San José System of Care

The City of San José System of Care is rooted in the County of Santa Clara Community Pathway of the Family First Prevention Services, reflecting the county's and city's commitment to a collaborative collective impact approach that creates a seamless system of care. This system bridges city and county services, ensuring families and children receive the support they need across multiple sectors. In partnership with the County of Santa Clara, collaborative partners integrate the goals and principles of the Family First Prevention Services Act and Assembly Bill 2083 throughout the design, development, implementation, and evaluation of the CSJ System of Care. This framework reduces barriers, promotes equity, and enhances the delivery of culturally responsive services, fostering a more accessible and effective multi-tier and cross-sector network.

Benefits of the CSJ System of Care

The CSJ System of Care simplifies and improves access, integration, coordination, and efficiency of service delivery and enhances outcomes:

- **Simplifies access:** Provides clear, consistent pathways to support.
- **Improves efficiency:** Reduces duplication of efforts and maximizes resources.
- **Enhances outcomes:** Focuses on holistic, coordinated care for better results.
- **Promotes equity**: Ensures universal access to quality services regardless of the entry point.

The City and its partners report annually on progress toward the goals of the Children and Youth Services Master Plan, including system transformation and the development of a comprehensive system of care using a no wrong door approach. Rather than duplicating efforts, the City of San José unifies and leverages existing initiatives across the city and Santa Clara County.

CSJ System of Care: A Collaborative Path Forward

The CSJ System of Care reflects the assets, needs, and lived experiences of the community. Through a "Community Co-Design" approach, community members, families, and youth serve as co-creators, ensuring that system are responsive, intentional, and accessible. The vision establishes a seamless person-centered system where individuals and families can access services without barriers.

Community Co-Design

The City of San José remains committed to ensuring the CSJ System of Care reflects the assets, needs, and lived experiences of the community. To achieve this, it was essential to engage all sectors throughout the design, implementation, and evaluation process. The system was not only designed for the community but with the community—positioning residents as co- creators rather than just participants.

The vision was clear: to create a seamless, person-centered system where individuals and families could access services without barriers, no matter where they enter the system. Achieving this vision requires deep community engagement to ensure the model was not only theoretically effective but also practically meaningful to the people it aims to serve.

The co-design process began with a commitment to listening and learning from those directly impacted. Thus, City departments in partnership with community-based organizations (CBOs), youth, families, school districts, County departments, and service providers were all engaged in shaping the model.

- We held listening sessions, engagement meetings, and design workshops, where community members shared their lived experiences, challenges, and aspirations.
- Youth participation was integral. Their perspectives, captured in graphics and visuals like the iceberg model (which illustrated systemic challenges), helped shape the approach.
- The design process prioritized cultural responsiveness, ensuring that the NWD model reflected the diverse needs of San José families.

Equitable access starts with communication, we developed materials in both English and Spanish and Vietnamese, upon request, to ensure that every community member could participate.

- Flyers and promotional materials were created to recruit families and community members into the process.
- CBOs played a critical role in outreach, using flyers, social media, and in-person outreach to invite families to engage in discussions about how services should be structured.
- A registration process was implemented to make participation easy and accessible, ensuring that all voices—regardless of language, literacy, or digital access—were included.

Key Actions:

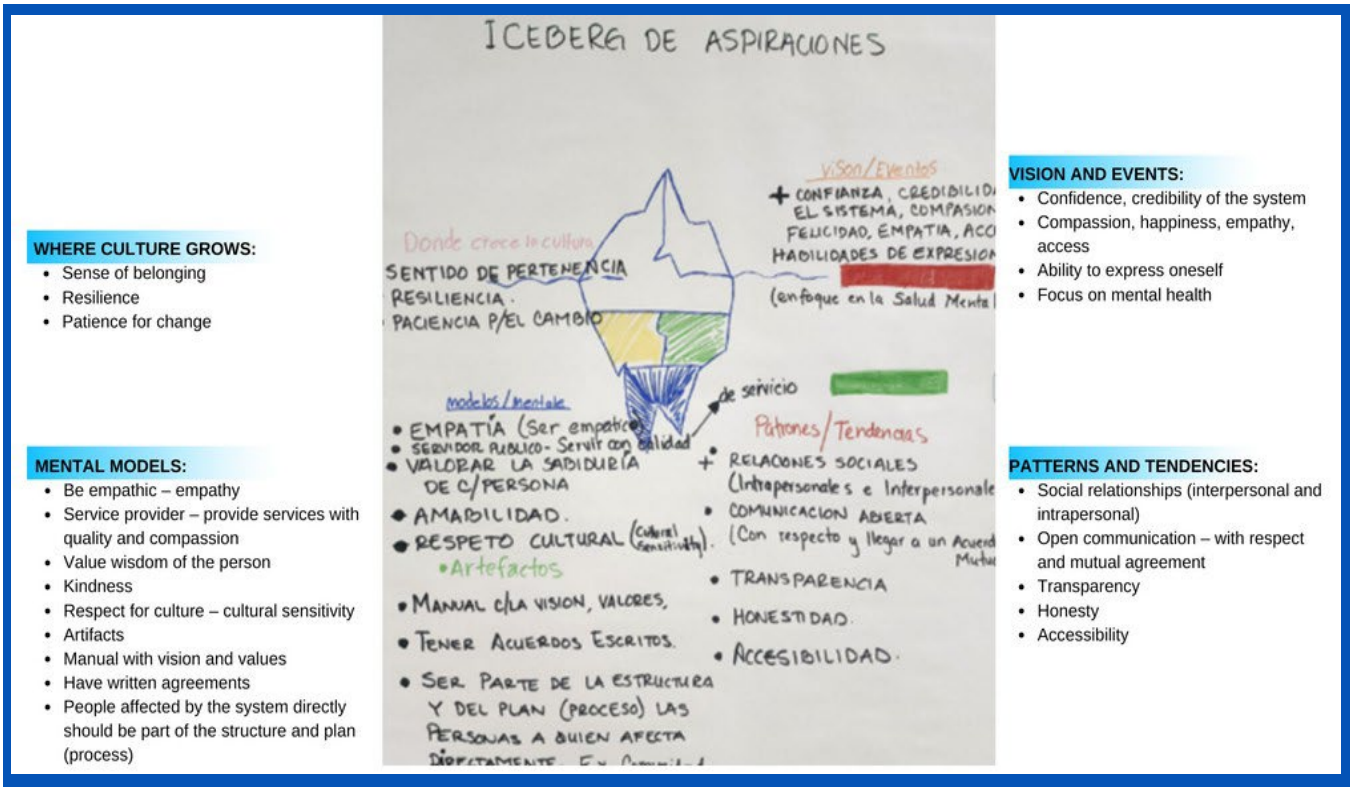
- Flyers were translated and distributed through trusted community partners, supporting grassroots recruitment rather than solely top-down outreach.
- Community members were compensated for their time and lived experience.

The CSJ System of Care was developed through extensive co-design sessions with community members, youth, service providers, and various stakeholders. These sessions emphasized lived experiences and community voice to identify system gaps and co-create solutions.

Community Mapping and Engagement

Community Mapping and Engagement: Participants engaged in exercises to map out current service delivery models, identifying barriers and best practices. One impactful exercise with community participants was the Aspirational Iceberg, see Figure 2. It was used to dig deep into the underlying values, structures, and mental models that show the service delivery experience of the community. This activity encouraged community members to envision their hopes and dreams and collaboratively identify the visible and invisible factors that contribute to the culture and success of the service system.

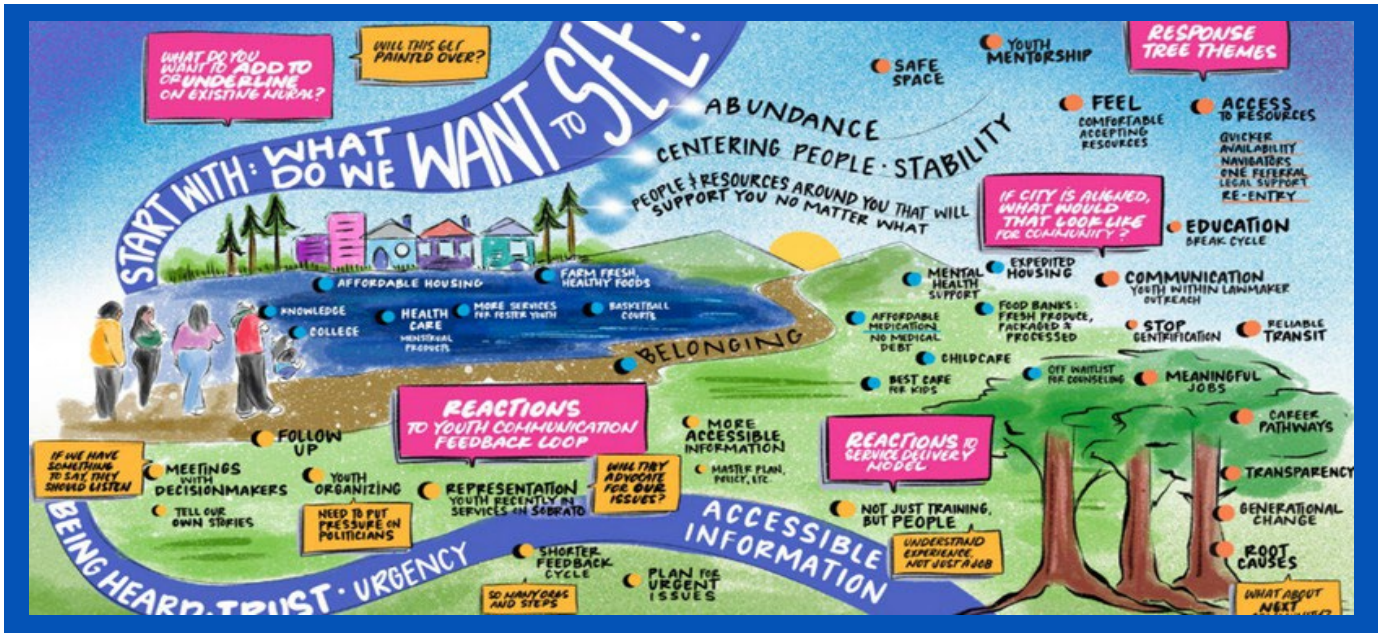
Figure 2: Aspirational Iceberg



The Aspirational Iceberg reveals a profound community vision for a healing and equitable system. This story is about moving beyond surface-level changes and focusing on the root causes of inequity, creating a service delivery model driven by compassion, cultural sensitivity, and shared accountability. By aligning values, patterns, and structures with this vision, the CSJ System of Care intends to be more than a system – but rather a community-driven culture of care and belonging.

Along with the efforts of incorporating family stories and experiences, commitment to centering youth voices was critical to ongoing community co-design. The City of San José, in partnership with Sobrato Philanthropy and Collective Impact Solutions, centered youth as key stakeholders in the transformation of the service delivery system, see Figure 3. The Sobrato Youth Engagement effort was grounded on the CYS Master Plan vision***: fostering a future where every child and youth in San José thrive—becoming resilient, self-sufficient adults with access to abundant opportunities to live, work, and prosper in the vibrant landscape of Silicon Valley.*** It is critically important that that the voices of young people—those most affected by these services — continue to be heard and acted upon.

Figure 3: Sobrato Youth Engagement Visioning



Thus, youth participation was integral to the co-design process. Their perspectives were captured in graphics and visuals—a model that illustrated systemic challenges and helped uncover the underlying values and structures that needed transformation. This exercise allowed youth to reimagine their city and co-identify the visible and invisible factors contributing to the culture and success of the service system. These activities revealed a profound community vision for a healing and equitable system, focusing on moving beyond surface-level changes to address root causes of inequity.

This was a story about building a service model driven by compassion, cultural sensitivity, and shared accountability. By aligning values, patterns, and structures with this vision, the CSJ System of Care became more than a system—it transforms into a community-driven culture of care and belonging.

County of Santa Clara System of Care Alignment

The CSJ System of Care integrated the County of Santa Clara's Community Pathway elements, emphasizing collaboration under the Family First Prevention Services Act and Assembly Bill 2083. This alignment ensures a continuum of services from prevention to intervention, meeting families' needs at every stage. The overarching intent is to reduce child welfare involvement through early intervention strategies that mitigate risks. As well as enhance community well-being by providing culturally responsive supports that built resilience.

Integrated System of Care

By aligning CSJ and Santa Clara County's systems of care, the framework:

- Ensures accessibility by reducing bureaucratic hurdles for families.
- Promotes equity by addressing systemic barriers.
- Strengthens partnerships through cross-sector collaboration.

NO WRONG DOOR

City of San José System of Care
No Wrong Door Service Delivery Model

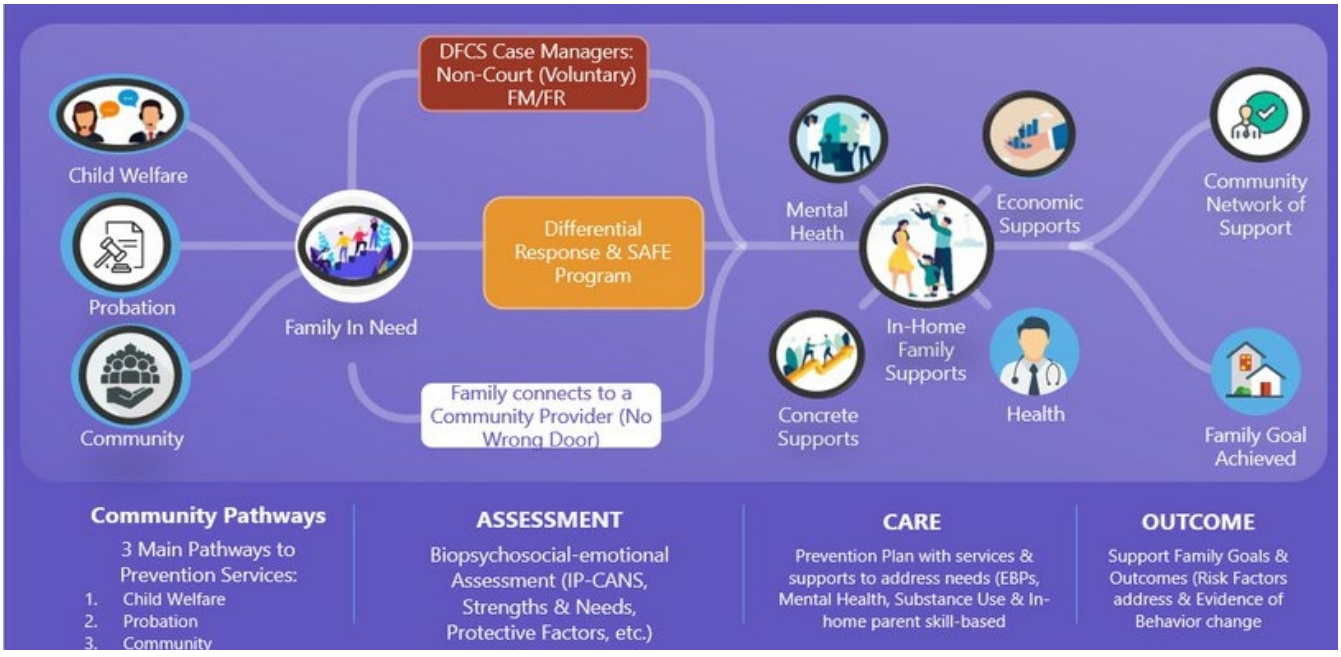
The City of San José System of Care, designed with a No Wrong Door Service Delivery Model (NWDSDM), ensures multiple agencies and service providers work together to maintain a continuity of care, reduce fragmentation, and address service gaps. Developed in collaboration with community-based organizations, school districts, city and county departments and other stakeholders, the system of care design and refinement will continue through shared tools, processes, evaluation framework, and data system platform in the launch and implementation of a pilot phase in spring 2025.

No Wrong Door Service Delivery Model

The No Wrong Door Service Delivery Model includes a continuous, integrated service delivery to ensure families experience seamless transitions between services with ongoing monitoring and feedback loops, see Figure 4:

- Initial contact and engagement
- Intake and screening
- Multidimensional assessment
- Service coordination and delivery
- Follow-up and monitoring
- Outcome evaluation and continuous improvement

Figure 4: No Wrong Door Service Delivery and Alignment with County of Santa Clara System of Care Community Pathways



Demonstration Site and Entry Point Implementation

The City of San José Children and Youth Services Master Plan serves as a strategic roadmap to guide policy priorities, investments, and service alignment, aiming to improve health outcomes and economic mobility for children, youth, and young adults.

The City of San José System of Care alignment with the County of Santa Clara centers the voices and lived experience of youth and families throughout the design, implementation, and delivery of services. This partnership creates a community- wide service pathway, leveraging county resources beyond the City's scope.

What is a demonstration site?

A demonstration site provides an opportunity to pilot new programs, models, or strategies in real-world settings. he key elements, and tools, processes, best practices, services, and strategies of the City of San José System of Care No Wrong Door Service Delivery Model are tested and refined by addressing challenges and barriers through scalable solutions.

Overview of NWDSDM Entry Points

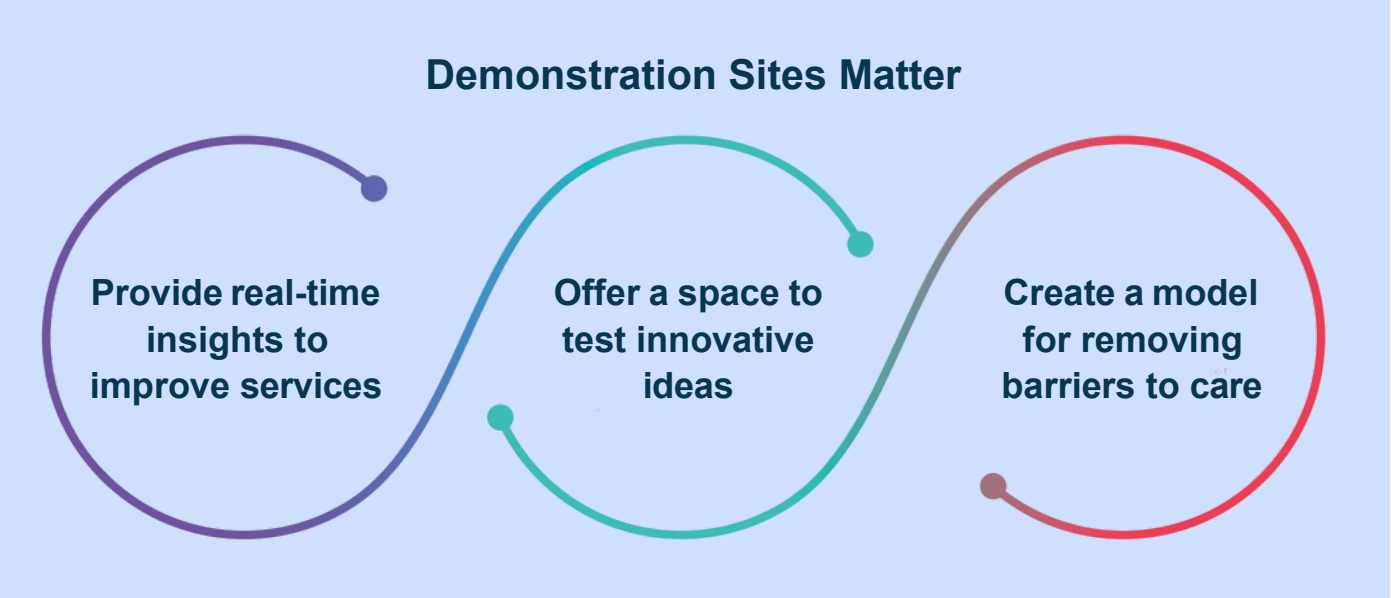
The CSJ System of Care ensures children, youth and families have improved access to services they need through multiple entry points, regardless of where their journey begins. City departments, schools and school districts, County departments, community-based organizations, and a cross-sector of partners play a vital role in coordinating services within an integrated service network.

Demonstration Site Implementation

The City of San José established two demonstration sites in partnership within community-based organizations, school districts, county departments, families, youth, and other community stakeholders to test and refine the No Wrong Door Service Delivery Model. These sites serve as multi-functional hubs providing:

- Central intake points to streamline referrals.
- On-site support services to address diverse needs.
- Community input sessions to ensure responsiveness.

By integrating intake, assessment and coordinated service delivery, the model eliminates systemic barriers and builds sustainable solutions for underserved communities.



Collaboration and Continuous Improvement

The success of the CSJ System of Care relies on collaboration with a cross-sector of stakeholders to create an integrated, measurable service delivery approach. Each demonstration site will conduct real-time evaluations of infrastructure, data, and services to identify challenges, refine processes and highlight best practices.

By fostering ongoing assessment and adaptation, the System of Care remains responsive to the evolving needs of San José children, youth, and families while developing a replicable framework for seamless access to services.

DID YOU KNOW?

The goal is to build a model that can be replicated citywide to make services more accessible, effective, and family-friendly.

Assessment and Evaluation Process

Throughout the implementation of the City of San José System of Care with a No Wrong Door Service Delivery Model an assessment and evaluation process will be ongoing. This will include reviewing service delivery reports, district and community data; conducting school site learning walks to observe current practices; and holding empathy interviews and listening sessions to capture lived experiences. These assessments ensure demonstration sites are guided by real-time data, community feedback and systemic analysis, providing a foundation for sustainable improvements.

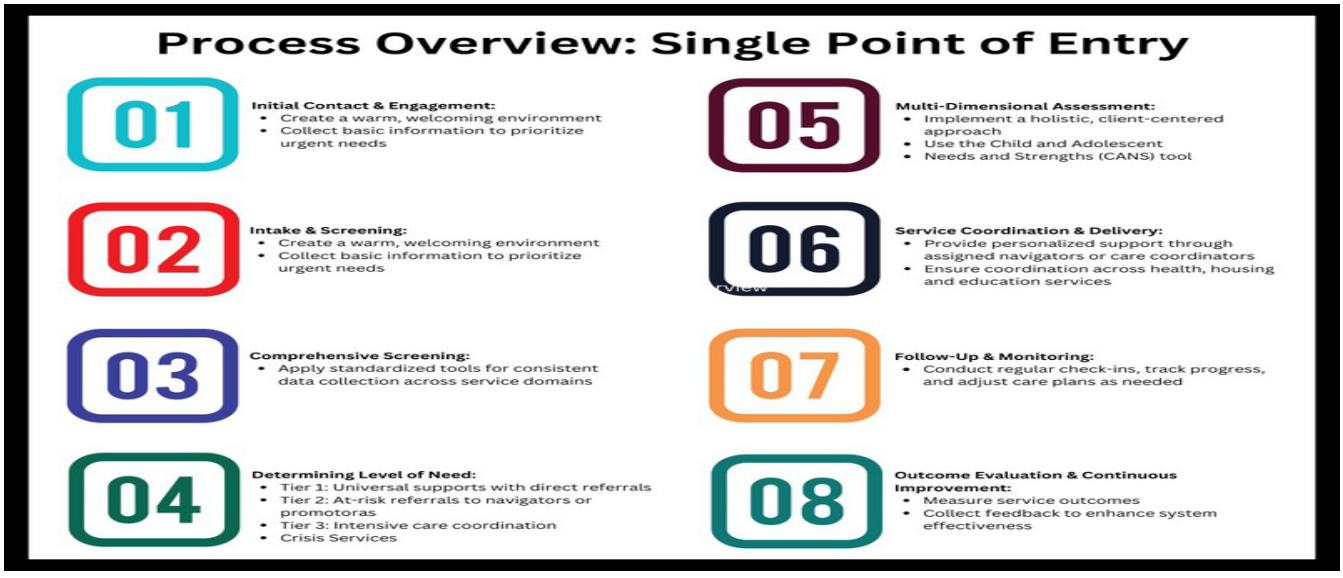
Single Point of Entry (SPE) Overview

The CSJ System of Care No Wrong Door Service Delivery Model – Community Pathway includes a centralized intake system that serves as the initial point of contact for community members. The Single Point of Entry (SPE) can take various forms, including a physical location, hotline, or online portal, ensuring accessibility and convenience. The CSJ System of Care includes a Community Pathway, with a SPE that begins with a physical location designed to foster a culture of care and belonging. This approach includes a Universal Initial Intake and Screening Form to efficiently streamline access to services and support for those entering the CSJ System of Care.

A key component of this model is a Unified Information System, utilizing a secure, shared data system platform accessible to all participating agencies. This system improves cross-agency collaboration, ensures integrated care and complies with privacy regulations such as Health Insurance Portability and Accountability (HIPAA).

By centralizing intake, information-sharing, and service coordination, the SPE model reduces barriers, improves efficiency, and ensures timely, well-coordinated supports for individuals and families, see Figure 5. The CSJ System of Care No Wrong Door Service Delivery Model streamlines access to services through a centralized intake system, unified information sharing and coordinated support, ensuring seamless and equitable care for individuals and families.

Figure 5: Single Point of Entry Process Overview



City of San José
- Community Centers
- Libraries

Partner Organizations
- Community-Based Organizations
- County of Santa Clara

Entry Points

School District Partners
- East Side Union High School District
- Alum Rock Union School District
- Franklin-McKinley Elementary School District

Pilot Sites

Installation and Implementation

The CSJ System of Care and No Wrong Door Service Delivery Model will follow a multi-phased implementation outlined in the Children and Youth Services Master Plan. Two demonstration sites will serve as learning communities to refine the model and remove systemic barriers for underserved communities.

During installation and initial implementation, sites will establish a core planning team, assess existing systems, data and practices, and refine service delivery models. Each demonstration site will function as a hub, integrating centralized intake, referrals, multi-dimensional assessments and coordinated service delivery. Cross-sector collaboration will ensure families access services seamlessly, from universal support to intensive wraparound care.

Ongoing Assessment and Improvement

A planning team of city leaders, school district representatives and community members will align structures with the System of Care framework, facilitate provider training and strengthen cross-agency communication. Ongoing assessments will evaluate service delivery, partnership and staff capacity, using data-driven strategies to improve access and coordination.

Building a Sustainable Model

Demonstration sites will transform services into a unified, responsive system. A centralized intake process will include:

- Standardized intake forms
- Screening tools
- Shared data platforms
- Coordinated service delivery protocols and processes

Through co-design and capacity-building, pilot sites will refine the model to ensure equitable, sustainable, and accessible services for all.

How It Works:

— and —

Process and Implementation Steps

Opening Doors with Care: A Safe and Supportive Start

The community member's journey begins with a welcoming, non-judgmental environment at the entry points, including city departments, school districts or demonstration sites. Staff greet community members warmly, ensuring they feel safe and supported from the very first interaction. During this step, basic information is collected to create a community member profile and prioritize urgent needs. Individuals can connect through multiple access points, such as phone lines, in-person visits or online portals. Implementing the CSJ System of Care and No Wrong Door Service Delivery Model requires a structured approach to reduce barriers, improve efficiency and ensure timely, well-coordinated support for individuals and families. Providers play a critical role in aligning structures and frameworks necessary for the Single Point of Entry model, creating a seamless, accessible system of care.

This section outlines the key elements and essential steps providers take to integrate standardized processes, enhance cross-agency collaboration, and streamlined service delivery. By establishing centralized intake, shared data systems and coordinated service protocols, providers foster a responsive, equitable and sustainable support network for the community. The following visual demonstrates an interconnected network of service providers working together ensures a seamless access, coordinated support and an equitable system of care within the CSJ No Wrong Door Service Delivery Model, see Figure 6.

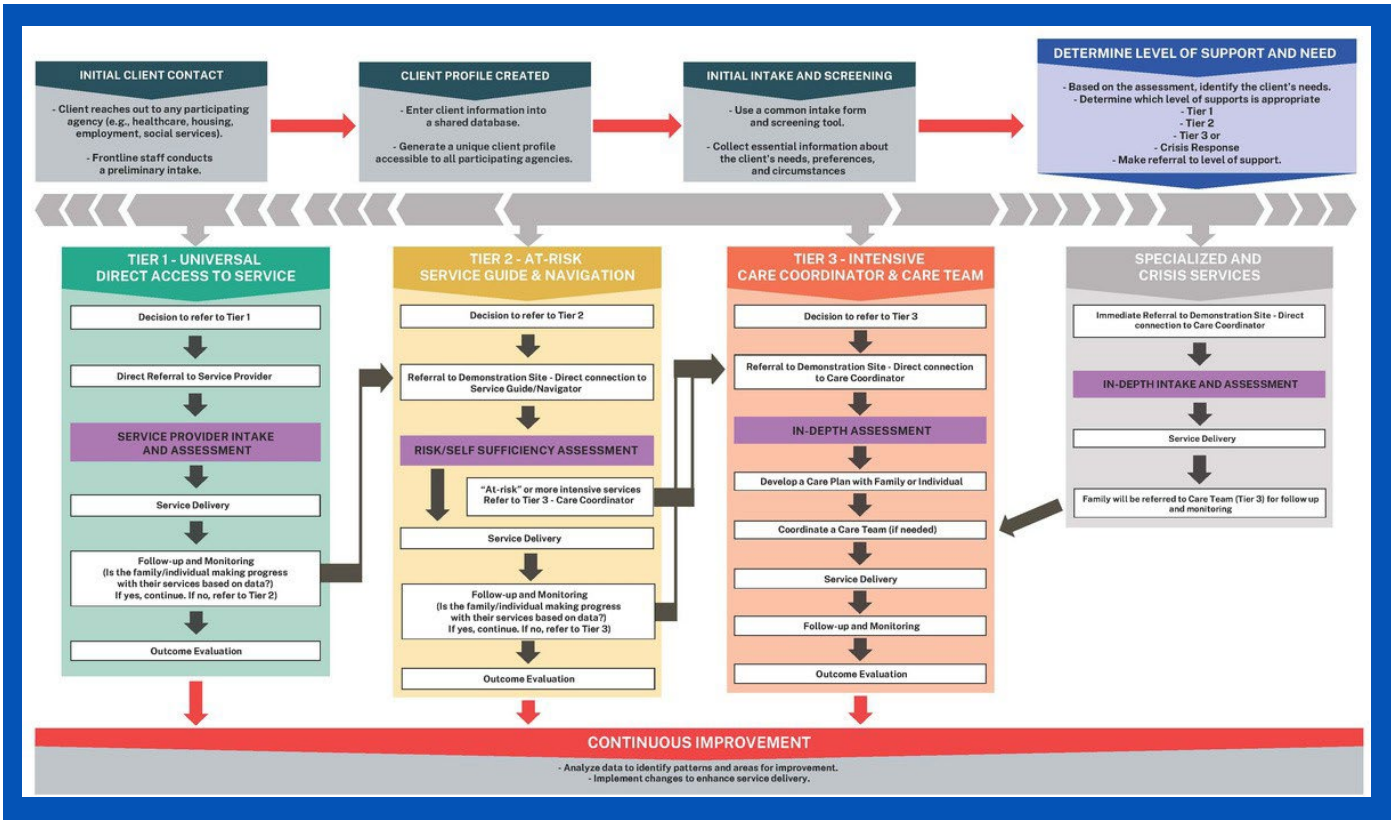
Figure 6: No Wrong Door Service Delivery Elements

Overview

The City of San José Department of Parks, Recreation and Neighborhood Services and Public Library provide inclusive environments that offer a variety of programs and services for children, youth and families. To effectively serve community members in need, the No Wrong Door Service Delivery Model (NWDSDM) ensures a seamless, coordinated approach where individuals seeking support are welcomed, assessed, and connected to appropriate resources—whether through city departments or external partners, see Figure 7.

Similarly, schools and school districts function as key access points, integrating health and human services with education through a Single System of Support Framework grounded in upstream prevention and collective impact. **Schools serve as a single point of entry**, ensuring that families and students receive the services they need without barriers such as insurance or diagnostic requirements. The following flowchart outlines the key elements and essential steps providers take to integrate standardized processes, enhance cross-agency collaboration, and streamline service delivery. A larger version can be found in the appendix.

Figure 7: City of San José System of Care No Wrong Door Service Delivery Approach



City of San José Department Entry Points

Libraries and community centers serve as natural entry points where trained staff and volunteers facilitate connections to needed services. The City of San José System of Care no wrong door service delivery approach include the following key elements and processes:

1. **Initial Contact**
   - Visitors are greeted by trained staff or volunteers in a safe, welcoming and trauma- informed environment.
   - Staff members are equipped with cultural humility training to provide empathetic and responsive support.
2. **Universal Intake and Screening**
   - A brief intake process helps individuals articulate their needs.
   - Staff use standardized universal intake and screening tools to assess needs across multiple domains, such as: health, housing, employment, education, and social support.
   - Immediate needs such as housing insecurity, food access or urgent health concerns are prioritized.
3. **Determining Level of Need**
   - After intake, staff assess whether the individual requires basic referrals or more comprehensive support.
   - Individuals needing further assistance are connected to external service providers.
4. **Warm Hand-Off and Service Navigation**
   - Staff coordinate a warm hand-off to the appropriate service provider or tier of need.
   - Support includes scheduling appointments, assistance with completing forms and navigation to specialized resources such as legal aid, financial assistance, or mental health services.
   - To prevent fragmentation, staff work closely with external partners to ensure individuals do not need to retell their stories multiple times.
5. **Creating a Community Hub**
   - Libraries and community centers act as more than just service gateways—they foster community connections and empowerment.
   - Services are tailored to meet individual goals and enhance overall well-being.

School Sites – Initial Contact with Students and Families

Schools and school districts serve as an essential single point of entry, integrating educational, physical and mental health services to support students and families.

1. **School-Based Support Teams**
   - Multi-disciplinary teams (MDTs), also known as Coordinated Care Teams or **Coordination of Services Teams (COST)**, use data to implement evidence-based interventions.
   - These teams focus on academic, behavioral, health and social-emotional needs at Tier 2 and Tier 3 levels.
2. **Identification and Referral Process**
   - Students requiring additional support are identified through COST meetings.
   - If family support or external services are needed beyond school-based interventions, a referral is made to a County of Santa Clara, school, school district, School Link Services (SLS), Wellness Center, or other partner service coordinator (coordinator).
3. **NWDSDM Process in Schools:** The coordinator facilitates the following steps, mirroring the city department process:
   - **Initial Contact:** Families are engaged with care and cultural humility, ensuring a welcoming and stigma-free experience.
   - **Universal Intake and Screening:** The coordinator assesses needs across domains such as education, health, mental health and social services. Immediate needs are prioritized.
   - **Determine Level of Need:** The coordinator determines whether the student and family require basic support or more intensive services.
   - **Warm Hand-Off to Appropriate Tier of Need:** The coordinator ensures a seamless transition to necessary services, reducing barriers to access. Families receive clear next steps and assistance in navigating external support systems.

Ensuring a Seamless and Equitable Process

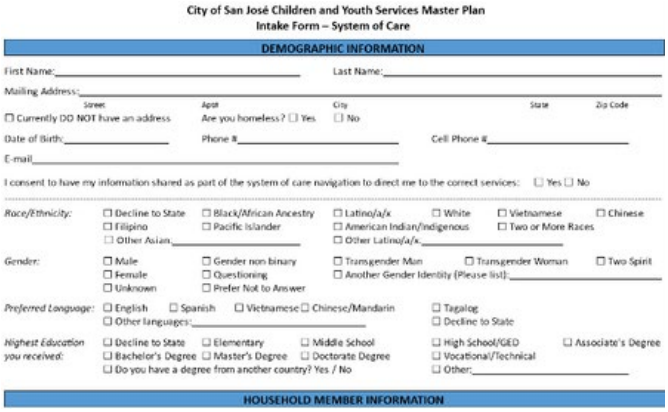
1. Both city department entry points and school sites align their processes with the CYS Master Plan values:
   - Accessibility and inclusion for all youth
   - Cross-sector collaboration
   - Investment and accountability
   - Equity
   - Outcomes and results-driven services
   - Youth and community voice-driven approach

2. The No Wrong Door Service Delivery Model ensures that children, youth, and families receive the right support without unnecessary barriers, making essential services available within the community and for the community.

Step 1: Initial Community Member Contact

The community member's journey begins in a welcoming, nonjudgmental environment at entry points, including city departments, school districts or demonstration sites. Staff greet community members warmly, ensuring they feel safe and supported from the first interaction. During this step, staff collect basic information to create a community member profile and prioritize urgent needs. Individuals can connect through multiple access points, such as phone lines, in-person visits or online portals. The City of San José System of Care Intake Form streamlines community member access by standardizing information collection, ensuring efficient service coordination and seamless support delivery, see Figure 8. A larger version can be found in the appendix.

Figure 8: City of San José System of Care Intake Form



City of San José Children and Youth Services Master Plan
Intake Form – System of Care

DEMOGRAPHIC INFORMATION

First Name:_____ Last Name:_____

Mailing Address:_____
Street Apt City State Zip Code

☐ Currently DO NOT have an address Are you homeless? ☐ Yes ☐ No

Date of Birth:_____ Phone #_____ Cell Phone #_____

E-mail_____

I consent to have my information shared as part of the system of care navigation to direct me to the correct services: ☐ Yes ☐ No

Race/Ethnicity: ☐ Decline to State ☐ Black/African Ancestry ☐ Latino/a/x ☐ White ☐ Vietnamese ☐ Chinese ☐ Filipino ☐ Pacific Islander ☐ American Indian/Indigenous ☐ Two or More Races ☐ Other Asian_____ ☐ Other Latino/a/x_____

Gender: ☐ Male ☐ Gender non binary ☐ Transgender Man ☐ Transgender Woman ☐ Two Spirit ☐ Female ☐ Questioning ☐ Another Gender Identity (Please list):_____ ☐ Unknown ☐ Prefer Not to Answer

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese/Mandarin ☐ Tagalog ☐ Other languages:_____ ☐ Decline to State

Highest Education you received: ☐ Decline to State ☐ Elementary ☐ Middle School ☐ High School/GED ☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate Degree ☐ Vocational/Technical ☐ Do you have a degree from another country? Yes / No ☐ Other:_____

HOUSEHOLD MEMBER INFORMATION

- **Single Point of Entry:** A centralized system ensures all initial contact follows a consistent process, regardless of where the individual first enters.
- **Clear Communication:** Staff explain that assistance is available across multiple services and that community members receive support throughout their journey.

Step 2: Universal and Initial Intake and Screening

Determining the level of need is essential for connecting individuals to services that match their unique circumstances and interest. The CSJ System of Care classifies needs in the following:

Tier 1 – Universal Supports: Immediate referral to services that promote general well-being and strengthen communities. These preventive services are designed for the general population.

Tier 2 – At-Risk Services: Referral to a site navigator or promotora for targeted interventions that help prevent emerging challenges from escalating.

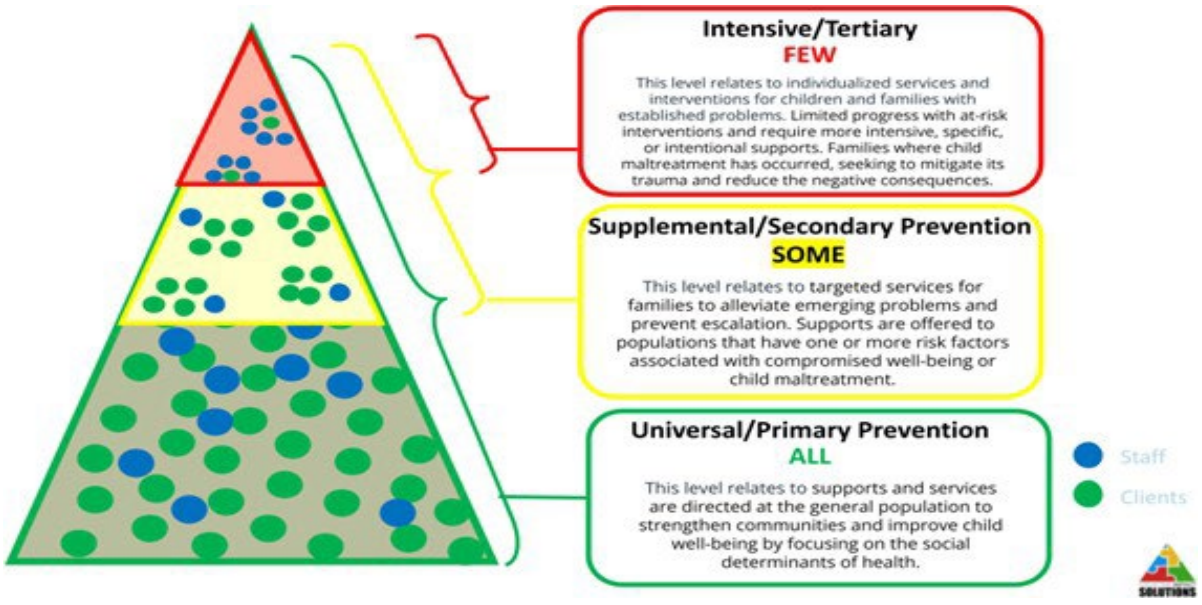
Tier 3 – Intensive Supports: Assignment to a care coordinator and care team for comprehensive, long-term support tailored to complex needs.

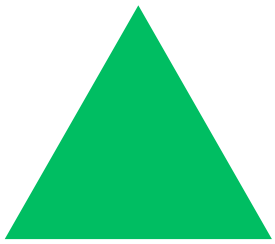
Guided service-planning for children, youth and families while ensuring they receive the right level of support at the right time.

For individuals needing more targeted support, a multi-dimensional assessment evaluates financial stability, mental and physical health, housing, employment, and social support systems. Multi-Tiered System of Supports (MTSS) is a three-tiered framework illustrating the levels of support provided to community members, see Figure 8. Each tier narrows as the intensity of support increases, illustrating the progressive levels of intervention within framework.

- **Community Member-Centered Approach:** Individuals actively participate in the assessment process, ensuring their voices are heard and their preferences respected.
- **State Requirements: For children and youth,** the Child and Adolescent Needs and Strengths (CANS) Assessment Tool informs care coordination and service planning.
- **Continuum of Service Delivery:** A no wrong door framework structures tiered services to match individuals' varying needs and complexities. This approach ensures community members receive appropriate interventions, with intensive services reserved for those with higher needs.

Figure 8: Multi-Tiered System of Supports (MTSS)





Tier 1: Universal Supports
Direct Referral to Service Provider

Tier 1 supports and services are directed at the general population to strengthen communities and improve child well-being by focusing on the social determinants of health. State Definition: These activities are directed at the general population to strengthen communities and improve child well-being by focusing on the social determinants of health, defined as the conditions into which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.

Target Group

All community members, regardless of specific needs.

State Definition

These activities are focused on the general population to strengthen communities and improve child well-being by addressing the social determinants of health. These determinants include the conditions into which people are born, grow, work, live, and age, as well as the wider set of forces and systems shaping the conditions of daily life.

Step 1: The family or individual is determined to be a "light touch" and is directly referred to the Service Provider.

Step 2: Referral to Service Provider and appointment scheduled within 36 hours or when family/individual available.

Step 3: All information and data of family/individuals is shared with the Service Provider. All information and data is reviewed by the Service Provider prior to engaging with family and/or individuals.

Step 4: Initial contact with Service Provider and family or individual.

- Establish trust and rapport.
- Family/individual is provided a welcoming environment.
- Service Providers will complete their internal assessment with Family/Individual.

Notes

Tier 2: At-risk
Referral to Demonstration Site Navigator/Promotora or Service Guide

Tier 2 services aim to alleviate emerging challenges and prevent escalation by addressing specific, moderate needs identified through assessment and providing focused support.

Target Group

Community members with identified needs that require more than universal services but do not need intensive intervention.

State Definition

These activities are offered to populations with one or more risk factors associated with compromised well-being or child maltreatment. These risk factors include poverty, parental substance abuse, young parental age, parental mental health concerns, exposure to violence, and parental or child disabilities. Programs seek to build protective factors and mitigate risk factors.

Early support can make a lasting difference.

Tier 2 services help families build resilience by addressing concerns before they escalate.

Steps of Interventions and Support

Step 1: The Family or Individual is determined to be "At-Risk" and resides in the zip codes of the demonstration sites.

Step 2: Referral to Site Navigator/Promotora or Service Guide (SN/SG) and appointment scheduled within 36 hours or when family/individual available.

Step 3: All information and data of family and individuals are shared with SN/SG. All information and data is reviewed by SN/SG prior to engaging with family and/or individuals.

Step 4: Initial contact with Service Provider and Family/Individual.

- Establish trust and rapport.
- Family/individual is provided a welcoming environment.
- Service Providers will complete their internal assessment with Family/Individual.

Tier 2: At-risk (continued)
Referral to Demonstration Site Navigator/Promotora or Service Guide

Step 5: SN/SG determines if a family/individual is "At-Risk" or/and needs more intensive services.

- If **Yes**, refer to Tier 3/Care Coordinator.
- If **No**, skip to Step 6.

Step 6: N/SG continues to work with the family/individual on developing a plan with the Self Sufficiency Assessment determining the best services/programs that will meet the needs of the family/individual.

- Goal Setting: Work with the family to identify their goals and desired outcomes.
- Action Plan: Develop a personalized service plan that outlines the specific services and supports needed to achieve the goals. Include clear timelines and responsibilities.
- Resource Identification: Identify available resources and services that match the family/individual's needs, including internal and external providers.

Step 7: Option of referral to a Triage Team

- If SN/SG determines that they need more support for a family/individual, they can refer a family/individual to a triage team to receive more guidance of services/programs to keep families and individuals from escalating into Tier 3.

The warm handoff builds trust. When families meet service providers with familiar support by their side, they feel more confident engaging with new resources.

Step 8: Service referral

- SN/SG makes formal referrals to the identified services and providers and ensures that referral documentation is complete and accurate.
- Warm Handoff: SN/SG facilitates a warm handoff by introducing the family to the service providers, ensuring a smooth transition.

Note: Referrals are to Health and Mental Health

- ***Health:*** *Referral to call center will vary depending on the insurance provider held by the family or individual.*
- ***Mental Health:*** *Referral directly to Behavioral Health Call Center*

Tier 3: Intensive/Tertiary

Referral to Care Coordinator and Care Team

Tier 3 is implemented when limited progress with Tier 2 interventions indicates the need for more intensive, specific, and intentional interactions. Interventions at this level are individualized based on collected data and provide comprehensive, sustained support for individuals with complex or multiple needs. These services require a higher level of coordination to address the unique challenges faced by community members.

Target Group

Community members with significant needs that require long-term and coordinated intervention. Individualized services and interventions are provided for children and families with established problems.

State Definition

These activities focus on families where child maltreatment has occurred, seeking to mitigate its trauma, reduce the negative consequences of the maltreatment, and prevent its recurrence.

Step 1: The family/individual is determined to be "At-Risk" and intensive supports and resides in the zip codes of the demonstration sites.

Step 2: Referral to a Care Coordinator (CC) and an appointment is scheduled within 36 hours or when family/individual available.

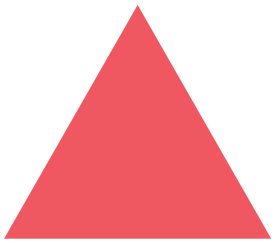
Step 3: All information and data of family and individuals are shared with the Care Coordinator. All information and data is reviewed by the Care Coordinator prior to engaging with family and/or individuals.

Step 4: Initial contact with the Care Coordinator and family/individual.

- Establish trust and rapport
- Completion of assessments
  Comprehensive Assessment (CANS)

Tier 3 interventions go beyond surface-level support.

They provide the intensive, personalized care needed to help individuals and families overcome complex challenges.



Tier 3: Intensive/Tertiary (continued)
Referral to Care Coordinator and Care Team

Step 5: Care Coordinator works with family/individual to develop a care plan determining the best services/programs that will meet the needs of the family/individual.

- **Goal Setting:** Work with the family to identify their goals and desired outcomes.
- **Action Plan:** Develop a personalized service plan that outlines the specific services and supports needed to achieve the goals. The plan includes clear timelines and responsibilities.
- **Resource Identification:** Identify available resources and services that match the family/individual's needs, including internal and external providers.

Step 6: Coordination of a Care Team

- If Care Coordinator determines the family/individual needs additional support, a Care Team is established to provide comprehensive, coordinated care by bringing together professionals from various fields to address the complex needs of individuals or families. The team works collaboratively to develop and implement a holistic care plan.

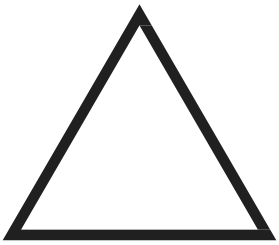
Step 7: Service Referral

- The care coordinator makes formal referrals to identified services and providers and ensures all referral documentation is complete and accurate.
- Warm Handoff: Facilitate a warm handoff by introducing the family to the service providers, ensuring a smooth transition.

Note: Referrals to Medical and Mental Health Services

- **Health**: Referral to the managed care or medical insurance call center will vary depending on the insurance provider held by the family or individual.
- **Mental Health**: Referral directly to County of Santa Clara Behavioral Health Call Center

Notes



Specialized and Crisis Services
Immediate Referral to Demonstration Site

An immediate needs assessment is conducted to identify any critical or emergency needs that require urgent attention and to provide referrals or direct assistance as needed.

Step 1: The family/individual is determined to be Intensive support and resides in the zip codes of the demonstration sites.

Step 2: Referral to a Care Coordinator (CC) and appointment is scheduled within 36 hours or when family/individual available.

- Follow steps for Tier 3.

Step 3: All information and data of family and individuals are shared with Care Coordinator. All information and data is reviewed by the care coordinator prior to engaging with family and/or individual.

Notes	

Establishing a Care Team

Establishing a Care Team for a No Wrong Door service delivery model within a community-based organization involves several key steps. Here's a general outline:

1. **Identify Stakeholders**
   - Engage key stakeholders, including community leaders, service providers, families, and youth. Ensure representation from various sectors such as education, healthcare, social services, and local government.
2. **Define Goals and Objectives**
   - Clearly outline the goals and objectives of the Care Team. Focus on improving access to services, enhancing coordination among providers and ensuring families receive comprehensive support.
3. **Develop a Framework**
   - Create a framework for the No Wrong Door model, which includes streamlined intake processes, centralized information systems, and a coordinated referral network.
4. **Train Staff**
   - Provide training for staff on the principles of the No Wrong Door model, person-centered care, and effective communication and collaboration techniques.
5. **Establish Partnerships**
   - Form partnerships with other organizations, agencies, and service providers to ensure a seamless network of support. This includes schools, healthcare providers, social service agencies, and community-based organizations.
6. **Implement Technology Solutions**
   - Utilize technology to create a centralized database and communication system that allows for easy access to information and coordination among team members.
7. **Create a Referral System**
   - Develop a referral system that ensures families can access the services they need without having to navigate multiple agencies. This system should be easy to use and accessible to all families.
8. **Monitor and Evaluate**
   - Continuously monitor and evaluate the effectiveness of the Care Team and the No Wrong Door model. Collect feedback from families and service providers to make necessary adjustments and improvements.
9. **Sustain and Expand**
   - Work on sustaining the Care Team by securing ongoing funding and resources. Explore opportunities to expand the model to other communities or service areas.

The Composition of the Care Team

The Triage and Care Team includes professionals from a cross-sector of service providers and disciplines convening as a team to address the diverse needs of individuals and families:

- **Mental Health Professionals:** Counselors, psychologists, and therapists for emotional and psychological support.
- **Social Services Staff:** Social workers to provide assistance with social and economic challenges.
- **Education Representatives:** School staff and educational specialists to support learning needs.
- **Housing Specialists:** Experts to assist with housing-related issues and stability.
- **Healthcare Providers:** Nurses and medical staff to address physical health concerns.
- **Community-Based Organizations:** Representatives from local organizations offering specialized services.
- **Individual/Family Representation and Advocates:** The individual/family members participate in team discussions and meetings to ensure their voices and lived experience are central to the service delivery plan and approach.

Establishing a Triage Team

Purpose: The primary role of a triage team is to conduct initial assessments of individuals or families to determine the level of support and intervention required. They act as the first point of contact to quickly identify urgent needs and prioritize cases for appropriate services.

> No individual/family should navigate complex challenges alone. The Triage and Care Team ensures support is coordinated, compassionate and customized for each family's unique needs.

Key Functions:

- Initial Assessment: Quickly evaluates the needs and urgency of each case.
- Prioritization: Determines the severity of needs and prioritizes cases based on urgency.
- Resource Allocation: Connects individuals or families to the appropriate services or support within the system.
- Coordination: Works to ensure that families are connected to the appropriate service or supports without having to navigate complex systems.

Triage Team Composition

Typically, social workers, intake specialists, and case managers who are trained in assessment and resource coordination.

Process to Coordinate a Triage Team

1. Define Objectives and Scope
   - Clearly outline the objectives of the triage team, such as assessing the needs of families, prioritizing cases, and connecting them to appropriate services.
   - Determine the scope of the triage team's work, including the types of cases they will handle and the criteria for triage.
2. Assemble the Triage Team
   - Identify and recruit team members with diverse expertise, such as social workers, case managers, health professionals, and intake specialists.
   - Provide comprehensive training on assessment tools, triage protocols, and the "No Wrong Door" approach.
3. Develop Triage Protocols and Tools
   - Create standardized assessment tools to evaluate the needs and urgency of each case.
   - Establish clear protocols for prioritizing cases based on severity and urgency. Include guidelines for decision-making and escalation.
4. Establish Communication Channels
   - Set up effective communication channels within the triage team for sharing information and coordinating efforts.
   - Develop procedures for communicating with other service providers and stakeholders to ensure seamless referrals.
5. Intake and Initial Contact
   - Implement an intake process for receiving referrals from various entry points, such as community organizations, schools, and self-referrals.
   - Ensure that the triage team makes timely initial contact with families to explain the process and gather preliminary information.
6. Needs Assessment and Prioritization
   - Use the standardized assessment tools to determine the individual's and family's needs and desired goals.
   - Apply the triage protocols to prioritize cases based on urgency and severity. Categorize cases into different levels of priority (e.g., high, medium, low).
7. Resource Identification and Referral
   - Identify appropriate services and resources that match the needs and goals of each family.
   - Make formal referrals to the identified services. Ensure that referral documentation is complete and accurate.
   - Facilitate a warm handoff to ensure smooth transition between family and service providers.

8. Follow-Up and Monitoring
    - Schedule regular follow-ups with families to monitor their progress and address any emerging issues.
    - Make necessary adjustments to the service plan based on feedback and changing needs.
9. Documentation and Reporting
    - Maintain accurate and up-to-date records of all interactions, assessments, and referrals.
    - Prepare reports as required by funding agencies, management, or other stakeholders.
10. Continuous Improvement
    - Collect feedback from families and service providers to identify areas for improvement in the triage process.
    - Implement changes to improve efficiency and effectiveness based on feedback and outcomes.

Step 3: Service Coordination

Service coordination within the CSJ System of Care with a no wrong door service delivery model is the process of managing and organizing services for an individual across multiple agencies or providers to ensure they receive comprehensive and integrated support. Different roles within the collaborative cross-sector partners of the CSJ System of Care provide different services to an individual or family. Case coordination focuses on providing personalized, continuous care across different sectors, preventing gaps or overlaps in services.

Once the assessment is complete, a personalized service plan is developed, and the individual is connected to the appropriate services.

Collaboration across agencies helps build trust, streamline services, and improve outcomes.

- **Assigned Navigators or Care Coordinators** (Tier 1 or 2):
- **Service Guides/Navigators (Tier 2):** Help individuals access short-term, immediate services.
- **Care Coordinators (Tier 3):** Provide long-term case management and coordinate multiple services for complex cases.
- **Cross-Agency Coordination:** Agencies collaborate to ensure seamless service delivery without duplication or service gaps. Regular communication among providers helps adjust services as needed.
- **Prevention Plan:** For at-risk individuals, a prevention plan is created to avoid escalation into crisis situations.

Service Coordination Process

1. **Service Coordination: Initial Assessment and Prioritization**
   - Conduct thorough assessments to understand the full scope of an individual's or family's needs and desired personal goals.
   - Use standardized tools to evaluate the urgency and complexity of each case.
   - Collect data from various sources, including interviews, surveys, and existing records.
   - Categorize cases into priority levels—high, medium, or low—and determine the appropriate level of intervention.

> The best systems evolve with the communities they serve. Feedback fuels growth.

2. **Resource Identification and Referral**
   - Identify services and resources that match the needs and goals of individuals or families.
   - Submit formal referrals with complete and accurate documentation.
   - Facilitate a warm handoff to service providers to ensure a smooth, supported transition.

3. **Holistic Care Planning**
   - Develop and implement a holistic care plan that addresses psychological, social, educational, and other needs or goals.
   - Incorporate community member input to ensure their preferences, interests, and goals are reflected in the plan.

> When individuals help shape their care plans, they are more motivated and engaged.

4. **Ongoing Support and Monitoring**
   - Provide continuous support and adjust care plans as needed based on community member progress and feedback.
   - Schedule regular follow-ups to track outcomes and address emerging needs.

Service Coordination Process (continued)

5. **Coordination and Collaboration**
   - Maintain clear, consistent communication with community members, school districts, community-based providers, and system partners.
   - Establish partnerships with other organizations, agencies, and service providers to create a robust support network.
6. **Documentation and Reporting**
   - Track community member information using a shared database to improve service coordination while ensuring privacy compliance.
   - Maintain accurate records of interactions, assessments, and referrals.
   - Prepare reports to meet funding requirements and support ongoing process evaluation.
7. **Continuous Improvement**
   - Provide ongoing support and make necessary adjustments to care plans.
   - Collect feedback from families and service providers to identify areas for improvement.
   - Implement changes to enhance the triage and care process, ensuring the model remains responsive to community needs.

Step 4: Service Delivery

Service delivery focuses on executing the personalized service plan developed during the service coordination process. The individual or family receives appropriate services based on their identified tier level and needs, whether through short-term interventions or long-term intensive support.

Service Delivery (continued)

Step 1 – Initiate Services

- The Service Guide, Navigator or Care Coordinator helps the individual connect with identified service providers based on the personalized service plan. This may involve scheduling appointments, making formal introductions, and ensuring the individual understands what to expect from each service provider.
- The Service Guide, Navigator or Care Coordinator also ensures all necessary documentation and information are shared with service providers to facilitate a smooth transition.

"Our goal is to learn, adapt, and improve — ensuring every family receives the best possible support.

Step 2 – Monitor Service Delivery

- Continuously monitor the quality and effectiveness of services provided. Address any issues or barriers that arise during service delivery.

Step 3 – Case Management and Ongoing Support

- The assigned Service Guide, Navigator or Care Coordinator oversees the implementation of the service plan and serves as the primary point of contact for individuals and families.
  - Conduct regular check-ins to assess progress and address new needs.
  - Adjust service plans as necessary based on feedback and changing circumstances.

Step 4 – Cross-System Coordination

- Ensure seamless integration and cooperation between different systems, such as healthcare, education, and social services, to provide holistic support.
  - Establish inter-agency agreements and protocols for information sharing and collaboration.
  - Identify and address potential gaps or overlaps in services.
  - Facilitate joint training and capacity-building activities for staff across systems.

Step 5: Follow-Up and Monitoring

Ongoing support ensures individuals continue receiving the services they need to achieve their goals. Regular follow-ups are scheduled to track progress and address emerging challenges.

Follow-Up and Monitoring (continued)

Key Support Actions:

- **Check-Ins:** Case managers review individual progress and update the care plan as needed.
- **Referral to Higher Tiers:** If progress stalls, individuals may be referred to higher-level services for more intensive support.
  - **Flexible Service Models** – Create flexible service models that allow smooth transitions between tiered service levels without gaps or delays.
  - **Regular Reassessments** – Implement regular reassessments to ensure individuals receive the appropriate level of support and can be stepped up or down as needed.

Step 1: Initial Follow-Up Contact

- **Schedule Follow-Up**
  - Arrange an initial follow-up contact with the community member shortly after service delivery begins. Ensure the timing is appropriate to gauge early progress and address any immediate concerns.
- **Individual/Family Check-In:**
  - Contact the community member to check on their well-being and assess their satisfaction with the services received. Discuss any initial challenges or barriers they may be facing.

Step 2: Regular Monitoring and Check-Ins

- **Establish a Follow-Up Schedule**
  - Develop a regular follow-up schedule based on the community member's needs and the nature of the services provided. Include both in-person meetings and phone or virtual check-ins as appropriate.
- **Conduct Regular Check-Ins**
  - Reach out to the community member at predetermined intervals to monitor their progress and assess their ongoing needs. Ensure consistent communication to build trust and rapport.

Step 3: Progress Assessment and Documentation

- **Gather Feedback**
  - Solicit feedback from the individual or family about their experiences with the services and any changes in their circumstances. Use surveys, interviews, or informal conversations to gather comprehensive information.
- **Document Progress**
  - Record the individual's or family's progress, noting any achievements, challenges, or changes in their situation. Update their care plan and case file with relevant information.

Follow-Up and Progress Monitoring (continued)

Step 4: Adjustments to Care Plan

- **Review and Evaluate**
  - Regularly review the individual's or family's care plan in collaboration with their service provider(s). Evaluate the effectiveness of the services and identify areas for improvement or areas of change.
- **Modify Care Plan**
  - Make necessary adjustments to the care plan based on the community member's feedback and progress. Ensure that the modified plan addresses any emerging needs or challenges.

Step 5: Coordination with Service Providers

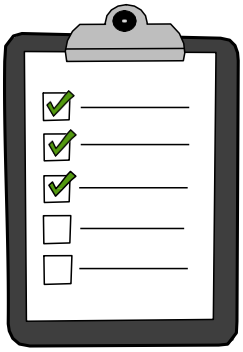
- **Communicate with Providers**
  - Maintain open lines of communication with all service providers involved in the community member's care. Share relevant updates and information to ensure coordinated service delivery.
- **Address Barriers**
  - Work with service providers to address any barriers or issues that may arise during the community member's progress. Develop joint strategies to overcome challenges and support the community member's goals.

Step 6: Ongoing Support and Resources

- **Provide Continuous Support**
  - Offer ongoing support to the individual and their families, including additional resources or referrals as needed. Ensure that the community member feels supported throughout their journey.
- **Empower**
  - Equip and support the entire family by involving them in decision-making and encouraging self-advocacy. Provide tools and resources to help families build their capacity and resilience.

Step 6: Final Evaluation and Outcome Measurement

Evaluating service outcomes ensures the effectiveness of care and supports continuous improvement. Data collection and family and community member feedback help refine care plans and enhance service delivery.



Key Support Actions:

- **Data Collection:** Gather feedback from individuals and track key performance indicators.
- **Plan Adjustments:** Refine care plans based on evaluation results to better meet individual needs.

Conduct Final Evaluation: Once a community member has achieved their goals or completed the service, conduct a final evaluation to measure outcomes. Use standardized tools to assess the impact of the services on the community member's well-being.

Document Outcomes: Record the final outcomes in the community member's case file, noting any key achievements or areas for further support. Use this information to inform future service delivery and program improvements.

> Outcome evaluation is not just about measuring success. It is about learning, adapting, and improving the quality of care and outcomes and overall wellbeing for children and youth and their families.

Closure or Transition: Provide a formal closure when appropriate, ensuring the community member understands how to access future support if needed. If transitioning to another service or support, facilitate a smooth handover to ensure continuity of care.

- Schedule appointments and follow-ups.
- Regular check-ins by the case manager or agency staff.
- Update the community member's profile and care plan as necessary. Address any emerging needs or challenges.

Driving Results and Ensuring Accountability

The CSJ System of Care prioritizes continuous improvement to create a seamless, responsive service delivery system that evolves alongside the individual's and family's needs and desired goals. Regular evaluation, open communication, and shared responsibility ensures services remain accessible, effective, and equitable for all.

Continuous improvement is not a fixed endpoint but an ongoing journey—one that reinforces the system's core values of accessibility, equity, and community member-centered care.

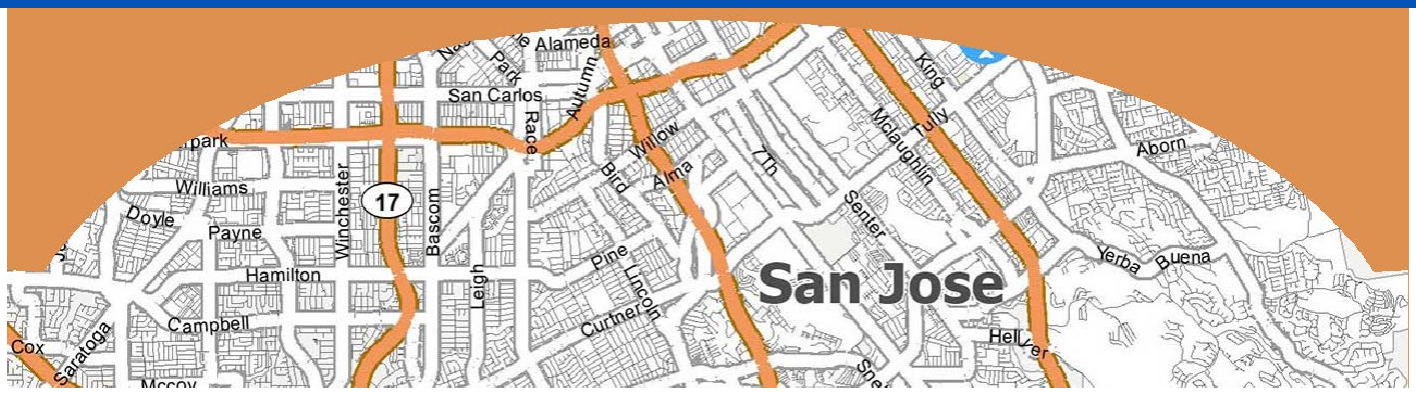
Unified Information System

A key component of the CSJ System of Care is the Unified Information System—a shared, secure database that stores community member information and facilitates real-time collaboration across participating agencies.

This system supports integrated, high-quality care by:

- **Centralizing community member Information:** Ensuring all authorized providers can access up-to-date information to deliver informed, coordinated support.
- **Improving Cross-Agency Collaboration:** Allowing agencies to work together more effectively, preventing duplication of services, and ensuring continuity of care.
- **Ensuring Data Security & Privacy:** Complying with federal, state, and local regulations— including the Health Insurance Portability and Accountability Act (HIPAA)—to protect community member confidentiality.

— Appendix —



Key considerations for practitioners to support consistent, high-quality care through structured processes and collaborative frameworks.

☐ **Initial Contact and Engagement**
- **Warm Welcome:** Staff create a welcoming nonjudgmental environment.
- **Basic Information Collection:** Gather demographic data and identify immediate needs.

☐ **Initial Intake and Screening**
- **Single Point of Entry:** Centralized system via location, hotline, or portal.
- **Unified Information System:** Secure database for cross-agency access.

☐ **Comprehensive Screening Process**
- **Standardized Tools:** Consistent data collection across housing, health, and education domains.

☐ **Determining Level of Need and Desired Goals**
- **Tier 1:** Universal Supports: Community-wide services targeting social determinants of health.
- **Tier 2:** At-Risk: Targeted interventions for emerging issues.
- **Tier 3:** Intensive/Tertiary: Individualized services for established problems.
- **Specialized/Crisis Services:** Immediate assessments to address urgent needs.

☐ **Multi-dimensional Assessment**
- **Holistic Approach:** Address all aspects of community member well-being.
- **Participant Centered:** Engage individual and their family actively in the process.
- **Assessment Tools:** Identified an agreed upon assessment tool that will be used by all partner agencies to assess family, individual, and child to determine needs and goals.

☐ **Service Coordination and Delivery**
- **Service Guides/Navigators (Tier 2):** Short-term goal-oriented support.
- **Care Coordinators (Tier 3):** Long-term comprehensive case management.
- **Cross-Agency Collaboration:** Ensuring continuity and avoiding service gaps.

☐ **Follow-Up and Monitoring**
- **Regular Check-ins:** Assess progress and adjust plans.
- **Outcome Evaluation:** Measure service impact, collect feedback and refine processes.

☐ **Universal Intake and Screening**
- **Common Intake Data:** Name, contact info, demographics, housing, income, and family structure.
- **Screening Questions:** Emergency needs, risk factors and developmental concerns.

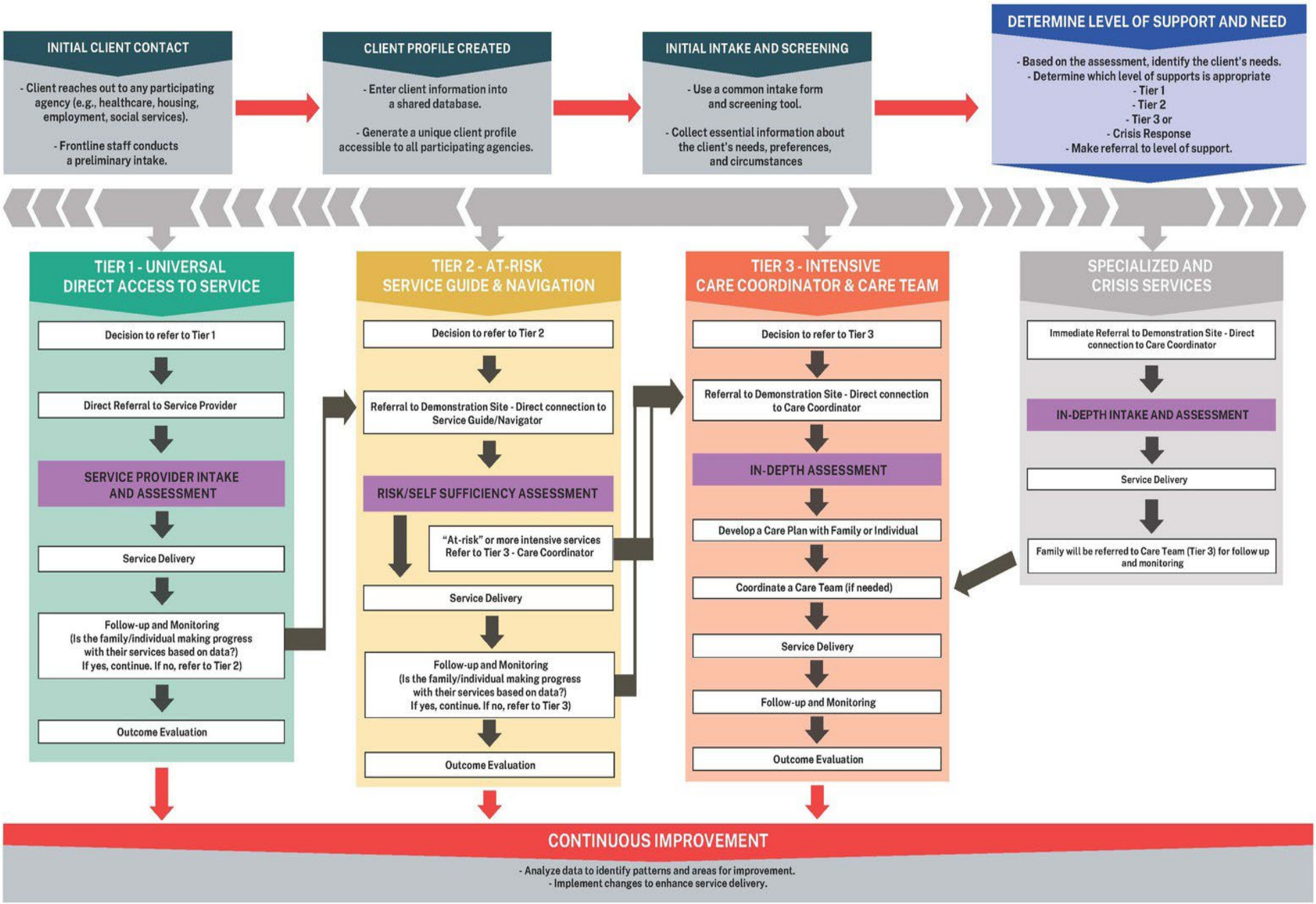
☐ ***Assessments**
- **Ages & Stages Questionnaire (ASQ-3):** Early childhood developmental screening.
- **Child and Adolescent Needs and Strengths (CANS):** Comprehensive youth assessment tool.

☐ **Capacity Building and Training**
- **Staff Training:** Emotional intelligence, trauma-informed care and cultural competency.
- **Environment:** Accessible welcoming spaces with multilingual resources.
- **Communication:** Authentic community member-centered engagement strategies.

☐ **Continuous Improvement**
- **Feedback Loops:** Incorporate community member and community input.
- **Data Analysis:** Identify trends and improve service delivery.

**Collaborative partners agree upon the most appropriate assessment tools to use that can best determine an individual's and family's needs and goals and facilitate referral and overall service delivery.*

City of San José System of Care No Wrong Door Service Delivery Approach



City of San José Children and Youth Services Master Plan, System of Care
Participant Intake Form

DEMOGRAPHIC INFORMATION

First Name:_____ Last Name:_____

Mailing Address:_____
Street Apt# City State Zip Code

☐ Currently DO NOT have an address Are you unhoused/homeless? ☐ Yes ☐ No

Date of Birth:_____ Phone #_____ Cell Phone #_____

E-mail_____

I consent to have my information shared as part of the system of care navigation to direct me to the correct services: ☐ Yes ☐ No ------

---

Race/Ethnicity: ☐ Decline to State ☐ Black/African Ancestry ☐ Latino/a/x ☐ White ☐ Vietnamese ☐ Chinese
☐ Filipino ☐ Pacific Islander ☐ American Indian/Indigenous ☐ Two or More Races
☐ Other Asian:_____ ☐ Other Latino/a/x:_____

Gender: ☐ Male ☐ Gender non-binary ☐ Transgender Male ☐ Transgender Female ☐ Two-Spirit
☐ Female ☐ Questioning ☐ Another Gender Identity (Please list):_____
_____
☐ Unknown ☐ Prefer Not to Answer

Preferred Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese/Mandarin ☐ Tagalog
☐ Other languages:_____ ☐ Decline to State

Highest Education you received: ☐ Decline to State ☐ Elementary ☐ Middle School ☐ High School/GED ☐ Associate's Degree
☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate Degree ☐ Vocational/Technical
☐ Do you have a degree from another country? Yes / No ☐ Other:_____

HOUSEHOLD MEMBER INFORMATION

1. Is anyone pregnant in the immediate family/household? ☐ Yes ☐ No

2. # of adults in the household (18 years or older): ___ Do adults in the household have insurance? ☐ Yes ☐ No

3. Do any adults have identified disabilities or functional needs?
   ☐ None ☐ Visual ☐ Mental Health ☐ Mobility ☐ Hearing ☐ Speech
   ☐ Developmentally disabled ☐ Other:_____
   ☐ Prefer not to answer.

4. # of children in the household (17 years and younger): _____if children present, complete screening
   ☐ No children in the home ☐ Decline to state

To determine all services that could be available due to funding restrictions, please let us know:

Name of child	Relationship	Age	Identified Disability	Immigration Status
Child 1			☐ No ☐ Yes (write it in):	☐U.S Citizenship ☐Legal Residency ☐Other: please indicate
Does this child have Medi-Cal or health insurance (Blue Cross, Kaiser, CHAMPUS, etc.) paid for by a parent or parent's employer? * ☐ Yes ☐ No				
Child 2			☐ No ☐ Yes (write it in):	☐U.S Citizenship ☐Legal Residency ☐Other: please indicate
Does this child have Medi-Cal or health insurance (Blue Cross, Kaiser, CHAMPUS, etc.) paid for by a parent or parent's employer? * ☐ Yes ☐ No				
Child 3			☐ No ☐ Yes (write it in):	☐U.S Citizenship ☐Legal Residency ☐Other: please indicate
Does this child have Medi-Cal or health insurance (Blue Cross, Kaiser, CHAMPUS, etc.) paid for by a parent or parent's employer? * ☐ Yes ☐ No				
Child 4			☐ No ☐ Yes (write it in):	☐U.S Citizenship ☐Legal Residency ☐Other: please indicate
Does this child have Medi-Cal or health insurance (Blue Cross, Kaiser, CHAMPUS, etc.) paid for by a parent or parent's employer? * ☐ Yes ☐ No				

SCREENING TOOL

1. Does anyone in your household have a personal emergency (T2)? ☐ No ☐ Yes (check all that apply)

   ☐ Pregnancy ☐ Immediate Medical Need ☐ Child Abuse ☐ Domestic Abuse

   ☐ Elder Abuse ☐ Other emergencies that threaten health or safety (Explain)_____

2. Have your utilities been shut off, or do you have a shut-off notice (T2)? ☐ Yes ☐ No

3. Do you need help with transportation to get food, clothing, medical care or other emergency items? ☐ Yes ☐ No

4. Do you need essential clothing, such as diapers or clothing needed for cold weather? ☐ Yes ☐ No

5. Anyone in the Household Associated and/or Impacted by Gangs ☐ Yes ☐ No

6. Are you a Veteran? ☐ Yes ☐ No

7. Is your household a migrant/seasonal farm worker? ☐ Yes ☐ No

I would like to be connected to the following services: (Check all that applies) Two or more services needed or T2 answered will be referred to Tier 2 Service Guide/Navigator	
HOUSING: ☐ Housing Information ☐ Emergency Housing ☐ An eviction or a notice (T2) ☐ Low-income Housing ☐ Unaccompanied Youth (25 yrs or below w/out family)	**EMPLOYMENT SERVICES:** ☐ You are currently employed ☐ Seeking a Job ☐ Seeking Vocational Training ☐ Career Counseling
EDUCATION SERVICES: ☐ K-12 Education of a Child ☐ High School, College or Vocational ☐ Special Needs of a Child ☐ Literacy/ESL Classes	**FOOD:** ☐ CalFresh (food stamps) ☐ Will your food run out (T2) ☐ Foodbank info
HEALTH/MEDICAL SERVICES: ☐ Health Insurance Support ☐ Specific Health Needs	**MENTAL HEALTH/COUNSELING SERVICES:** ☐ You ☐ Your child/children
CHILDCARE SERVICES: ☐ Extra services outside of child development centers ☐ Services for child/ren not enrolled	**OTHER SERVICES:** ☐ Parenting Education ☐ Legal Services

8. Are you currently receiving any public assistance: ☐ No ☐ Yes (mark all that apply):

   ☐ CalFresh ☐ Cash Aid ☐ Health Coverage ☐ Housing Voucher ☐ WIC (Women, Infants and Children) Program

   ☐ Other:_____

9. Does anyone in the household receives or expect to receive any income from the following (mark all that apply):

☐ Supplemental Security Income/State Supplementary Payment (SSI/SSP),
☐ Earnings (from a job) ☐ Social Security Benefits, ☐ Child Support,
☐ Foster Care Payment, ☐ Veterans Benefits ☐ Other (explain):_____

If any income box was checked, complete below:

Amount	When will it be received	How often?	Will Income continue
			☐ Yes ☐ No
			☐ Yes ☐ No

10. What is the Annual Household Income (check one):

☐ $20,000 or less ☐ $21,000 to $40,000 ☐ $41,000 to $60,000 ☐ $61,000 to $80,000
☐ $81,000 to $100,000 ☐ $100,000 to$160,000 ☐ $161,000 or more

11. Is your household's combined gross income and liquid resources less than the combined rent/mortgage and utilities? ☐ Yes ☐ No

Consent to Share Information

By signing below, I understand and agree that the information I provide during this intake and screening process may be shared with relevant entities, including City departments, County agencies, nonprofit organizations, and other service providers, to address my needs and provide appropriate services and support. I understand that this information sharing is a part of the City of San Jose's system of care and the "No Wrong Door" service delivery model, designed to ensure I receive coordinated and comprehensive assistance.

I acknowledge that my information will be shared only with those entities directly involved in providing services or support relevant to my situation and needs. I understand that my information will be handled confidentially and only shared with those authorized to assist in addressing my needs.

By providing my consent, I authorize sharing my information as described above. I understand that I may revoke my consent at any time by providing written notice, though I acknowledge that doing so may affect the services I receive.

_____ _____

Your Printed Name Your Signature

Date: _____

Access Point: A location or platform where individuals can seek assistance and be connected to services.

California Family First Prevention Services Act (FFPSA): Legislation focusing on providing preventive services to keep children out of the foster care system.

Care Coordinator: A professional responsible for managing and coordinating an individual's care plan and services.

Care Plan: A personalized plan outlining the services and supports an individual will receive.

Case Management: Ongoing support provided to individuals including monitoring progress and adjusting care plans as needed.

City of San José Children and Youth Services Master Plan (CSJ CYSMP): A strategic plan guiding policies, investments and services for children and youth in San José.

Collaboration: Working together across organizations, sectors and communities to achieve common goals.

Community-Based Organizations (CBOs): Nonprofit groups that provide services and support within the community.

Community Co-Design: A collaborative process involving community members in the development and implementation of programs and services.

Community Engagement: The process of involving community members in decision-making and service planning to ensure programs meet their needs.

Community Pathway: A coordinated network of services designed to guide individuals through the support system effectively.

Continuous Improvement: The ongoing process of evaluating and enhancing services to improve outcomes.

Co-Design: The collaborative development of programs and services with active participation from community members and stakeholders.

Cross-System Coordination: Collaboration among different systems (e.g., education, healthcare, social services) to provide comprehensive support.

Cultural Responsiveness: The practice of recognizing and respecting the cultural backgrounds and needs of individuals when providing services.

Demonstration Site: A pilot location where new service delivery models are tested and refined before broader implementation.

Entry Point: Any location or platform where individuals can access services such as community centers, schools or online portals.

Equity: The practice of ensuring fair access to opportunities and resources for all individuals regardless of their background or circumstances.

Feedback Collection: The process of gathering input from service recipients and providers to improve programs and services.

Holistic Care Plan: A comprehensive plan that addresses an individual's physical, emotional, social and educational needs.

Initial Assessment: The process of evaluating an individual's needs to determine the level of support required.

Initial Contact: The first interaction an individual has with the service system, often involving basic information collection and needs assessment.

Multi-Tiered System of Supports (MTSS): A framework that provides varying levels of support based on the intensity of an individual's needs.

Navigator/Promotora: A community-based professional who guides individuals through the service system, often focusing on cultural responsiveness.

No Wrong Door (NWD): A service delivery model ensuring individuals receive the support they need regardless of the entry point into the system.

Outcome Measurement: Evaluating the effectiveness of services in achieving desired results for individuals and communities.

Prioritization: Determining the severity of needs to ensure urgent cases receive prompt attention.

Resource Allocation: The process of directing individuals to appropriate resources based on their assessed needs.

Risk Assessment: The process of identifying factors that may pose a threat to an individual's well-being.

Self-Sufficiency Assessment: A tool used to evaluate an individual's ability to meet their basic needs independently.

Service Delivery Model: A structured approach outlining how services are provided to individuals including processes, protocols and pathways.

Service Provider: An organization or individual responsible for delivering specific services or supports to individuals.

Shared Data and Feedback Loops: Systems that allow for the exchange of information among service providers to enhance coordination and continuous improvement.

Single Point of Entry (SPE): A centralized system where individuals can access multiple services through one contact point.

Stakeholders: Individuals or groups with an interest or role in the development and implementation of programs and services.

System of Care: A coordinated network of services designed to meet the diverse needs of individuals and families within a community.

Triage Team: A group of professionals responsible for assessing the urgency of needs and directing individuals to appropriate services.

Universal Assessment: A standardized evaluation used to determine an individual's needs across multiple service areas.

Universal Intake: A standardized form or process used across agencies to collect initial information from individuals seeking services.

Warm Handoff: A direct, personal introduction from one service provider to another to ensure continuity of care.