HopeSource Datasheet

Template created by KCPHD

Instructions: Please provide a brief summary of progress made for each activity below for the CURRENT REPORTING QUARTER.

	Q1 2026	Q2 2026	Q3 2026	Q4 2026	Q1 2027	Q2 2027	Q3 2027	Q4 2027
Project Planning and Coordination	The project is actively operating as designed, with strong coordination between HopeSource staff and subcontractors. Systems, workflows, and communication channels have been established and are functioning effectively, allowing for ongoing alignment and responsiveness to client and program needs.							
Contract with behavioral health services partner and offer one-on-one counseling with licensed professional	A contract with a behavioral health services partner has been successfully executed. One-on-one counseling with a licensed professionals are currently being offered and integrated into client care, increasing access to mental health support for participants.							
Build relationships and coordinate with community partners	HopeSource has continued to build and strengthen relationships with community partners. Collaboration has expanded across agencies, resulting in increased coordination of services and more streamlined support for shared clients.							

Provide Care Navigation and Case Management	Care Navigators are providing comprehensive, whole-person case management. Services address housing stability, behavioral health, income, and other social determinants, ensuring each client receives holistic and individualized support.							
Conduct comprehensive mental health and needs assessments	All clients are receiving thorough mental health and needs assessments at intake. These assessments are being used to inform service planning and ensure that interventions are tailored to each client's unique circumstances.							
Make closed-loop referrals	Closed-loop referral processes are actively in place for both internal and external partners. Care Navigators are following through on referrals to ensure successful connections and tracking outcomes to support continuity of care.							

Develop personalized stability plans with clients	Clients are actively engaged in developing personalized stability plans. Goals are client-driven and reflect immediate needs as well as long-term stability, with Care Navigators providing ongoing support in implementation.							
Review and adjust clients' goals as needed	Client goals are reviewed regularly and adjusted as needed. This process is collaborative and responsive, allowing plans to evolve as clients make progress or encounter new challenges.							
Offer workshops and one-on-one support	HopeU is providing workshops focused on budgeting and financial literacy, alongside individualized one-on-one support. These services are equipping clients with practical skills to improve financial stability.							
Involve certified peer support specialists	Certified peer support specialists, through partnerships with local organizations, are actively engaged in supporting clients. Peer services are enhancing engagement, trust, and relatability within the program.							

Provide navigation and connection to resources	Care Navigators and community-based staff are consistently connecting clients to needed resources, including housing, healthcare, employment, and benefits. This support is ongoing and tailored to each client's situation.							
Housing Access and Support Services	Care Navigators are actively guiding clients through housing navigation, including applications, coordination with housing providers, and support in overcoming barriers to access.							
Track and report on key metrics	Key metrics are being tracked through the Apricot data system. Data collection processes have been implemented and are being refined to ensure accuracy and usefulness for ongoing program evaluation.							
Review client outcomes and gather feedback	Client outcomes and feedback are being gathered through direct conversations and surveys. This information is being used to assess program effectiveness and inform continuous improvement efforts.							

Coordinate community engagement and increase awareness	HopeSource is engaging in consistent community outreach on a weekly basis. Efforts include participation in local meetings, partner collaboration, and direct engagement to increase awareness of available services.							
Improve access to educational materials	Access to educational materials has been expanded through workshops, one-on-one support, and resource sharing. Efforts are ongoing to improve the availability, relevance, and accessibility of materials for clients, with a focus on practical tools that support stability and self-sufficiency.							

HopeSource Successes

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Instructions: Please provide a brief summary of successes you've seen during the CURRENT REPORTING PERIOD.

Q1 2026	Q2 2026	Q3 2026	Q4 2026	Q1 2027	Q2 2027	Q3 2027	Q4 2027
Through the integration of Care Navigation and Behavioral Health Counseling, HopeSource has increased access to services and supported clients in making meaningful progress toward stability. For example, one client who had never previously engaged in counseling and had been on a long waitlist was able to access timely services, work through a significant life challenge, and ultimately secure housing. Care Navigators supported consistent follow-through through personalized stability plans and closed-loop referrals, reducing barriers and increasing engagement. The collaboration between Care Navigation, behavioral health, and peer support has created a cohesive system that is improving client outcomes and stability.							

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HopeSource Output Data

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Instructions: Please provide updated numerical data for each of the following outputs for THE CURRENT QUARTER. Please do not use a year to date count.

	Q1 2026	Q2 2026	Q3 2026	Q4 2026	Q1 2027	Q2 2027	Q3 2027	Q4 2027	Total to date	Average
a. Number of unique individuals receiving or participating in evidence-based behavioral health-related services as a result of the grant	10								10	10
b. Number of unique individuals screened for behavioral health or related interventions	16								16	16
c. Number and percentage of unique individuals accessing services after	25%								25%	25%
d. Number of unique individuals referred to crisis or other behavioral health services for suicide risk, ideation, or behavior	3								3	3
e. Number of unique individuals screened for suicide ideation as a result of the grant	3								3	3
f. Number of unique individuals screened for trauma-related experiences as a result of the grant	3								3	3