Washoe County
Sequential Intercept Model

# System Map: Behavioral Health and Housing with Supports

January 2026

# Table of Contents

# Document Synopsis

## Background and Purpose

In 2024, partners across Washoe County collaboratively developed the Washoe County Sequential Intercept Model Strategic Framework to support planning and implementation of effective deflection and diversion strategies in the county. The Sequential Intercept Model (SIM) framework, developed by the Substance Abuse Mental Health Services Administration (SAMHSA), was designed to prevent the criminalization of mental illness and enhance collaboration between the justice and behavioral health systems by identifying critical intercept points where interventions can prevent further justice system penetration.

Through the development of the Washoe SIM Strategic Framework, it was determined that mapping behavioral health services and supportive housing options in the county available to individuals who have behavioral health challenges who are justice-involved was the most effective first step towards understanding the critical services available to support deflection and diversion in Washoe County.

This document provides a comprehensive overview of how behavioral health and supportive housing systems in Washoe County serve individuals with behavioral health challenges who are also involved in the justice system. The project sought to clarify what services exist, how accessible they are, and where critical system gaps and barriers persist. By aligning behavioral health and housing data, the project also aims to inform future strategies to improve coordination, accessibility, and outcomes for this vulnerable population.

## Approach

SIM partners used a structured four-phase research process to conduct the project.

**Phase One** involved compiling a preliminary list of behavioral health and supportive housing providers using the 2024 Washoe County Housing Inventory Count, the Nevada Medicaid Provider List, and the Nevada State Licensing Inventory.

In **Phase Two**, the team conducted outreach to 16 case managers, social workers, and outreach staff working across Intercepts 1 through 4 of the SIM Strategic Framework: Intercept 1 | Law Enforcement, Intercept 2 | Initial Detention/Initial Court Hearings, Intercept 3 | Jails/Courts, and Intercept 4 | Reentry. These conversations were designed to identify how frontline staff refer clients to services and to highlight where they encounter obstacles in doing so.

During **Phase Three,** the provider lists were refined and validated through direct outreach to providers between May and July 2025.

Finally, in **Phase Four,** semi-structured interviews were conducted with 25 providers representing 88 behavioral health programs and services and 32 providers representing 49 supportive housing programs and services. The purpose was to gather detailed information on service availability, accessibility, barriers to entry, and system-level challenges. Because participation was voluntary and based on self-report, findings reflect the providers' own perspectives and have not been independently verified through audits or site visits.

# Results

The results reveal behavioral health and supportive housing systems with significant strengths but also clear limitations that critically impact access to services for justice-involved individuals with behavioral health challenges.

## Behavioral Health System Key Takeaways

Behavioral health programs across Washoe County that serve justice-involved individuals and accept Medicaid—a total of 88 included in this mapping—offer a broad spectrum of services, including crisis stabilization, inpatient and outpatient treatment, medication-assisted therapy, detoxification programs, and case management.

Washoe County's behavioral health system has theoretical capacity based on programs interviewed collectively indicating the ability to serve approximately 16,739 individuals at any given time. However, providers and case managers described meaningful gaps in the system of care and barriers to access. They consistently indicated the need for:

- Intensive outpatient and outpatient service expansion
- Long-term residential and outpatient programs designed specifically to serve justice-involved individuals
- Access to transportation to connect clients with services and supports

Additionally, limited bed space and staffing were listed as constraining options for those needing higher levels of care. As it stands, 86.4% of Washoe County residents live in a Mental Health Healthcare Provider Shortage Area (HPSA).[1] Considering real world demand and acuity, the Washoe region likely needs more providers than the current capacity to provide timely access, reduce waitlists, and meet complex needs.

While documentation requirements generally do not block entry into services, persistent barriers related to transportation, insurance, financial, and eligibility remain widespread, posing the greatest threat to equitable access across the behavioral health system. Wait times can also impact initiation into treatment which can result in more jail days for persons not able to be released from jail without admission into a program.

Individuals with prior criminal justice involvement face additional barriers. Some programs explicitly exclude people with certain criminal histories from participation, particularly those convicted of sex crimes or violent offenses, limiting their pathways into treatment and stability.

[1] Office of Statewide Initiatives. (2025). *Population Percent Residing in a Mental Care HPSA (2025).* University of Nevada, Reno School of Medicine. Accessed on November 20, 2025: https://med2.unr.edu/SI/CountyData/atlas.html

## Housing System Key Takeaways

The supportive housing landscape mirrors the complexity of the behavioral health system. In total, 49 housing programs across Washoe County were identified as serving justice-involved individuals with behavioral health needs.

The landscape of available supportive housing services for individuals with justice involvement shows a strained system with need heavily outweighing capacity. There are strict eligibility rules that often preclude individuals with sex and/or violent crime convictions from enrollment. The system currently relies on Transitional Living/Transitional Housing programs (39% of programs), while Permanent Supportive Housing remains scarce (12% of programs) and overwhelmed (400 individuals on the waiting list for PSH alone).

There are multiple barriers that impact entry into housing. Providers noted the need for and lack of documentation, including Social Security cards, identification, birth certificates, and other documentation as a barrier frequently encountered. Guidelines set by specific programs and criteria for eligibility can also be a barrier. Even when those factors are addressed, there are still long waitlists, and systemic hurdles like Coordinated Entry delays and landlord discretion, which can make access uneven and uncertain for individuals with justice involvement.

When considering the behavioral health and housing services available in Washoe County, the lack of coordination between the behavioral health and housing systems further compounds these issues, resulting in fragmented care and missed opportunities for seamless service delivery.

# Considerations for Strengthening the System

## Behavioral Health System

A summary of the key themes identified through interviews with behavioral health providers, as well as suggestions to address these challenges, are outlined below. The suggestions are informed both by the challenges and gaps described by the providers, open-ended responses they provided throughout the interviews, as well as the results of external research conducted by the mapping team.

There are five challenges/gaps:

- Lack of Transportation
- Lack of Financial and Funding Supports
- Waitlists
- Exclusions for Individuals with Specific Types of Justice Involvement
- Exclusions for Individuals with Complex Health Conditions

## Challenge/Gap 1: Lack of Transportation

Transportation was cited as a barrier to accessing behavioral health care for nearly half of the programs.

The following are suggestions offered specifically to address gaps related to transportation as experienced by behavioral health clients seeking services.

- Develop a transportation assistance program that operates countywide for behavioral health clients, offering bus passes, ride-share vouchers, or mobile van services to treatment sites.
- Coordinate transportation schedules between behavioral health providers and courts, particularly for clients with multiple appointments in a day.
- Explore partnerships with public transit agencies and local nonprofits to create sustainable, low-cost transport options for high-needs populations.

## Challenge/Gap 2: Lack of Financial and Funding Supports

A lack of financial resources limits certain populations' participation in services and continuity of care. A lack of insurance or inability to pay the sliding scale fee were common reasons reported for why individuals were not eligible for participation in interviewed programs.

The following are suggestions offered specifically to address gaps related to financial and funding supports as experienced by clients seeking services.

- Expand sliding fee scale and financial assistance programs across all service types, ensuring clients can continue care despite income changes.
- Pursue county-level funding or public-private partnerships to subsidize care for uninsured or individuals with justice involvement.
- Advocate for state-level reimbursement reform to better fund wraparound and case management services not currently covered by Medicaid.

## Challenge/Gap 3: Waitlists

Nearly half of Washoe County's behavioral health programs maintain waitlists. Notably, outpatient and intensive outpatient services currently have more than 150 individuals waiting for care. This suggests that, while some providers indicate that they could serve more clients, current capacity for some program types is insufficient to meet community demand, particularly for timely outpatient and intensive outpatient services.

The following are suggested to address waitlists and reduce the amount of time that individuals go without access to needed services.

- Leverage data on waitlists and utilization to guide Washoe County, state partners, and behavioral health providers in strategically allocating public and private resources where demand is highest, ensuring more equitable and efficient service availability across program types.
- Expand intensive outpatient and outpatient service capacity through targeted funding and workforce incentives that attract and retain qualified behavioral health professionals, reducing wait times and improving access to ongoing care.

## Challenge/Gap 4: Exclusions for Individuals with Specific Types of Justice Involvement

Individuals with specific types of justice involvement—especially those with sex crime or violent convictions—face significant exclusion from the county's behavioral health programs. Nearly a quarter of all interviewed programs preclude individuals convicted of a sex crime from participating, and all four long-term residential programs interviewed disallow sex offenders from participating.

The following are suggested to assist individuals with justice involvement in accessing behavioral health services.

- Pilot specialized residential and outpatient programs designed for individuals with justice involvement, focusing on recovery and reentry rather than exclusion.
- Revisit program eligibility criteria that use blanket exclusions for certain criminal histories and work with providers to develop risk-based, case-by-case admission protocols.
- Strengthen collaboration with the justice system to align behavioral health access with diversion, probation, and reentry support efforts.
- Expand capacity to develop and sustain specialized programs for high-need and justice-involved populations, including individuals with sex crime convictions or complex behavioral health needs, to ensure these groups have meaningful access to appropriate treatment options.

## Challenge/Gap 5: Exclusions for Individuals with Complex Health Conditions

It was reported that acute psychiatric and/or certain medical conditions could impact client eligibility, as programs may lack the resources or capacity to meet complex needs. Nearly a fifth of interviewed programs indicated that mental health issues or diagnoses could serve as a barrier to entry; this included three of the four long term residential programs, making this program type difficult to access for justice-involved people in the county.

The following are suggested to assist justice-involved individuals with complex health conditions and/or acute mental health issues access behavioral health services.

- Expand integrated behavioral health and primary care models that can manage both mental and physical health needs within one system.
- Create specialized treatment tracks for individuals with dual diagnoses or high medical complexity.
- Invest in crisis stabilization and step-down facilities to bridge the gap between inpatient and outpatient care.

## Housing System

A summary of the key themes identified through the interviews with housing providers, as well as suggestions to address these challenges, are outlined below. The suggestions are informed both by the challenges and gaps described by the housing and support providers, open-ended responses they provided throughout the interviews, as well as the results of external research conducted by the mapping team. There are three challenges/gaps:

| Documentation Barriers | Specific Barriers to Permanent Supportive Housing Access | Lack of Housing Options for High-Barrier Populations |
|---|---|---|

### Challenge/Gap 1: Documentation Barriers

The requirement that applicants have certain types of documentation was reported as being a significant barrier to housing program participation by at least a third of interviewed programs. This may be compounded for justice-involved individuals, who may lose access to vital documents during times of incarceration.

The following suggestions are offered to address challenges and gaps related to documentation and reduce the length of time that justice-involved individuals with behavioral health challenges remain without access to housing.

- Work with providers to streamline program entry to change upfront documentation requirements to only those that are essential, with additional documents gathered once tenants are stabilized.
- Promote provider partnerships with the DMV, Social Security Administration, and legal aid providers to help tenants obtain IDs, Social Security cards, and income validation.
- Promote acceptance of flexible documentation (e.g., parole/probation paperwork or affidavits) to remove immediate barriers to participation.

### Challenge/Gap 2: Specific Barriers to Permanent Supportive Housing (PSH) Access

Permanent supporting housing, which is the most stabilizing type of housing, may also be the least accessible in the county. While the six programs interviewed can serve approximately 278 people in a year, there are reported to be 400 people on the waitlist for just four of those programs. PSH programs also have some of the most significant documentation requirements, and, while not specifically noted in the body of this report, half of the PSH programs surveyed noted that they preclude enrollment of individuals convicted of certain sex and violent crimes and two noted that a history of drug offenses can preclude enrollment.

The following suggestions are offered to address these challenges and gaps and make PSH more accessible for justice-involved individuals in Washoe County.

- Providers could work at a systems-level with funders and policymakers to re-examine restrictive eligibility criteria, especially when PSH is designed for those with the highest needs.
- Pilot PSH units could be created that allow entry for individuals typically excluded such as persons with a drug related felony conviction.
- Providers can expand landlord engagement through incentives like risk mitigation funds or guaranteed rent.

### Challenge/Gap 3: Lack of Housing Options for High-Barrier Populations

Similar to limitations that all populations face in accessing PSH, Washoe County's supportive housing programs can be out of reach for many individuals with justice involvement due to their backgrounds and personal circumstances.

Although only housing programs who indicated they are open to justice-involved individuals were included in interviews, many limited program eligibility based on the specific criminal history of applicants. At least two-thirds of programs had some preclusion in place, primarily based on sex or violent crime convictions. Some programs also had sobriety, drug and alcohol testing, and/or work and income requirements in place, which conflict with low-barrier approaches such as Housing First models, and which can create barriers for high needs groups such as people exiting incarceration and/or experiencing behavioral health challenges.

The following suggestions were identified to address these challenges or gaps and reduce barriers to accessing stable and supportive housing for justice-involved individuals with behavioral health challenges.

- Work with providers to develop housing tracks tailored for individuals excluded due to conviction history or behavioral health acuity. These tracks could be paired with enhanced supervision, treatment, and support services.
- Promote a Housing First approach, removing sobriety or drug/alcohol testing requirements for admission and continued tenancy. This approach acknowledges that stable housing is an overdose prevention tool.
- Provide intensive case management to assist people moving from congregate living settings to individualized housing as they require ongoing medication management, social and living skills, and support to sustain independence.
- Collaborate with justice agencies, behavioral health providers, and community organizations to co-develop solutions for high-barrier populations and share costs/liability, including solutions that accommodate people in both permanent housing and transitional settings.

## Considerations for Strengthening the System by Providers

During interviews, all providers were asked to share their insights into how behavioral health and housing systems could be improved. Their responses are synthesized and presented below to represent the provider perspective on how to strengthen the behavioral health and housing systems and better serve persons with behavioral health challenges who are justice-involved. This population is frequently housing insecure, which can further entangle them in the justice system, when their behavioral health needs may be unmet due to housing insecurity. Note that the strategies included in this section were offered directly by the providers interviewed.

### Behavioral Health System

#### Opportunity 1: Strengthen Communication Channels between Behavioral Health and Criminal Justice Systems, including Improved Case Information Sharing

Persons interviewed noted that information is not shared across systems and as a result, clients may get lost in the process and miss opportunities for accessing behavioral health services. Strategies suggested to enhance collaboration and communication include:

- Create a centralized communication system for sharing client updates, medication information, and treatment progress between courts, probation, and behavioral health providers. This could include the following actions.
    - Establish a protocol across systems to share information on clients, medication management, treatment progress, and other critical information relevant to courts, probation, and behavioral health providers in understanding the clients' unique needs and status.
    - Establish designated justice liaisons—a single point of contact at each major justice partner (e.g., jail, courts, probation) with a shared email address rather than individual staff names.
    - Develop a secure shared data platform to allow authorized access to referral forms, assessment results, and treatment notes while maintaining HIPAA and 42 CFR Part 2 compliance.
- Establish pre-release case summaries from jails that accompany clients upon discharge.
- Integrate case information sharing protocols between probation officers, courts, and behavioral health providers to avoid redundant assessments and delays.

#### Opportunity 2: Improve Continuity of Care between Jail and Behavioral Health Providers

Providers noted that discharge planning for jail release is not effective in ensuring a seamless transition into community care, particularly when access to behavioral health services is needed upon discharge. The following were suggested for enhancing transitions from jail or time of arrest into treatment or upon return to the community:

- Implement a standard process to ensure that individuals leaving jail have several days' worth of medications, treatment referrals, and scheduled follow-ups.

- Establish a rapid notification system when a client under care is arrested or released so providers can coordinate care transitions in real time.

### Opportunity 3: Address Administrative and Procedural Barriers

Providers described how barriers that routinely delay accessing treatment could be avoided if processes were in place to address administrative or procedural hurdles. They include:

- Streamline Medicaid credentialing for clinicians to reduce delays in service delivery and workforce turnover.
- Accelerate tuberculosis test processing and documentation, as slow testing delays treatment entry.
- Simplify or automate Release of Information (ROI) and record-sharing procedures between correctional facilities and community providers.

### Opportunity 4: Enhance Cross-System Training and Collaboration

Providers noted that behavioral health program staff could benefit from training with and on other systems serving their clients including the criminal justice system and housing supports, and vice versa. Joint training and enhanced exposure to other systems were perceived as ways to enhance collaboration across systems. Suggestions to support cross-system training efforts include:

- Conduct joint training sessions for behavioral health providers and criminal justice staff on topics like harm reduction, trauma-informed care, and medication for opioid use disorder (MOUD).
- Encourage law enforcement and court staff to visit treatment centers to reduce stigma and build familiarity with behavioral health services.
- Develop a shared understanding of language of care goals—shifting court expectations from “program graduation” to “sustained recovery and wellness.”

Washoe County’s behavioral health providers and criminal justice partners share the same mission—stability, recovery, and safety. With better coordination, both systems can more effectively serve individuals cycling between incarceration and care, transforming points of crisis into points of connection.

## Housing System

### Opportunity 1: Enhance Coordination and Communication between Court Officials, Law Enforcement, and Behavioral Health with Housing Providers and Case Managers

Providers described how coordination is needed to implement a system where people with behavioral health concerns who are justice-involved are quickly identified and referred into housing to reduce the likelihood of additional justice involvement. Suggestions to expedite access to housing include:

- Integrate Coordinated Entry (CE) into justice reentry planning to ensure individuals leaving incarceration are assessed and added to the community housing queue before release, rather than after.

- Align housing availability with predictable release dates to reduce mismatches.
- Create systems to share information openly to allow providers to prepare and deliver appropriate support.
- Standardize release-of-information processes so providers receive timely referrals and records.
- Embed housing representatives in specialized courts (e.g., drug court, mental health court, veterans/camo court) to streamline referrals.
- Improve interagency communication (courts, DOC, probation/parole, community living) to ensure consistent, transparent coordination.

### Opportunity 2: Support Medical and Behavioral Health Needs

Housing providers noted that people in need of housing often have complex medical and behavioral health needs. Supporting those needs as part of their housing plan increases the likelihood clients served will retain housing. The following strategies can help facilitate supporting those medical and behavioral health needs.

- Guarantee continuity of medications, medical records, and assessments during jail discharge.
- Establish multidisciplinary consultations for clients with complex needs.
- Strengthen partnerships with behavioral health services to address issues that can lead to lease violations (e.g., cleanliness, hoarding).
- Accelerate TB test results and access to health documentation.

### Opportunity 3: Reduce Financial and Legal Barriers

Providers reported that financial and legal barriers often result in people losing housing and can lead to recidivism. The following strategies are suggested to reduce financial and legal barriers and help justice-involved people retain access to stable housing.

- Expand Department of Corrections/state funding to cover prohibitive program fees and stabilize reentry.
- Provide eviction prevention supports and assist with sealing eviction and criminal records.
- Simplify and clarify guardianship processes for clients with justice involvement.

### Opportunity 4: Minimize Administrative Burdens on Providers

Providers noted that there are some administrative improvements that could reduce duplication of efforts and expedite entry into housing if providers are able to share information and eliminate extra steps. These strategies include:

- Accept existing provider reports instead of requiring duplicate data entry into court systems.
- Ensure compliance with AB236 to improve cross-agency coordination.
- Avoid referring clients with needs beyond a program's capacity without prior consultation.

Taken together, these opportunities highlight the importance of synchronization: aligning justice and housing systems so that clients leaving incarceration can transition smoothly into stable housing with the resources and support needed to succeed.

# System Recommendations Based on a Synthesis of All Mapping Activities

The following system recommendations, informed by the mapping results, align with provider-identified opportunities to improve service access and reduce barriers to care. They, and the associated goals, objectives, and strategies, are intended for inclusion in the Washoe region's Strategic Framework as outcomes of this mapping initiative. There are four themes:

| Strengthen Coordination Across Systems | Remove Policy and Eligibility Barriers | Expand Housing Options and Treatment Capacity | Tailor Services for High-Barrier Populations |
|---|---|---|---|

## Theme: Strengthen Coordination Across Systems

**Goal: Improve communication and integration between behavioral health, housing, and justice systems to reduce delays and ensure continuity of care.**

***Objective***: Shorten the time from identification to referral and enrollment while eliminating handoff failures.

*Strategies*:

- Establish a **common intake and warm-handoff process** across crisis, booking, and early court stages (Intercepts 0–2).
- Implement **universal screening** for mental health, substance use, and housing needs, followed by immediate referral to a care navigator who ensures clients are not lost between systems.

## Theme: Remove Policy and Eligibility Barriers

**Goal: Simplify access to services by addressing documentation, insurance, and criminal history restrictions.**

***Objective***: Remove procedural barriers that delay access and impede continuity of care.

*Strategies:*

- Create **"documentation-first" reentry protocols** to secure IDs, Social Security cards, and birth certificates before release.
- Use Nevada's **1115 reentry demonstration** to extend pre-release services for up to 90 days, covering case management, medications, and community linkages.
- Partner with Medicaid to **suspend rather than terminate coverage** during incarceration so individuals have active insurance upon release.

## Theme: Expand Housing Options and Treatment Capacity

**Goal: Increase the supply of safe, supportive housing and behavioral health services that stabilize individuals, promotes health, and prevents returns to jail or homelessness.**

***Objective***: Scale the right mix of units and supportive services including access to treatment to reduce cycling through jail, ED, and shelter.

*Strategies*:

- Prioritize development of **Permanent Supportive Housing (PSH)** aligned with Housing First principles.
- Create **PSH set-asides** for justice-involved individuals and ensure service rates are adequate to maintain stability.
- Balance the housing portfolio with **transitional and medical-respite options** to support recovery and step-down care.
- Expand **outpatient and intensive outpatient** services for justice-involved individuals.
- Develop **specialized residential and outpatient programs** based on pilot programs that are designed for individuals with justice involvement, focusing on recovery and reentry rather than exclusion.

## Theme: Tailor Services for High-Barrier Populations

**Goal: Ensure that people with serious mental illness (SMI), intellectual or developmental disabilities (I/DD), or complex criminal histories have access to appropriate, effective services.**

***Objective***: Remove procedural barriers that impede continuity of care.

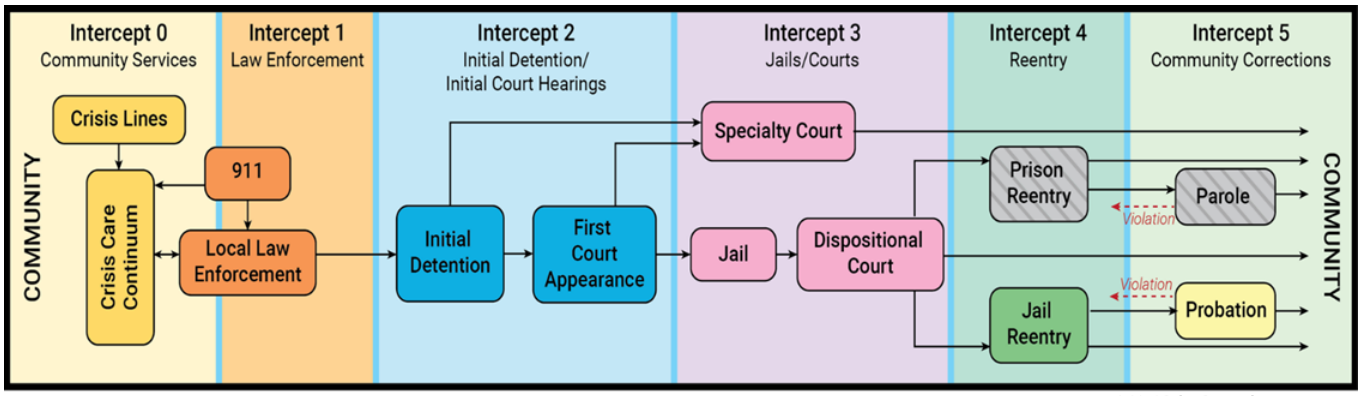
*Strategies*:

- Implement **Assertive Community Treatment (ACT) combined with PSH**, ensuring low-barrier entry and continuity of psychiatric care.
- Apply **ADA-aligned screening and crisis protocols** that account for disability-related needs.
- Offer **pre-release document clinics** in collaboration with DMV and SSA to reduce administrative barriers.
- Encourage providers to adopt **individualized eligibility assessments** rather than blanket exclusions based on criminal history.

These coordinated, practical strategies work within the intercepts and across the system as a whole. They aim to close service gaps, reduce recidivism, and create a more integrated behavioral health and housing system that promotes stability and recovery for justice-involved residents in Washoe County.

# Background and Introduction

In 2023, Washoe County began exploring how to implement the Sequential Intercept Model (SIM), a framework designed to prevent the criminalization of mental illness and enhance collaboration between the justice and behavioral health systems. The SIM framework, developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), identifies critical intercept points where interventions can prevent further system penetration. For more information on the SIM Framework, visit: https://www.samhsa.gov/communities/criminal-juvenile-justice/sequential-intercept-model.
The accompanying graphic illustrates the six SIM intercepts. For Washoe County's initial SIM Implementation Initiative, efforts focus on Intercepts 1-4. There is a separate significant collaborative initiative where participants are working to build out the Crisis Care Continuum in Washoe County which addresses Intercept 0.




In 2024, partners across Washoe County collaboratively developed the Washoe County SIM Strategic Framework to support planning and implementation of effective deflection and diversion strategies in the county.

## The Washoe SIM Strategic Framework

The Washoe SIM Strategic Framework focuses on four main goals, as depicted in the graphic below.

**Washoe SIM Strategic Goals**

- Improve early identification and assessment of individuals who have behavioral health needs with or at-risk of justice involvement.
- Deflect and divert appropriate individuals with behavioral health needs from justice system involvement to a behavioral health system of care.
- Enhance the behavioral health system of care, improve navigation of services, and promote support and recovery for individuals with or at-risk of justice involvement.
- Increase access to integrated services in the community that address criminogenic risks and meet needs.

This document summarizes the results of mapping which was identified as an important initiative of the Framework. It was determined that mapping available behavioral health services and supportive housing options to individuals who are justice-involved and have behavioral health challenges was the most effective first step towards understanding the critical services available to support deflection and diversion in Washoe County.

## Understanding The Link between Housing and Behavioral Health

Finding sufficient housing for people with justice involvement is challenging, and people who are also experiencing behavioral health challenges may face additional barriers. Individuals experiencing serious mental illnesses "may often rely on Social Security Insurance (SSI) and Social Security Disability Insurance (SSDI) payments, making many housing options unaffordable."[2] When this is not the case, other behavioral health issues may also cause instability related to employment and behaviors that may impact individuals' ability to remain housed.

Supportive housing, a form of affordable housing that provides residents with access to support services tailored to help them maintain housing stability and improve their quality of life, is an important solution. Supportive housing is, according to the Corporation for Supportive Housing, "an innovative and proven solution that helps people facing complex barriers to housing thrive and break the cycle of homelessness."[3] One such barrier is unaddressed behavioral health concerns. Services available within supportive housing are designed to "help tenants use stable housing as a platform for individual health, recovery and personal growth."[4]

It is important to note, however, that not all housing options in which services may be provided or coordinated are considered supportive housing. Supportive housing is a specific, evidence-based model

**Supportive Housing vs. Housing with Supports and Services**

As used throughout this document, supportive housing should be differentiated from housing with supports and services.

**Supportive Housing:** *A federally recognized, evidence-based permanent housing model with specific, flexible, voluntary services designed to support individuals*

**Housing with Supports and Services:** *Any type of housing available with services provided or coordinated by the housing provider that serves people with behavioral health and justice involvement*

[2] National League of Cities. (2024). *Exploring the Link Between Housing Stability and Mental Health*. Accessed July 2025: https://www.nlc.org/article/2024/05/28/exploring-the-link-between-housing-stability-and-mental-health/

[3] Corporation for Supportive Housing. (nd). *What is Supportive Housing?* Accessed July 2025: https://www.csh.org/supportive-housing-101/

[4] Corporation for Supportive Housing. (2022). *Standards for Quality Supportive Housing Guide.* Accessed November 2025: https://www.heartlandhoused.org/Resources/0b48f5c5-1b4d-4080-a3b6-4a42f3023ab8/standards-for-quality-supportive-housing-guidebook-2022.pdf

that supports permanency.[5] Other housing with lighter-touch service provision or coordination is also available within Washoe County and serves people with behavioral health issues and justice involvement.

## Purpose of this Document

In recognition of the link between housing and behavioral health and in alignment with the SIM Strategic Framework described above, this document maps existing behavioral health programs and services and housing programs available in Washoe County that serve people with justice involvement and behavioral health challenges. It is intended to provide a clear picture of currently available assets as well as highlight barriers and needs. This information will allow Washoe SIM partners to identify system and service gaps and consider how they may be addressed.

### Organization of this Document

This report is divided into six sections.

1. The first section describes the **methods and approach** used to develop the report and describes any limitations that should be considered when interpreting the findings.
2. The second section provides initial **guidance and data from case managers, social workers, and outreach staff** that informed sections 2 and 3 (i.e., relevant summary results from Phase 2 activities).
3. The third section provides a high-level overview of the available **behavioral health programs and services** in Washoe County that accept Medicaid and serve people with justice involvement.
4. The fourth section provides a high-level overview of the **housing programs** in Washoe County that serve people with behavioral health challenges and justice involvement.
5. The fifth section provides a high-level overview of **system challenges and gaps** across behavioral health and housing programs and services.
6. The sixth section provides **system strengthening opportunities** in response to the data collected in previous sections.

The appendices of this document comprise the following:

- Appendix A: Individual Program Profiles for each Behavioral Health Provider Interviewed
- Appendix B: Individual Program Profiles for each Housing Program Interviewed
- Appendix C: Supportive Housing Programs in Development

Note: Text boxes like this appear throughout the document and include quotes from providers interviewed during the project.

[5] Substance Abuse and Mental Health Services Administration (SAMHSA). (2010). *Permanent Supportive Housing Evidence-Based Practices*. Accessed July 2025: https://library.samhsa.gov/product/permanent-supportive-housing-evidence-based-practices-ebp-kit/sma10-4509

# Methods and Approach

Washoe SIM partners developed five overarching questions to guide the research approach for this project:

1. **Availability:** What behavioral health and supportive housing programs and services are available for people with justice involvement and behavioral health challenges in our community?
2. **Access:** How do people with justice involvement access available behavioral health and supportive housing programs and services?
3. **Barriers to Access:** What barriers do people with justice involvement experience when accessing available behavioral health and supportive housing programs and services?
4. **System Gaps:** What gaps in the behavioral health and supportive housing system exist that may be impacting services and supports?
5. **System Strengthening Considerations:** What can strengthen the service delivery system to help clients with behavioral health concerns who are housing insecure?

To explore these questions, research was conducted in the following four phases.

**Phase 1: A Preliminary List of Supportive Housing and Behavioral Health Providers Was Developed**

Sources used to develop the preliminary housing list comprise the following:

- Final 2024 Housing Inventory Count.[6]
- List of Community Based Living Arrangement (CBLA) Providers for the Nevada State Licensing Inventory.[7]
- Further online research of publicly available information including organizational websites and resource lists

The list of behavioral health providers was created with a focus on systems-level service providers offering key behavioral health services such as inpatient substance use treatment and acute care, intensive outpatient, medication assisted therapy, ambulatory or outpatient detox, and mobile crisis services. In addition, providers were only interviewed if they accepted and billed Medicaid in 2024, and if they were willing to serve people with justice involvement.

[6] U.S. Department of Housing and Urban Development. (2024). *HUD 2024 Continuum of Care Homeless Assistance Programs Housing Inventory Count Report*. Accessed November 3, 2025: https://files.hudexchange.info/reports/published/CoC_HIC_CoC_NV-501-2024_NV_2024.pdf

[7] Nevada Division of Public and Behavioral Health (DPBH). (nd). *Licensee Search*. Accessed November 3, 2025: https://nvdpbh.aithent.com/Protected/LIC/LicenseeSearch.aspx?Program=HF&PubliSearch=Y&returnURL=~/Login.aspx?TI=2#noback

Sources used to develop the preliminary behavioral health provider list comprise the following:

- Medicaid Provider List from State of Nevada
- 2024 SIM Mapping Brief
- Further online research of publicly available information including organizational websites

It is important to note that the list of Medicaid providers was intended to determine which providers had recently served Medicaid patients and billed Medicaid for behavioral health services, as providers who billed Medicaid were identified as those who were most likely to contribute to serving the justice involved population.

**Phase 2: Outreach to Case Workers, Social Workers, and Outreach Staff in Intercepts 1-4**

Outreach was conducted with direct service staff from the following programs within these intercepts; these engagements were intended to refine the list of providers developed in Phase 1, identify to which providers they currently refer, and understand potential challenges they experience in supporting clients in accessing housing and behavioral health resources.

While most program representatives participated in an interview, some representatives instead elected to complete a form to answer the interview questions. Wherever possible, follow up conversations were held to clarify responses. The results of this outreach were aggregated and are presented in the Results | Direct Service Staff Guidance on Mapping section. Results helped solidify the providers to conduct outreach to in Phase 3 and to interview in Phase 4 and informed the areas of inquiry to be pursued via interviews in Phase 4.

| Intercept | Program |
|---|---|
| **Intercept 1: Law Enforcement** | Reno Mobile Outreach Safety Team<br>Sparks Mobile Outreach Safety Team<br>Washoe Mobile Outreach Safety Team<br>Washoe Homeless Outreach Proactive Engagement (HOPE) Team |
| **Intercept 2: Initial Detention/Initial Court Hearings** | Support Treatment Accountability Recovery (STAR) Program<br>Second Judicial District Court (SJDC) Pretrial Services |
| **Intercept 3: Jails/Courts** | Washoe County Sheriff's Office—Medication Assisted Treatment (MAT) Program<br>Washoe County Sheriff's Office Detention Services Unit (DSU)<br>Competency Court Treatment Team and Case Management<br>Reno Justice Court Specialty Court<br>Reno Municipal Court Specialty Court—Fresh Start<br>SJDC Assisted Outpatient Treatment (AOT)<br>SJDC Competency Court<br>SJDC Specialty Court<br>Sparks Municipal Court (SMC) Alcohol and Other Drugs (AOD) Court<br>SMC Co-Occurring Disorder Court |
| **Intercept 4: Reentry** | NaphCare Medication and Prescription Access |

**Phase 3: Provider List Refined and Full Outreach Conducted**

Phase 2 activities resulted in a refined list of behavioral health and housing service providers in the county, with some additional providers being added to each list. Some providers were also removed when it was clear they did not serve justice-involved clients in the Washoe County region, or when staff interviewed in Phase 2 had no knowledge of the program or evidence it was operational. Outreach was conducted to the refined list of identified behavioral health and housing providers who serve individuals with justice involvement and behavioral health concerns. Through emails and phone calls, these providers were asked to participate in a semi-structured interview about their services. A complete list of these providers can be found in Appendices A (Behavioral Health) and B (Housing).

**Phase 4: Semi-Structured Interviews Conducted**

Semi-structured interviews designed to explore availability, access, barriers, and systems-level issues took place with providers who agreed to participate. As additional providers were identified during the course of these interviews, those providers were also considered interviews as well.

## Assumptions and Limitations

This section describes assumptions and limitations that should be considered when interpreting the findings of this report and outlines key assumptions that informed the development of outreach lists.

### Assumptions

- This document maps behavioral health programs and supportive housing resources reported by providers that serve justice-involved individuals with behavioral health concerns. The analysis assumes that respondents provided accurate and complete information to the best of their knowledge at the time of data collection.
- It is assumed that providers interpreted key terms—such as *behavioral health*, *supportive housing*, and *justice-involved*—in a consistent way, and that the participating organizations reflect a meaningful cross-section of the service landscape within the study area.

### Limitations

- Several limitations should be considered when interpreting the findings. Because the data are based on self-report, responses may include unintentional inaccuracies, incomplete information, or overstatements of capacity or services. The assessment did not independently verify the data through audits or site visits.
- Participation was voluntary, so not all relevant providers may have been captured, and some geographic areas or service types may be underrepresented. Differences in how organizations define and deliver services can also limit comparability across programs.
- The mapping reflects the perspectives of providers rather than those of justice-involved individuals themselves. As a result, the findings do not capture client experiences, unmet needs, or barriers to accessing care from a participant's point of view.

- Additionally, the data describes program characteristics rather than individual-level outcomes and should not be interpreted as a measure of service quality or effectiveness. Because the information reflects conditions at the time of data collection (Phase 2 data collection occurring April-May 2025 and Phase 4 data collection occurring May-August 2025), recent program changes, new initiatives, or funding shifts may not be represented.
- The results are intended to offer a descriptive snapshot of existing behavioral health and housing with supportive resources available to justice-involved individuals. They provide a foundation for identifying service gaps, improving coordination, and guiding future planning efforts, rather than an evaluative assessment of program performance.
- For many questions in both the Phase 2 and Phase 4 data collection activities, providers were presented with a list of pre-populated multiple choice answer options. While the inclusion of "Other, please specify" options as well as the semi-structured, flexible nature of the interview was designed to support rich data collection, the inclusion of pre-selected answer choices may have led to some response bias or inadvertently influenced participant responses.

# Results | Direct Service Staff Guidance on Mapping

During Phase 2 of this mapping project, case managers, social workers, and outreach staff (referred to throughout this section as frontline or direct service staff) were engaged to identify the behavioral health programs and supportive housing options available to justice-involved individuals in Washoe County. This effort was designed to further refine the continuum of behavioral health and housing service providers to be interviewed in Phase 4 and explore how the population of focus access care, what barriers they face, and where gaps persist.

The guidance gathered from the 16[8] direct service staff who participated in this data collection activity provided essential insight into the service landscape. It revealed not only what programs exist, but also how staff navigate them on behalf of clients, and where the system falls short.

## Service Connection Needs

Frontline staff were asked to indicate what services (i.e., behavioral health or supportive housing) they normally seek for justice-involved clients. The majority of respondents (12 respondents, 75%) selected both, indicating they sought **both behavioral health and supportive housing services** for those they served. Four respondents (25%) reported focusing primarily on behavioral health services, and none reported seeking supportive housing alone.

When asked to identify the **three most important behavioral health services** the community needs to serve their clients, respondents most frequently cited acute inpatient mental health services (n=8), followed by crisis stabilization (n=7), and residential substance use treatment or detox (n=6). Related comments from staff emphasized the importance of a continuum of care that supports individuals throughout their recovery and promotes diversion from justice settings, as illustrated by the quote to the right.

> "For diversion [we] need something between acute inpatient and intensive outpatient."
>
> — Frontline Staff Interview Participant

When asked to share the **three most important types of supportive housing** the community needs to serve their clients, respondents indicated strong demand across multiple levels of supportive housing. Permanent Supportive Housing emerged as the top identified need (n=10), followed by Transitional Living (n=9), and Rapid Rehousing (n=5).

Overall, participants noted that the services most difficult for their clients to access are **supportive housing** (n=14) and **mental health services** (n=11), followed by crisis response (n=8), case management (n=6), substance use treatment (n=5), and medication access (n=4), reinforcing the importance of mapping the behavioral health and housing systems in order to implement SIM.

[8] Note that for the majority of questions summarized in this section, the number of participants who provided a specific response (n) is offered rather than a percent.

## Access and Eligibility Barriers

Participants shared a variety of barriers that impacted the ability for clients to enroll in and access their programs.

When asked what **frequently delays and/or prevents services**, the most common responses were waitlists (n=15), criminal history restrictions (n=12), mental health diagnosis (n=11), and Medicaid requirements (n=10). Additional challenges included lack of documentation, transportation, and client's lack of financial resources (each n=7).

Participants were also asked to consider **specific barriers that clients face when accessing services**. The most common responses were a lack of providers and rent-related expenses (both n=11), long wait times and no income for basic needs (n=10), transportation and insurance (both n=9), followed by medication and stigma (both n=5), and utilities deposit (n=4).

With waitlists and wait times appearing as common responses to both questions, the issue of wait times is explored in more detail in a subsequent section below.

Given its central importance to the SIM initiative, the potential impact of an individual's criminal history on their ability to access services was also further explored via a subsequent question. When asked what **criminal charges most often prevent services**, violent offenses and sexual offenses (each n=13) were the most common responses provided, followed by domestic violence (n=9) and arson (n=7). One participant indicated sexual offenses, violent offenses, and domestic violence charges may keep people from needed programs, such as mental health court.

> "Many lose their documents and they [are] not able to reconcile official identity because of mental state."
>
> — Frontline Staff Interview Participant

Participants were also asked to share the **top three documentation barriers** that clients face. Results indicated IDs/driver's license (n=10) as the most common documentation barrier, followed by Social Security cards (n=9), and birth certificates (n=8). Two respondents noted that generally, clients have documentation or that this isn't a challenge as they are able to do what needs to be done to get documentation; however, at least one participant noted that some clients may struggle to obtain the documents needed due to behavioral health challenges.

**Access to health insurance** plays a defining role in service availability. Nearly half of respondents (44%) said insurance was a barrier for some clients, while another 22% viewed it as a major barrier for most clients, and yet another 22% noted that its impact varies widely by provider. Only 11% described insurance as a minor issue. These findings suggest that gaps in coverage or administrative requirements continue to restrict entry into critical programs.

## Wait Times

Participants reported that **wait times to access behavioral health services** varied by whether the services were outpatient or inpatient, and whether their clients were in custody or out of custody. Overall, in custody clients seeking inpatient services tended to experience the longest wait times, with half of respondents indicating at least a month wait for these services (6/12).[9] and another four reporting a 1-4 week wait. Same day access was only reported by one program, for an inpatient, out of custody scenario.

> "At the beginning of the month, it is easier; towards the end of the month it is harder to get patients in because there are more individuals in crisis—the insurance cycle also impacts this. For chronic individuals, this is impacted. Cold weather also impacts availability."
>
> — Frontline Staff Interview Participant

For **supportive housing**, 1-3 months was the most commonly reported wait time, followed by waits of more than three months. A few respondents highlighted distinctions by housing type, noting that long-term placements may require the longer wait times. These findings reinforce the limited readily available supply of permanent housing options and indicate bottlenecks at key transition points for justice-involved individuals seeking stability after release.

## Populations Facing Unique Challenges

Frontline staff were also asked to identify subpopulations that face unique challenges in accessing services. The most frequently cited group was individuals with serious mental illness (SMI) or post-traumatic stress disorder (PTSD), named by 15 respondents, and 9 identified individuals with intellectual or developmental disabilities (I/DD) as facing unique challenges. Other vulnerable groups mentioned included LGBTQ+ individuals (n=3) and veterans (n=3), older adults (n=2), and young offenders (18-30) and unhoused individuals (both n=1).

[9] Not all participants provided a response to each question (i.e., outpatient, out of custody; inpatient, out of custody, etc.), so for this section both the number of people who provided the response being explored and the total respondents to the specific question are provided in the parenthetical.

## Phase 2 Key Findings and Themes

The following key themes are based on the results of these 16 interviews:

1. **High Demand, Limited Supply**: Behavioral health and supportive housing resources are insufficient to meet community demand, with most participants reporting that the services most difficult for their clients to access are supportive housing and mental health services. Wait times are long, especially for inpatient treatment for individuals in custody.
2. **Systemic Access Barriers**: Criminal history restrictions prevent service access, especially for individuals with certain criminal charges such as violent or sexual offences.
3. **Documentation and Insurance Coverage as Structural Obstacles**: The absence of identification and other documentation or insurance coverage prevents many individuals from even entering service pipelines, highlighting the importance of reentry planning that prioritizes these foundational needs.

## Phase 2 Conclusions

The Phase 2 findings paint a clear picture of a system under strain for those individuals interviewed. Frontline staff are actively working to connect individuals with behavioral health and housing supports, but their efforts are often constrained by resource scarcity and eligibility barriers. Access is particularly limited for those without documentation or insurance coverage, and for individuals with serious mental illness or intellectual and/or developmental disabilities. Addressing these challenges will require a comprehensive, coordinated strategy that expands capacity, streamlines access, and strengthens partnerships between behavioral health, housing, and justice systems. The data underscores the importance of viewing supportive housing and behavioral health as interdependent pillars in promoting stability and reducing justice system involvement.

While not specifically described in the content above, the persons interviewed in Phase 2 also helped to identify behavioral health and supportive housing programs that serve the target population for SIM to be engaged in Phase 3. The results of the Phase 2 activities also helped to refine the interview questions used, and the areas of inquiry explored in Phase 4 of the mapping project, as the research team delved further into the issues identified by frontline staff and summarized above.

# Results | Interviews with Behavioral Health Program Providers

The following section provides an overview of the behavioral health programs in Washoe County that serve people with behavioral health challenges and justice involvement, and that also accept Medicaid. It describes the availability of behavioral health programs, how individuals access those programs, and what barriers may be impacting access.

A total of 25 individuals were interviewed representing **88 behavioral health programs and services** across Washoe County that met the criteria described above.

## Service Composition

The 88 programs were categorized into the following types based on a description of the services offered during interviews.[10]

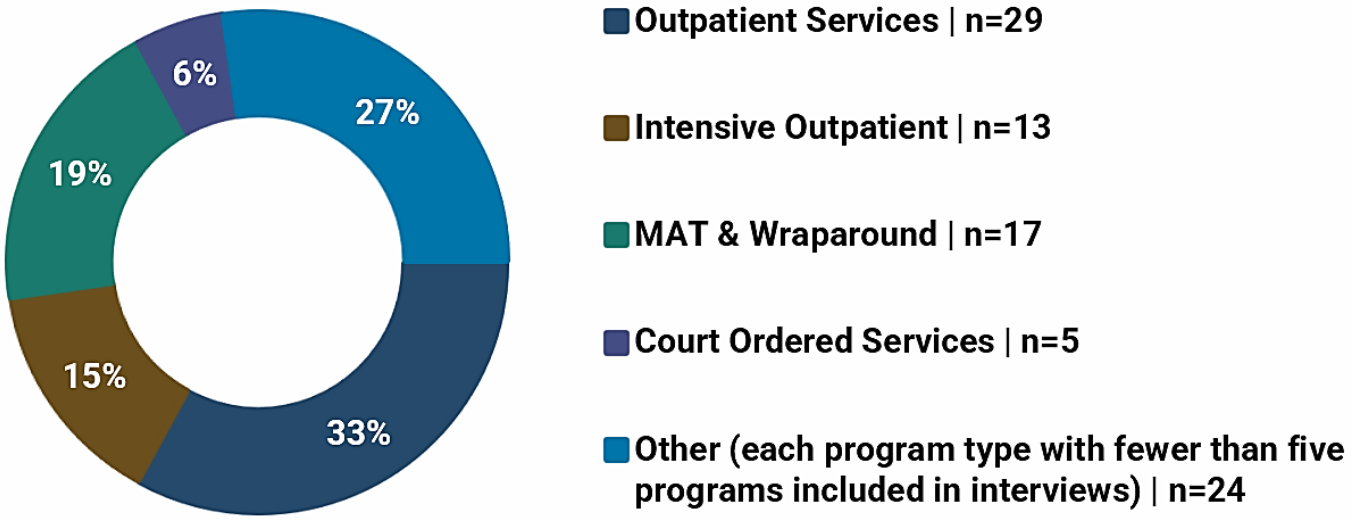
| Description | Definition | # of Providers Identified |
|---|---|---|
| **Outpatient Services (OP)** | Outpatient services serve as a key access point in a comprehensive and effective continuum of care. These services include assessment and diagnosis, testing, basic medical and therapeutic services, crisis intervention, therapy, partial and intensive outpatient hospitalization, medication management and case management services. | 29 |
| **Intensive Outpatient (IOP)** | Intensive Outpatient Programs consist of a prearranged schedule of core services (e.g., individual counseling, group therapy, family psychoeducation, and case management provided for a specified number of hours per week). | 13 |
| **Long-term Residential (RTC)** | Long-term residential treatment are non-hospital settings providing structured, 24/7 support for individuals with substance use or mental health disorders who need intensive care beyond outpatient options but not hospital-level care. These programs typically last longer than 30 days, often for several months or even a year, and include a range of services to help prepare individuals for community reintegration. | 4 |

[10] The definition in the table below for the most part align with previously published Medicaid state manual provider type definitions, which have since been updated on the https://www.medicaid.nv.gov/providers/billinginfo website. The exception is long-term residential, which aligns more with the SAMHSA definition at https://www.samhsa.gov/find-support/learn-about-treatment/types-of-treatment#:~:text=Inpatient%20(meaning%20you%20stay%20at,Peer%20recovery%20support.

| Description | Definition | # of Providers Identified |
|---|---|---|
| **Medication Assisted Treatment (MAT) and Wraparound Services** | MAT is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. For those with an opioid use disorder (OUD), medication addresses the physical difficulties that one experiences when they stop taking opioids. | 17 |
| **MAT Detox** | During the detox phase, MAT can be used to safely manage acute withdrawal symptoms and stabilize a patient before transitioning to ongoing treatment for long-term recovery. | 1 |
| **Crisis Stabilization Services (CSS)** | Crisis Stabilization Services provide immediate, short-term behavioral health care for individuals experiencing a mental health or substance use crisis. CSS are designed to de-escalate or stabilize acute symptoms, ensure safety, and restore functioning while connecting individuals to appropriate ongoing care and supports. These services aim to prevent unnecessary hospitalization or justice system involvement and are a vital component of the behavioral health crisis continuum. Core elements include rapid access, a supportive and recovery-oriented environment, and a focus on hope, empowerment, and connection to continued care. | 4 |
| **Mobile Crisis Stabilization** | Community-based mobile crisis intervention services rely on trained teams that provide immediate, 24/7 response to individuals experiencing a mental health or substance use crisis in their own environment, like at home. The goal is to de-escalate the crisis, provide stabilization services, and connect the person to care, preventing unnecessary emergency room visits or hospitalization. | 2 |
| **Psychiatric Access** | Access to psychiatry is often utilized to establish a diagnosis and treatment plan for individuals with severe mental health or substance use disorders or to establish a legal hold. Diagnosis, access to prescription medication, and follow-up are provided to facilitate treatment. Services are provided in an outpatient setting or via telehealth and often include medication management. | 4 |

| Description | Definition | # of Providers Identified |
|---|---|---|
| **Inpatient Psychiatric** | Inpatient mental health services provide the highest level of care for individuals with severe mental health or substance use disorders. Delivered in freestanding psychiatric hospitals or general hospitals with specialized units, these programs offer 24-hour supervision in a secure, structured environment. Treatment follows a multidisciplinary approach focused on stabilization, symptom management, skill development, relapse prevention, and discharge planning to ensure continuity of care after hospitalization. | 4 |
| **Case Management** | Case management is a coordinated approach to linking clients with appropriate services to meet specific needs and achieve goals. It is a strategy for helping individuals, especially those with substance use and mental health disorders access essential resources like financial aid, housing, and medical care by coordinating services and mobilizing support. Key functions include assessment, planning, linkage, monitoring, and advocacy. | 3 |
| **Court Ordered Services** | Court ordered services are a court-mandated requirement for individuals who are unwilling or unable to seek treatment voluntarily. The goal is to provide access to care, reduce criminal justice involvement, and help individuals stabilize and improve their behavioral health outcomes through a variety of treatment approaches like outpatient counseling, medication, and inpatient care. | 5 |
| **Family Services** | Family services are a spectrum of interventions, programs, and support systems that address the complex needs of families, particularly those facing mental health and/or substance use challenges. This includes family-centered treatment, which provides comprehensive clinical and support services for all family members, and family peer support services, where individuals with lived experience guide other families. The goal is to enhance family well-being, improve relationships, and connect families with the resources they need to navigate their specific challenges. | 2 |

Forty-eight percent of programs (42 of 88) are outpatient or intensive outpatient services and 19% of programs (17) are MAT and wraparound services. Taken together, these represent 67% (59) of programs interviewed. Mobile crisis and crisis stabilization (6), long-term residential (4), and inpatient psych (4) represent 16% of programs (14). This is depicted in the figure below.



## Service Capacity

Across the 88 programs interviewed, an estimated 16,739 individuals can be served at any given time. This is summarized by program type in the table below.

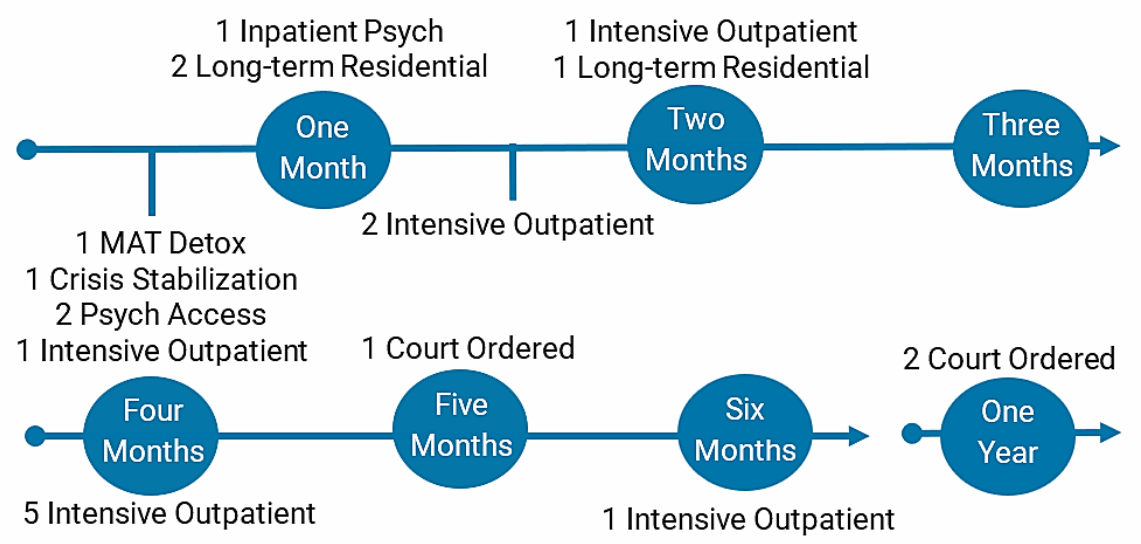
Eighty-six percent of programs (76 of 88) indicated they currently have the capacity to serve additional individuals.[11] This suggests that the current behavioral health network in Washoe County is not strained but may speak to other limitations providers mentioned, such as funding, staffing, admission criteria, or slow Medicaid credentialing and reimbursement.

| Program Type | # of Programs | Serves at One Time | Serves in a Year |
|---|---|---|---|
| **Outpatient Services** | 29 | 8,880 | 24,696 |
| **Intensive Outpatient** | 13 | 416 | 8,337 |
| **Long-term Residential** | 4 | 70 | 568 |
| **MAT & Wraparound** | 17 | 5,541 | 15,935 |
| **MAT Detox** | 1 | 40 | 40 |
| **Crisis Stabilization** | 4 | 716 | 18,846 |
| **Mobile Crisis Stabilization** | 2 | 18 | 6,200 |
| **Psychiatric Access** | 4 | 105 | 8,250 |
| **Inpatient Psychiatric** | 4 | 125 | 22,255 |
| **Case Management** | 3 | 450 | 3,022 |
| **Court Ordered Services** | 5 | 228 | 340 |
| **Family Services** | 2 | 150 | 400 |
| **Total** | **88** | **16,739** | **108,889** |

[11] Some of the programs indicating a capacity to serve additional individuals do not have a waitlist.

## Program Length

Seventy-six percent of programs (67 of 88) have a length of stay that is **individualized to meet participant needs**.




The durations of the other 21 programs that participated in interviews varied by program type as depicted in the graphic below, ranging from five days up to one year.

Additionally, nearly all programs interviewed (93%) reported that they provide resource navigation services to connect a client to community resources or the next level of care as program services end.

**Key Takeaways: Behavioral Health Services Availability**

Washoe County's behavioral health system has capacity with programs interviewed collectively indicating the ability to serve approximately 16,739 individuals at any given time. However, providers and case managers described meaningful gaps in the system of care and barriers to access. They consistently indicated the need for:

- Intensive outpatient and outpatient service expansion
- Long-term residential and outpatient programs designed specifically to serve justice-involved individuals
- Access to transportation to connect clients with services and supports

Additionally, limited bed space and staffing constrained options for those needing higher levels of care.

As it stands, 86.4% of Washoe County residents live in a Mental Health Healthcare Provider Shortage Area (HPSA).[12] Considering real world demand and acuity, the Washoe region likely needs more providers than the current capacity to provide timely access, reduce waitlists, and meet complex needs.

[12] Office of Statewide Initiatives. (2025). *Population Percent Residing in a Mental Care HPSA (2025).* University of Nevada, Reno School of Medicine. Accessed on November 20, 2025: https://med2.unr.edu/SI/CountyData/atlas.html

# Program Access

## Waitlist Availability

Forty-nine percent of programs (43 of 88) reported maintaining a waitlist, with an estimated 224 individuals waiting for services at the time interviews were conducted. It is important that an entry in the "No" waitlist column is not interpreted to mean that individuals are not waiting to be served by a program; this may instead mean that a program does not maintain a waitlist, putting the burden on individuals seeking care to continue to follow up with the program in hopes of a vacancy.

Outpatient service programs reported the largest number of people on their combined waitlists, with an estimated 137 individuals waiting for services at the time of interview.

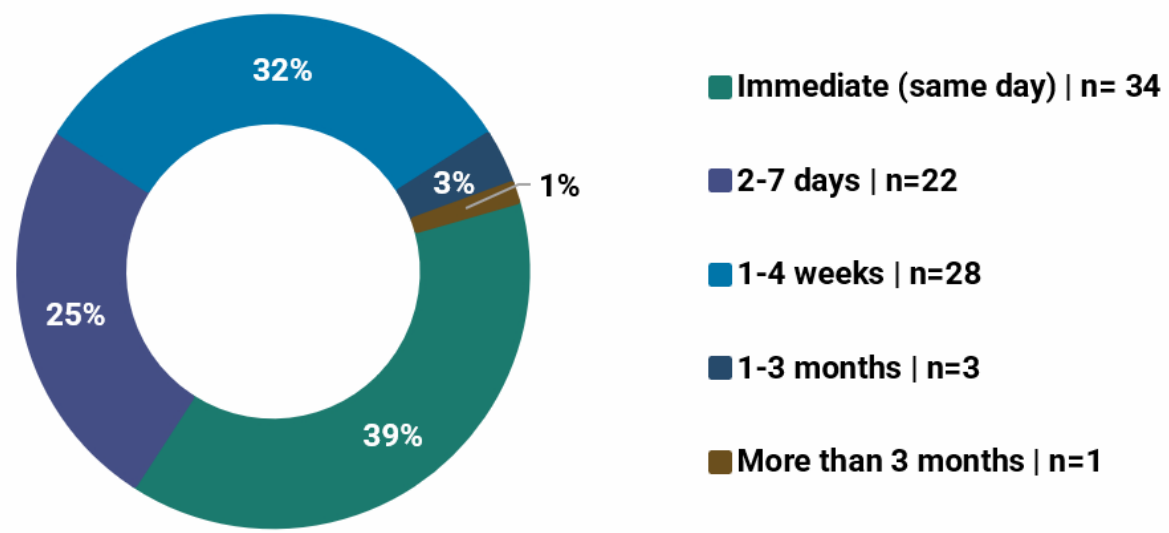
Information on the availability of a waitlist by program type is summarized in the table below.

| Program Type | Waitlist | | Estimated # of People on Waitlist |
|---|---|---|---|
| | No | Yes | |
| **Outpatient Services** | 11 | 17 | 137 |
| **Intensive Outpatient** | 6 | 7 | 27 |
| **Long-term Residential** | 2 | 2 | 6 |
| **MAT & Wraparound** | 10 | 8 | 25 |
| **MAT Detox** | 2 | 0 | 0 |
| **Crisis Stabilization** | 4 | 0 | 0 |
| **Mobile Crisis Stabilization** | 2 | 0 | 0 |
| **Psychiatric Access** | 2 | 2 | 12 |
| **Inpatient Psychiatric** | 1 | 2 | 6 |
| **Case Management** | 1 | 2 | 6 |
| **Court Ordered Services** | 2 | 3 | 5 |
| **Family Services** | 2 | 0 | 0 |
| **Total** | **45** | **43** | **224**[13] |

[13] Some programs that maintain waitlists indicated there were currently zero individuals on the list at the time of interview.

## Referral-to-Intake Time

Providers were asked about the referral-to-intake times for their programs. Times were broken down into the following periods: **immediate (same day), two through seven days, one through four weeks, one through three months,** and **more than three months**.




Overall, the Washoe County behavioral healthcare system is able to respond with an intake a third of the time as thirty-nine percent of programs (34 of 88) are able to immediately serve individuals once they are referred to or initiate contact for services. A quarter of clients wait between 2 – 7 days to be seen for intake. A third of programs have a delay of between 1-4 weeks from referral to intake. Four programs have referral-to-intake times longer than four weeks.

The table on the following page summarizes the wait times reported by each program included in the interview, by program type. One long-term residential program reported a wait time of more than three months, while the other three long-term residential programs reported a wait time of less than four weeks. More than half of outpatient and intensive outpatient services programs reported a wait time of less than one week, while two outpatient and one intensive outpatient services programs reported a wait time between one and three months.

| Program Type | Immediate (same day) | 2-7 days | 1-4 weeks | 1-3 months | More than 3 months |
|---|---|---|---|---|---|
| **Outpatient Services** | 6 | 11 | 10 | 2 | 0 |
| **Intensive Outpatient** | 5 | 4 | 3 | 1 | 0 |
| **Long-term Residential** | 1 | 1 | 1 | 0 | 1 |
| **MAT & Wraparound** | 6 | 3 | 8 | 0 | 0 |
| **MAT Detox** | 0 | 0 | 1 | 0 | 0 |
| **Crisis Stabilization** | 4 | 0 | 0 | 0 | 0 |
| **Mobile Crisis Stabilization** | 2 | 0 | 0 | 0 | 0 |
| **Psychiatric Access** | 3 | 0 | 1 | 0 | 0 |
| **Inpatient Psych** | 4 | 0 | 0 | 0 | 0 |
| **Case Management** | 1 | 1 | 1 | 0 | 0 |
| **Court Ordered Services** | 0 | 2 | 3 | 0 | 0 |
| **Family Services** | 2 | 0 | 0 | 0 | 0 |
| **Total** | **34** | **22** | **28** | **3** | **1** |

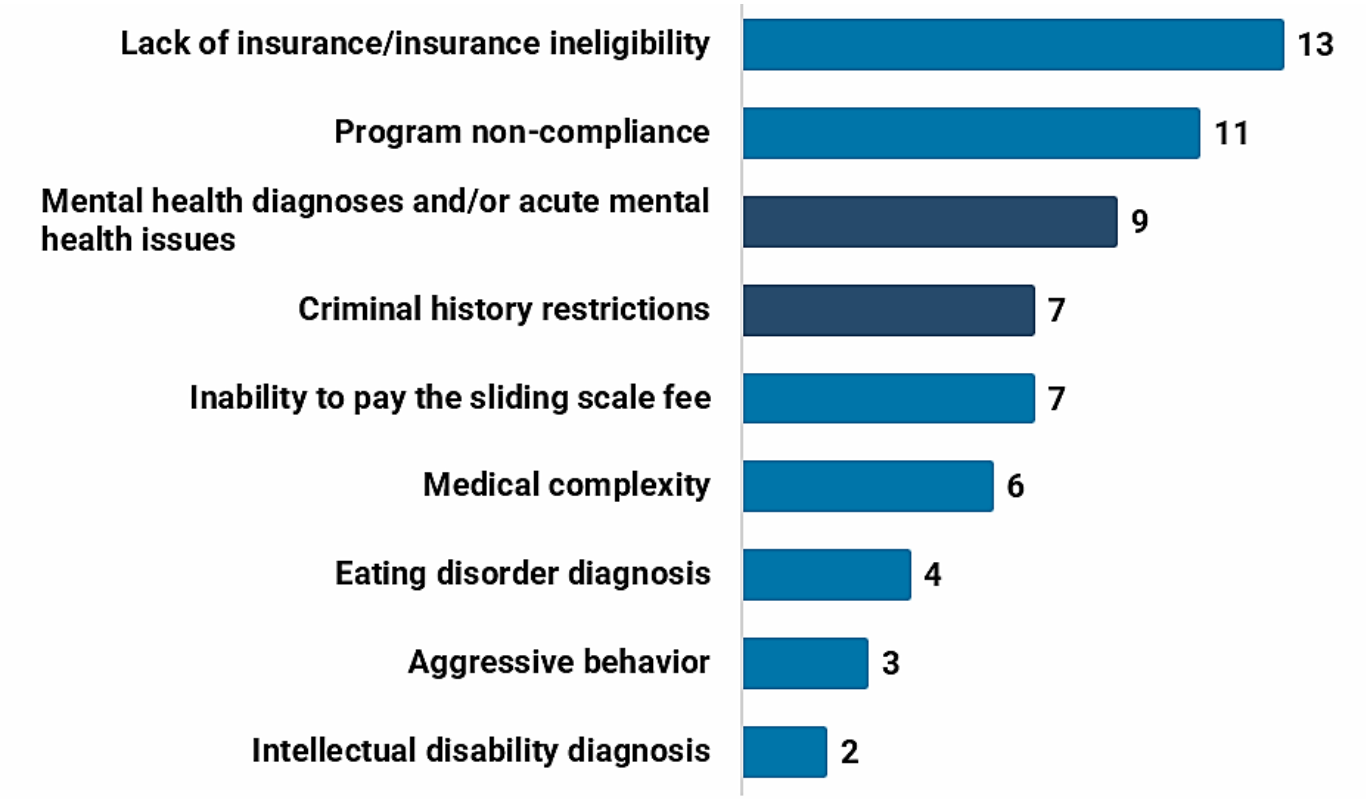
In addition to referral-to-intake times, providers were asked if there were any factors that can help to accelerate a client's entry into services for each program. The most common factors that accelerate entry to services are

- Court order, justice system referral or legal hold (20 programs noted this as a factor)
- Acuity or crisis (16 programs noted this as a factor)
- Client pregnancy (8 programs noted this as a factor)

Other factors that help accelerate a client's entry into services are **assessment completion already taken place** (e.g., ASAM; 5 programs noted this as a factor), **history or current use of injection drugs or fentanyl** (noted by 5 programs), **Tuberculosis (TB) test and/or medical clearance** (noted by 3 programs), **assignment to a case worker/manager** (noted by 2 programs), and **outside referrals** (e.g., hospital, primary care doctor, church; noted by 2 programs).

## Eligibility Requirements

Providers were asked to discuss the most common reason why individuals were not eligible for participation in their programs. The most common responses are provided in the figure below.




However, of note for individuals with behavioral health challenges and justice involvement:

- **Criminal history restrictions** serve as a barrier to eligibility for **seven programs;**[14] with five programs noting that these restrictions were specific to violent or sexual offenses
- **Mental health diagnoses and/or acute mental health issues** serve as a barrier to eligibility for **nine programs,** three of which are long term residential programs (out of a total of four programs interviewed); the other six are either outpatient or intensive outpatient programs

Providers were also asked explicitly via a separate question if there were specific groups they were unable to serve due to funding, capacity, or mandate. Of most relevance to the SIM initiative is that

- **Twenty-two percent of programs (19 of 88) preclude individuals convicted of a sex crime from participating**. All four long-term residential programs disallow sex offenders from participating, making this type of treatment out of reach for individuals in the county with a sex crime conviction.

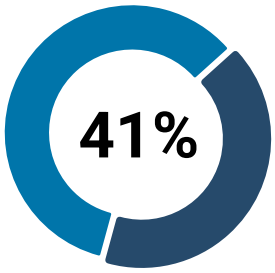
[14] Note that at the start of the interviews, only programs that indicated they served justice-involved individuals were included in subsequent questions. Therefore, these responses should be indicative of specific types of criminal history restrictions.

The response to this question is likely so notably different from that above because the eligibility question asked respondents to provide the most common reasons an individual might not be eligible for participation in their program.

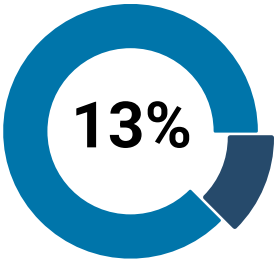
Taken together, these preclusions appear to **limit access to behavioral health support for individuals with justice involvement or acute mental health needs, particularly for individuals who may lack insurance or financial resources**.

## Documentation Requirements as a Barrier to Access

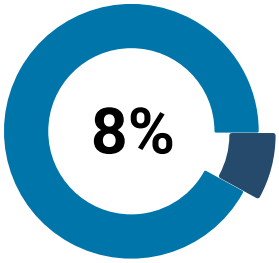
In order to access behavioral health services, most programs reported having certain **documentation requirements**, including **ID/driver's license, birth certificate, Social Security card, proof of income, proof of residency, medical records**, and **court documents**. The most common documents required by programs are illustrated below.




Or 36 of 88 programs require an **ID/driver's license** for enrollment.




Or 11 of 88 programs require **court documents** for enrollment.




Or 7 of 88 programs require **medical records** for enrollment.

Additionally, some programs noted requiring another form of documentation that was not explicitly listed as an answer choice. These include proof of tribal enrollment or descendancy, proof of health insurance, an outside referral, completion of the ASAM, copy of a legal hold, proof of medical clearance, and proof of court petition initiation.

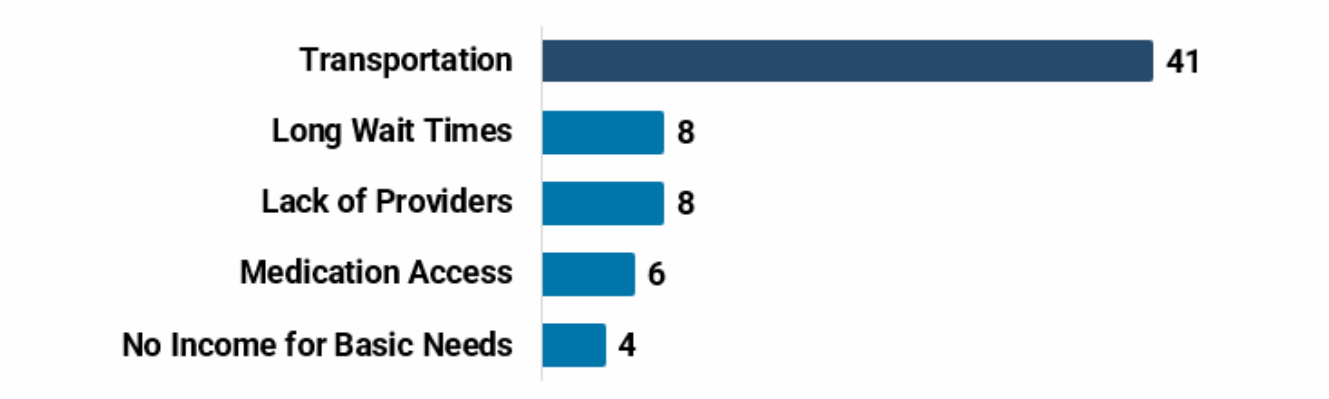
Some, but not all, programs indicated they offer assistance in obtaining these vital documents.

Providers were also asked to indicate which documentation requirements have served as a "big barrier to participation." They reported that while documentation requirements can create administrative friction, documentation needs are not a major barrier overall. The most common documentation-related obstacle is the ID/driver's license requirement, identified as a significant barrier by five of 88 programs.

> "[People] leaving incarceration often lack proper documentation needed for program entry"
>
> — Housing Provider Interview Participant

## Additional Barriers

In addition to documentation, providers were asked to share other barriers that people face when attempting to access their programs. The figure below illustrates responses provided, with transportation being the biggest barrier reported by 41 of 88 programs.




Other barriers to access reported by providers include language (n=2), failing to obtain timely medical clearance (n=2), safety concerns of providers (n=1), and childcare concerns (n=1).

**Key Takeaways: Behavioral Health Program Access**

While documentation requirements generally do not block entry into services, transportation, insurance, financial, and eligibility barriers remain persistent and widespread access challenges, posing the greatest threat to equitable access across the behavioral health system. Wait times can also impact initiation into treatment which can result in more jail days for persons not able to be released from jail without admission into a program.

Individuals with prior criminal justice involvement face additional barriers. Some programs explicitly exclude people with certain criminal histories from participation, particularly those convicted of sex crimes or violent offenses, limiting their pathways into treatment and stability.

# Results | Interviews with Housing Programs with Supports

The following section provides an overview of the housing programs in Washoe County that serve people with behavioral health challenges and justice involvement. It describes the availability of housing programs, how individuals access those programs, and what barriers may be impacting access.

A total of 32 individuals were interviewed representing **49 housing programs and services** in Washoe County that met the criteria described above. Other housing providers in the area were also interviewed but were not included in this count if they did not offer or coordinate supportive services for residents.

## Service Composition

The 49 housing programs and services were categorized into one of the following types:

| Housing Type | Description | Features | # of Providers Identified |
|---|---|---|---|
| **Community Based Living Arrangements (CBLA)** | CBLAs offer flexible, individualized services, including training and habilitation services, that are provided in the home, for compensation, to people with serious mental illness or developmental disabilities. Services are designed and coordinated to assist residents in maximizing their independence.[15] | • In facilities, on-site staff 24/7<br>• Services may include medication management, management of mental health symptoms, safety and security, meal planning/preparation, and other activities of daily living | 3 |

[15] Nevada Division of Public and Behavioral Health. (nd). *Community-Based Living Arrangements*. Accessed November 3, 2025: https://dpbh.nv.gov/Reg/HealthFacilities/HF_-_Non-Medical/Community-Based_Living_Arrangements/

| Housing Type | Description | Features | # of Providers Identified |
|---|---|---|---|
| **Permanent Supportive Housing (PSH)** | PSH paired with long-term housing with supportive services ranging from case management to training to treatment. For Department of Housing and Urban Development (HUD) funded PSH, individuals must have a disability.[16] | • Tenants sign a lease<br>• Time in housing is not limited<br>• Supportive services are individualized and are designed to maintain housing<br>• Often funded through HUD programs, state housing initiatives, or non-profits | 6 |
| **Rapid Rehousing (RRH-PSH)** | RRH rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services.[17] | • Tenants sign a lease<br>• Time in housing is limited to up to 24 months<br>• Case management and connection to services | 3 |
| **Specialized Reentry Housing (SRH)8 (SRF** | Supervision is typically a pre-requisite to SRH. SRH may seek to address the specific needs of formerly incarcerated people.[18] | • Trained staff<br>• May offer the opportunity for peer-support and mentorship | 2 |

[16] Department of Housing and Urban Development. (nd). *Permanent Supportive Housing (PSH).* Accessed July 8, 2025: https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-program-components/permanent-housing/permanent-supportive-housing/

[17] HUD Exchange. (nd). *Rapid Re-housing (RRH)*. Accessed November 6, 2025: hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-program-components/permanent-housing/rapid-re-housing/

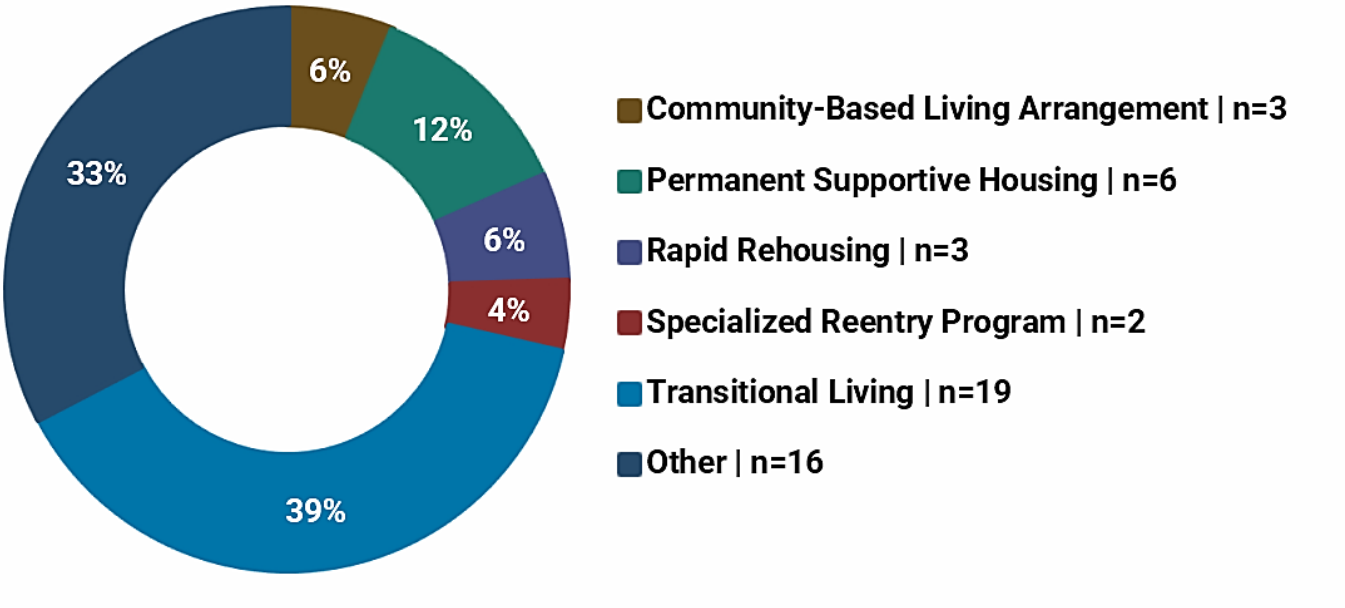
[18] Council of State Governments Justice Center. (2010). *Reentry Housing Options: The Policymakers' Guide*. Accessed July 2025: https://www.cmcainternational.org/wp-content/uploads/2019/10/reentry-housing-options-policymakers.pdf

| Housing Type | Description | Features | # of Providers Identified |
|---|---|---|---|
| **Transitional Living (TL)/Transitional Housing (TH)** | TL and TH are temporary housing with some supportive services for individuals and families experiencing homelessness, with the goal of interim stability and support to successfully move to and maintain permanent housing.[19] This type of housing may allow individuals to work while keeping expenses low and some may offer a highly supervised environment.[20]<br><br>*Note: transitional housing (TH) and transitional living (TL) are categorized as TL in both data collection and reporting to capture the breadth of this type of temporary housing.* | • Usually time-limited<br>• Supportive services can be offered and/or may be required as a condition of residency<br>• Structured, monitored, and secure environment | 19 |
| **Other Housing with Service Coordination or Referral** | Other housing resources in the community offering a range of coordination, case management, or services or programs that self-identified as "Other." | • Features vary by housing provider but do not align with the categories previously listed<br>• See table below for a more detailed overview of these programs | 16 |

[19] HUD Exchange. (nd). *Transitional Housing (TH).* Accessed July 2025: https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-program-components/transitional-housing/

[20] Council of State Governments Justice Center. (2010).

The majority of programs serving the Washoe region that were surveyed are either designated as Transitional Living (39% or 19 of 49) or are challenging to categorize and are designated as “Other” (33% or 16 of 49). Only 12% (6 of 49) of programs are categorized as Permanent Supportive Housing (PSH). This is depicted in the figure below.




The lack of PSH in Washoe County is notable since it is the most stabilizing housing option for individuals with behavioral health challenges experiencing homelessness, which often includes justice-involved clients.

“Other” programs include services to support individuals with complex behavioral health and medical needs, affordable housing and innovative housing programs, and programs that are designed to meet specific needs. The table on the next page provides more information on these programs.

| Agency | Program(s) | Description | # of Providers Identified (n=16) |
|---|---|---|---|
| **Washoe County Human Services Agency** | • CrossRoads<br>  ○ Men's Program<br>  ○ Women's Program<br>  ○ Women and Children's Program<br>  ○ Families Program | Structured and Supervised Living Community using Community as Method (CAM) approach | 4 |
| **Northern Nevada Adult Mental Health Services** | • Board and Care<br>• HIRC<br>• Independent Placement<br>• Independent Supportive Placement | Programs that range from 24-hour care for complex medical and behavioral needs to independent living with CBLA services | 4 |
| **Washoe County Housing and Homeless Services** | • Emergency Housing Vouchers with Tenancy Supports<br>• TSSS- Tenancy Supports with Shallow Subsidy | Voucher or tenant based housing with service offerings that are between RRH and PSH | 2 |
| **Reno-Sparks Gospel Mission** | • CARE Program | Drug and Alcohol Residential Recovery Program - Faith Based | 1 |
| **Volunteers of America** | • Affordable Senior Housing<br>• Community-Based Emergency Residential Services for Veterans<br>• Village on Sage | Programs range from emergency housing services to bridge housing with monthly rent and shared community living | 3 |
| **Eddy House** | • Community Living | Community living with individual bed spaces in a sober living environment[21] | 1 |
| **Heaven Bound Lifestyle Center** | • Heaven Bound Aging and Disability Services | Independent living with a family member or on their own where rent is paid by social security or the state | 1 |

[21] Eddy House. (nd). *Programs & Services*. Accessed November 2025: https://eddyhouse.org/services/

**A Special Note about Community-Based Living Arrangements (CBLAs)**

CBLAs are state-licensed supportive housing programs regulated through the Nevada Health Authority's (NVHA) Bureau of Health Care Quality and Compliance (HCQC)s. An interview with representatives from Northern Nevada Adult Mental Health Services provided insight into how CBLAs operate in Washoe County. According to that conversation, "the request for a CBLA license must go through HCQC, and each facility is licensed for a specific number of beds. CBLAs serve adults with serious mental illness (SMI) who have been assessed, interviewed, and deemed appropriate for this level of placement."

In Washoe County, Northern Nevada Adult Mental Health Services (NNAMHS) conducts this assessment and categorizes them into Tier 1–4, which determines the funding rate paid to the provider based on the acuity of their needs. Importantly, NNAMHS shared that it does not decide who is admitted; after clients are assessed, individual CBLA providers determine whether a client will be accepted into a CBLA. Although a CBLA home may be licensed for a particular number of beds, providers may use those beds at their discretion, meaning the actual capacity may be lower than the licensed capacity. Therefore, individuals assessed as needing CBLA placement may not always have access to a bed based on the full licensed capacity of a facility.

In Washoe County, CBLA participation requires that clients:

- Have a **diagnosis of serious mental illness (SMI)** under **NRS eligibility**; and
- If funded through NNAMHS, the individual must be a NNAMHS client and undergo **state screening and approval** prior to placement.

Although NNAMHS oversees housing management, it noted it is not required to provide housing directly and instead coordinates placements through licensed providers. Three of five CBLA programs identified on their website as licensed by Health Care Quality and Compliance (HCQC) under the Nevada Health Authority participated in this information gathering process.

## Service Capacity

Across the 49 programs interviewed, an estimated 2,139 individuals can be served at any given time. This is summarized by program type in the table below, but it should be noted that these numbers are *estimated* as some programs reported how many individual beds were available and others reported housing units serving families. Thirty-seven percent (18 of 49) of these programs accept **Medicaid**.

| Program Type | # of Programs | Serves at One Time[22] | Serves in a Year[23] |
|---|---|---|---|
| **CBLA** | 3 | 62 | 137 |
| **Permanent Supportive Housing** | 6 | 278 | 278 |
| **Rapid Rehousing** | 3 | 79 | 500[24] |
| **Specialized Reentry Program** | 2 | 149 | 360 |
| **Transitional Living** | 19 | 486[25] | 2,748 |
| **Other** | 16 | 1,085[26] | 1,377 |
| **Total** | **49** | **2,139** | **5,400** |

All programs indicated that they were willing and able to serve individuals with justice involvement, although many programs indicated challenges in serving people with specific types of criminal history.

## Facility Type

Providers were asked if their programs were **facility** or **voucher- or tenant-based**. A facility-based program indicates the organization owns or rents a permanent space(s) to house people in this program; **33 programs reported being facility-based**. A voucher- or tenant-based program indicates the organization uses vouchers to house people for this program in spaces they do not own or have a rental agreement for, such as motels/hotels; **10 programs reported being voucher- or tenant-based**. This includes tenant-based rental assistance where individuals can select their own housing and enter into an agreement with the landlord directly.

Three programs are both facility and voucher or tenant based. Additionally, one program indicated that participants live independently or with family members, while two programs did not indicate the facility type of housing offered. Crucially, neither facility type designation is an assurance that

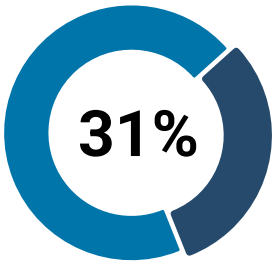
[22] This is a minimum because two programs were unable to provide capacity and utilization numbers.
[23] This is a minimum because one program was unable to provide capacity and utilization numbers.
[24] For one program included in this total the number of people served through RRH cannot be separated from the number of people served through both RRH and case management; as such, this number may be inflated.
[25] One Transitional Living option will soon increase its capacity from six to 36.
[26] This is a minimum as capacity for some programs varies greatly and minimums and estimates cannot be provided.

accommodations are compliant with the Americans with Disabilities Act (ADA). This factor may serve as a non-negotiable barrier to access for individuals with physical disabilities.

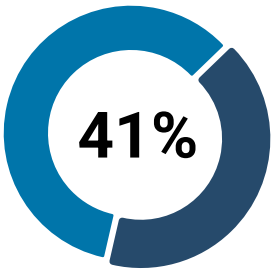
## Populations Served

Providers were asked whether their programs served 1. **People who are Exiting Incarceration**, 2. **People Experiencing Chronic Homelessness**, or 3. **People with a Disability**. They were also asked to indicate any "**Other**" populations of focus. Housing providers who indicated "Other" (63% or 31 of 49) populations of focus noted that these included people with substance use disorders (n=8), veterans (n=5), people with mental health disorders (n=4), people living under the poverty line (n=2), individuals fleeing domestic violence (n=1), and youth under 25 (n=1).

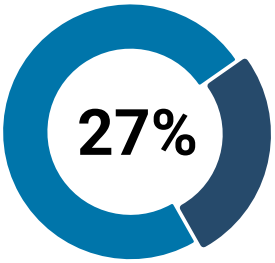
Note that focus populations may be overlapping. For example, a program may serve both people with a disability and people who are exiting incarceration.




(15 of 49) serve **people who are exiting incarceration** as a population of focus.




(20 of 49) serve **people experiencing chronic homelessness** as a population of focus.




(13 of 49) serve **people with a disability** as a population of focus.

While all of the 49 programs included in this section indicated that they serve individuals with criminal justice involvement, it is important to note that the ten programs that are voucher- or tenant-based may struggle to place individuals with criminal justice involvement if landlords are unwilling to accept those individuals, for example if they have a felony on their record and do not qualify for some federal housing options. This is further reflected in the bullets below, which explore the **specific groups that programs are unable to serve due to funding, capacity, or mandate**. Across program types,

- **61%** (30 of 49[27]) of programs **preclude individuals convicted of a sex crime** from enrollment
- **49%** (24 of 49[28]) of programs **preclude enrollment of individuals with a history of violence** and/or a violent crime conviction
- **14%** (7 of 49) of programs **preclude individuals convicted of arson** from enrollment

In two PSH programs and one program designated as "Other," a history of drug offenses can preclude enrollment. In one "Other" program, conviction of manufacturing drugs in Public Housing precludes participation. Additionally, three Transitional Living programs do not serve individuals with high acuity mental health needs as facilities and staffing resources are insufficient to do so safely.

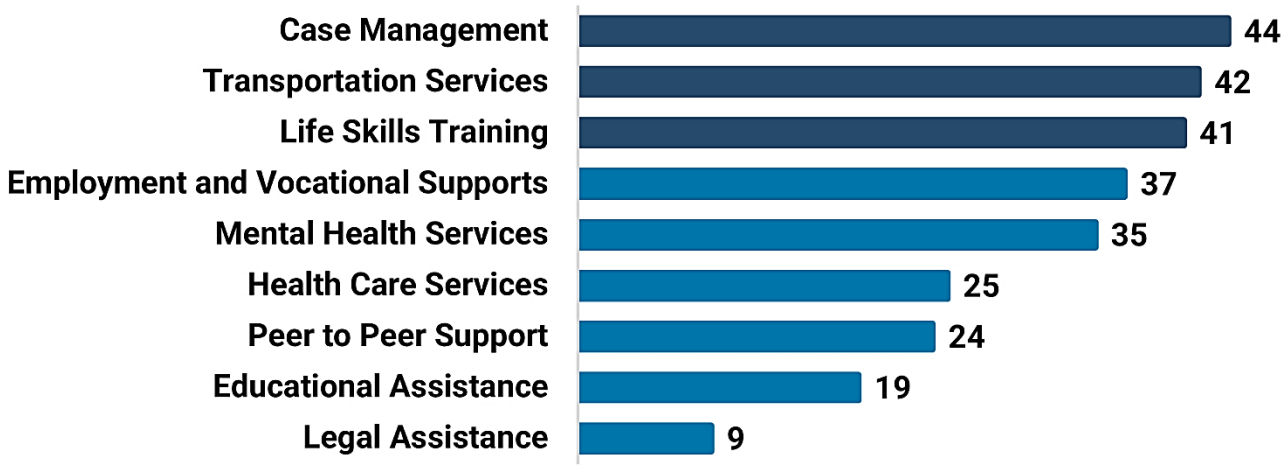
[27] Some programs consider low level (Tier 1 and Tier 2) sex offenders on a case-by-case basis.
[28] Some programs consider violent offenses on a case-by-case basis.

Taken together, these preclusions **reduce access to housing for specific subpopulations of individuals with prior justice involvement**.

## Supportive Services

In addition to housing assistance, the programs interviewed all offer **supportive services**. Providers were asked if their individual programs provide any of the following nine supportive services: **Case Management, Life Skills Training, Employment and Vocational Services, Legal Assistance, Transportation Services, Education Assistance, Health Care Services, Peer to Peer Support**, and **Mental Health Services**.

The following figure depicts the types of services offered across interviewed programs, with most programs reporting that they offer at least several of these supportive services.

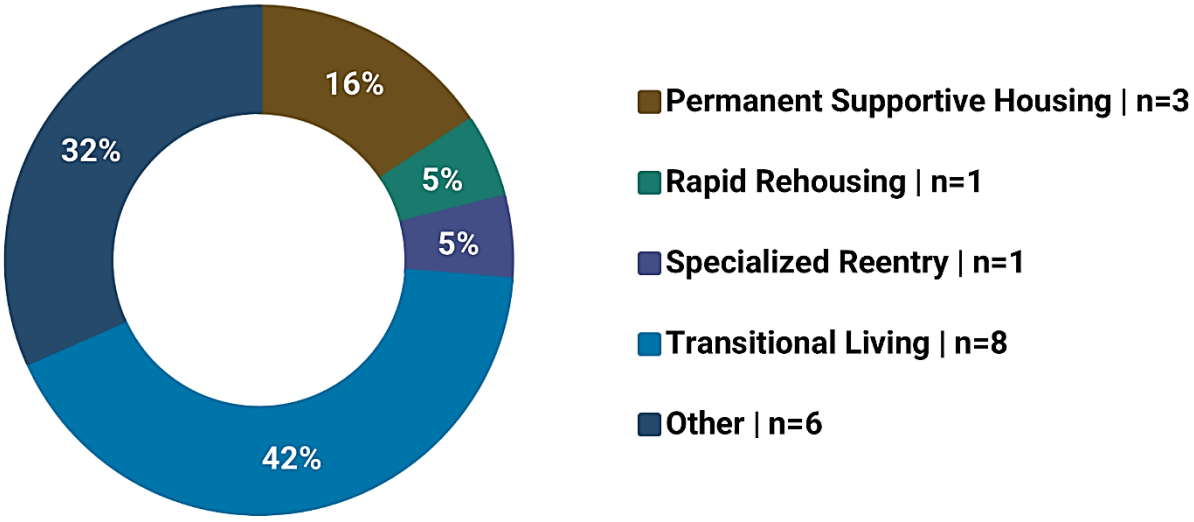



Case management, life skills training, and transportation services are the three most common services offered by the programs interviewed, with almost all programs reporting that they offer these. Legal assistance was the service that is least frequently offered by interviewed programs.

Of particular interest for people with behavioral health challenges and justice involvement, 71% (35 of 49) of programs reported offering mental health services.

> "Any service providers that are out at a distance, we have a couple of drivers, but not very many, so transportation is an issue getting them to dental appointments and getting them a primary care doctor…If somebody's been in prison for a while, they don't know how to navigate the bus system, so that takes a minute to learn."
>
> — Housing Provider Interview Participant

Of the nine common supportive services indicated in the figure above, 39% (19 of 49) of interviewed programs offer seven or more, as depicted in the pie chart below. There are no CBLAs that offer seven or more of these common supportive services, so that program type is not included in the chart below.




The types of services available vary widely. For example, two Transitional Living programs offer only one supportive service each, transportation and case management, respectively. One “Other” program offers coordination to outside organizations for supportive services.

Providers also described additional supportive services they offer including nutritional assistance (n=2), recreational activities (n=2), physical and occupational therapy (n=1), and faith-based services (n=1).

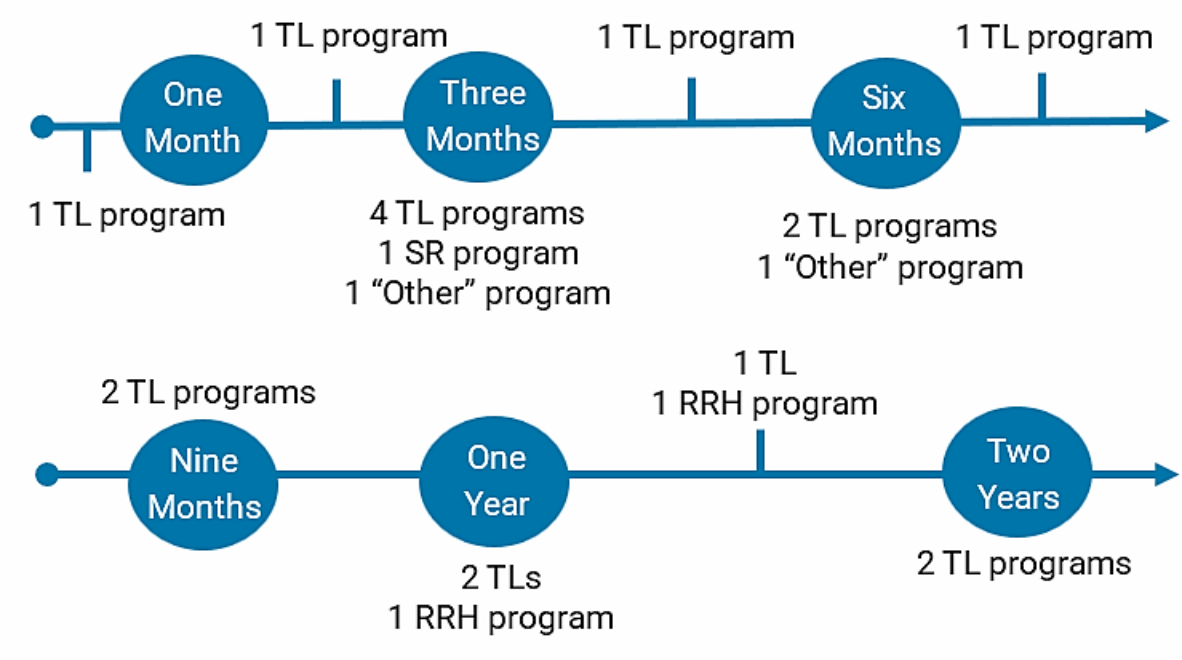
"People come here and they get sober and they get comfortable, and with the structure that we have, a lot of them aren't sure that they can face it on the outside."

— Housing Provider Interview Participant

## Program Length

Forty-three percent of programs (21 of 49) have a length of stay that is **individualized to meet participant needs,** and an additional six Permanent Supportive Housing programs do not have a maximum length of stay.

The durations of the other 22 housing program, which range from 14 days up to two years, are demonstrated in the graphic below; over half of these programs (12) support housing for six months or less, providing individuals with a relatively short period of stability before they are required to transition to other accommodations.




**Key Takeaways: Housing Availability**

The landscape of available supportive housing services for individuals with justice involvement shows a strained system with need heavily outweighing capacity. There are strict eligibility rules that often preclude individuals with sex and/or violent crime convictions from enrollment. The system currently relies on Transitional Living/Transitional Housing programs (39% of programs), while Permanent Supportive Housing remains scarce (12% of programs) and overwhelmed (400 individuals on the waiting list for PSH alone). At the same time, 39% of programs offer seven or more supportive services to enrolled individuals.

# Program Access

## Referral Pathways

Referral pathways vary by program and are further complicated by the fact that many housing programs operate within the federally-funded homeless services (the Continuum of Care Program) and Veterans Affairs (VA) systems, and/or individual programs may have their own individual requirements and referral pathways.

This complexity is illustrated by the multiple referral pathways providers indicated in their interviews, which are listed in the table below.

| Referral Sources | |
|---|---|
| • Coordinated Entry<br>• Residential Treatment Facility<br>• Churches/Faith-Based Organizations<br>• Anthem Medicaid<br>• Treatment Centers<br>• Veteran's Services/VA<br>• Self-referral<br>• NNAMHS<br>• Hospitals | • Word of Mouth<br>• Community and Partner Organizations<br>• Criminal Justice System<br>• Child Protective Services<br>• Walk-ins<br>• Emergency Shelters<br>• City of Reno<br>• Other Housing Providers |

### Coordinated Entry

An important referral pathway to highlight for the federally-funded homelessness services system is the Coordinated Entry (CE) system, a standardized, community-wide process to connect people experiencing homelessness to housing services. The Northern Nevada Continuum of Care (NNCoC) organizes the federally mandated CE system in Washoe County. Individuals are assessed with the Community Housing Assessment Tool (CHAT) and placed on a community-wide queue that prioritizes the most vulnerable individuals for available housing services.[29]

NNCoC-funded PSH programs are required to use CE to receive referrals for housing. If an individual with justice involvement is seeking PSH, they must meet the requirements of the homeless services system in order to be placed in these PSH programs.

[29] The Northern Nevada Continuum of Care. (2022). *Coordinated Entry Policies and Procedures*. Accessed October 2, 2025: https://www.washoecounty.gov/homeless/files/NNV-CES-Policies-Procedures-1.12.22-1.pdf

The following eight interviewed programs across housing types indicated that they participate in the CE system, although this information has not been verified with the NNCoC:

| Program Type | Programs Requiring CE |
|---|---|
| **CBLA** | Rising Star |
| **Permanent Supportive Housing** | Carvill Court<br>ReStart PSH<br>Washoe County Human Services PSH |
| **Rapid Rehousing** | SSVF from Nation's Finest<br>Volunteers of America RRH |
| **Transitional Living** | Veteran's Program from WestCare |
| **Other** | Heaven Bound Aging and Disability Services |

Three of the seven programs listed above noted that long wait times and the number of people on the community queue may be a challenge.

### Veterans Affairs

Five of the interviewed programs accept referrals from **Veterans Affairs (VA)**:

| Program Type | Programs Requiring VA |
|---|---|
| **Permanent Supportive Housing** | Dick-Scott Manor from Reno Housing Authority |
| **Rapid Rehousing** | SSVF from Nation's Finest |
| **Transitional Living** | Behavioral Health Center on Montello from Nation's Finest<br>Steps to New Freedom |
| **Other** | Community-Based Emergency Residential Services from Volunteers of America |

### Criminal Justice System

Half of the programs interviewed (49%, or 24 out of 49) reported accepting referrals from criminal justice system entities.

- **17** reported accepting referrals from **jails, prisons, the Department of Corrections (DoC)**, or **Parole and Probation**, including one TL program that only receives referrals from the DoC
- **Seven** reported accepting referrals from **Washoe County courts and the Department of Alternate Sentencing**

This highlights an opportunity to strengthen relationships between criminal justice organizations and the remaining 25 programs, helping individuals with justice involvement more easily access and maintain stable housing.

## Waitlist Availability

Sixty-three percent (31 of 49) of programs reported that they maintain waitlists, with a combined estimated size of 845 individuals. This is likely an *underestimate* of the number of individuals who are awaiting supportive housing services because a lack of a waitlist does not necessarily mean that the program is serving all individuals seeking services and not all programs responded to this question. As noted in the behavioral health section, when a program does not maintain a waitlist, the burden is often put on the individuals seeking housing to continue to follow up with the program in hopes of a vacancy.

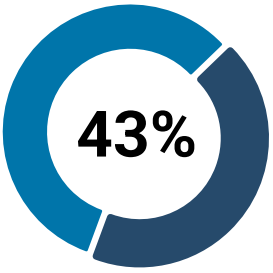
Information on the availability of a waitlist by program type is summarized in the table below. Permanent Supportive Housing has a large waitlist at least in part due to the lack of turnover in their services.

| Program Type | Waitlist[30] | | Estimated # of People on Waitlist |
|---|---|---|---|
| | Yes | No | |
| **CBLA** | 0 | 3 | 0 |
| **Permanent Supportive Housing** | 4[31] | 2 | 400 |
| **Rapid Rehousing** | 1 | 2 | 20 |
| **Specialized Reentry Program** | 1 | 1 | 30 |
| **Transitional Living**[32] | 14[33] | 4 | 95 |
| **Other** | 11 | 5 | 300 |
| **Total** | **31** | **17** | **845** |

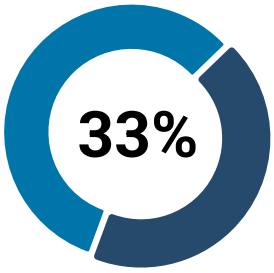
[30] One program did not respond to this question.
[31] Two programs indicated 'Yes' but did not report an estimated number.
[32] One program did not respond to this question.
[33] One program indicated 'Yes' but did not report an estimated number.

## Eligibility Requirements

Eligibility requirements vary widely from program to program, and across program types. The two most common requirements across program types are **sobriety and/or drug and alcohol testing** and a **work or income** requirement.




Or 21 of 49 programs require **sobriety and/or regular drug and alcohol testing**




Or 16 of 49 programs have a **work or income requirement**

None of the PSH or RRH programs interviewed reported requiring sobriety and/or drug or alcohol testing. 79% (15 of 19) of the Transitional Living programs interviewed do have this requirement.

Requiring sobriety or mandatory drug/alcohol testing as a condition to *enter* or *stay* in housing conflicts with a Housing First model, which acknowledges most people struggling with substance use disorders experience failures and setbacks.[34]

Additionally, work or income requirements may disproportionally impact people with behavioral health challenges. A Housing First model rejects preconditions like income or employment because they create barriers for high needs groups, including people with behavioral health challenges. Housing itself serves as recovery support for behavioral health challenges, making up-front work/income rules especially exclusionary.[35]

Other eligibility requirements reported include participation in an (intensive) outpatient program (reported by two programs), and the following, each reported by one program: medication compliance, parole/probation compliance, participation in individual and/or group counseling, curfew compliance and background check clearance).

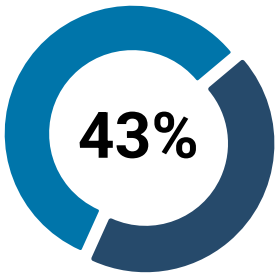
> "A lot of great programs do work with a very specific population. There are a handful of people that don't fit in the eligibility boxes for the services that they need. I think we need to have community discussions and brainstorming about these cases to find solutions instead of trying to make the person fit into a program that isn't designed for their needs and then being surprised when they don't succeed."
>
> — Housing Provider Interview Participant

[34] National Alliance to End Homelessness. (2022). *Protecting the Use of Housing First*. Accessed on October 2, 2025: https://endhomelessness.org/resources/policy-information/protecting-the-use-of-housing-first

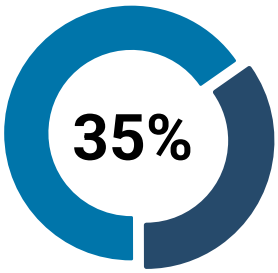
[35] National Low Income Housing Coalition. (nd). *The Evidence is Clear: Housing First Works*. Accessed on October 3, 2025: https://nlihc.org/sites/default/files/Housing-First-Evidence.pdf

## Documentation Requirements as a Barrier to Access

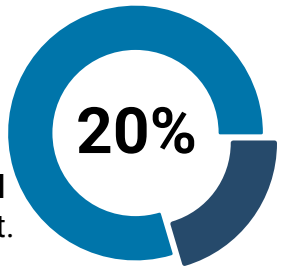
In order to access housing services, programs across types reported certain **documentation requirements**, including **ID/driver's license, birth certificate, Social Security card, proof of income, proof of residency, medical records**, and **court documents**.




Or 21 of 49 programs require an **ID/driver's license** for enrollment.



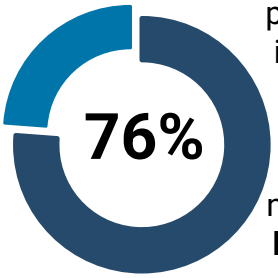

Or 17 of 49 programs require a **Social Security card** for enrollment.



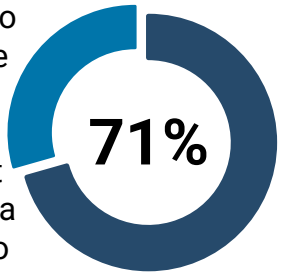

Or 10 of 49 programs require a **birth certificate** for enrollment.

45% (22 of 49) of programs across types report no vital documentation requirements listed above. However, 20% (10 of 49) of programs require another form of documentation that was not explicitly listed. Other types of documentation listed included proof of income or assets (n=4), proof of Medicaid or insurance enrollment (n=2), a VA card (n=2), or tuberculosis test clearance (n=1). Some providers emphasized that other documents are required by individual landlords, which may include the previously listed vital documents (e.g., ID, proof of income, etc.). Some program representatives noted that they provide critical document assistance during the application process.

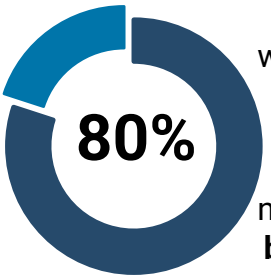
Providers who noted particular documentation requirements were also asked to indicate if it served as a "big barrier to participation."




Or 16 of 21 providers who indicated the **ID/driver's license** requirement noted it was a **big barrier** to enrollment.




Or 12 of 17 providers who indicated the **Social Security card** requirement noted it was a **big barrier** to enrollment.




Or 8 of 10 providers who indicated the **birth certificate** requirement noted it was a **big barrier** to enrollment.

Although many programs require proof of income, only 31% (5 of 16) indicated that it was a barrier for participants. As a housing type, PSH requires the greatest level of documentation, which could impact its accessibility.

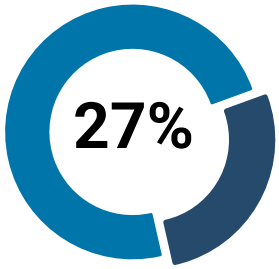
While 45% of programs do not require the vital documents listed above, many housing providers mentioned that the lack of documents will present challenges to clients in other areas of their lives.

## Additional Barriers

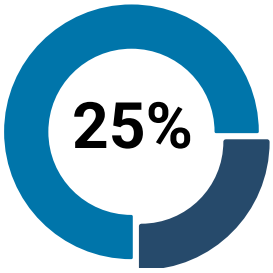
In addition to documentation, providers reported a variety of barriers to justice-involved individuals seeking and achieving permanent and stable housing.

It is first worth reiterating that while 31% of programs across types serve people who are exiting incarceration as a population of focus, at the same time, as mentioned above, certain criminal offenses preclude acceptance into these, and other, housing programs (namely sexual and violent convictions).

Other barriers to access include those illustrated below, followed by **inability to meet preconditions** (with eight programs indicated this was a barrier to enrollment), and **lack of income** (with six programs indicating this was a barrier to enrollment).




Or 13 of 49 programs indicating that **long wait times** are a barrier.




Or 12 of 49 programs indicating that **inability to meet eligibility requirements** was a barrier.

28 programs indicated that there were other barriers to access to their services. These barriers include availability of beds/units (n=3), mental health acuity (n=2), landlords' willingness to accept clients (n=2), client's inability to pass a background and/or drug test (n=2), communication barriers (n=1), Medicaid enrollment (n=1), client's history of eviction (n=1), complexity of individuals' needs (n=1), complexity of paperwork (n=1).

**Key Takeaways: Housing Access**

There are multiple barriers that impact entry into housing. Providers noted the need for and lack of documentation, including Social Security cards, identification, birth certificates, and other documentation as a barrier frequently encountered. Guidelines set by specific programs and criteria for eligibility can also be a barrier. If both those factors are addressed, there are still long waitlists, and systemic hurdles like Coordinated Entry delays and landlord discretion, which can make access uneven and uncertain for individuals with justice involvement.

## Housing Programs in Development

There are three additional Permanent Supportive Housing programs that are currently in development to serve the Washoe region. A brief overview of each can be found in Appendix C. Note that these programs are not included in the analyses above.

# System Challenges and Gaps

## Behavioral Health System Challenges and Gaps

Washoe County's behavioral health system is broad, committed to serving the community, and offers a wide range of flexible programs, at least 88 of which are open to people with justice-involvement. However, despite its strengths, real challenges exist.

Interviews with behavioral health providers indicate that the system is extensive, flexible, and has the theoretical capacity to serve more people, but is impacted by uneven access across program types, by applicant backgrounds, and because of infrastructure limitations. Enhanced coordination with the justice and healthcare systems would help close these critical gaps in care.

Overall, there are three service areas that should be prioritized based on Washoe County's current behavioral health system and the needs of justice-involved individuals:

- Intensive outpatient and outpatient services expansion
- Long-term residential and outpatient programs designed specifically to serve justice-involved individuals
- Access to transportation to connect clients with services and supports

A summary of the key themes identified through interviews with behavioral health providers, as well as suggestions to address these challenges, are outlined below. The suggestions are informed both by the challenges and gaps described by the providers, as well as open-ended responses they provided throughout the interviews, as well as the results of external research conducted by the mapping team.

**Challenge/Gap 1: Lack of Transportation**

Transportation was cited as a barrier to accessing behavioral health care for nearly half of the programs.

The following are suggestions offered specifically to address gaps related to transportation as experienced by behavioral health clients seeking services.

- Develop a transportation assistance program that operates countywide for behavioral health clients, offering bus passes, ride-share vouchers, or mobile van services to treatment sites.
- Coordinate transportation schedules between behavioral health providers and courts, particularly for clients with multiple appointments in a day.
- Explore partnerships with public transit agencies and local nonprofits to create sustainable, low-cost transport options for high-needs populations.

**Challenge/Gap 2: Lack of Financial and Funding Supports**

A lack of financial resources limits certain populations' participation in services and continuity of care. A lack of insurance or inability to pay the sliding scale fee were common reasons reported for why individuals were not eligible for participation in interviewed programs.

The following are suggestions offered specifically to address gaps related to financial and funding supports as experienced by clients seeking services.

- Expand sliding fee scale and financial assistance programs across all service types, ensuring clients can continue care despite income changes.
- Pursue county-level funding or public-private partnerships to subsidize care for uninsured or individuals with justice involvement.
- Advocate for state-level reimbursement reform to better fund wraparound and case management services not currently covered by Medicaid.

**Challenge/Gap 3: Waitlists**

Nearly half of Washoe County's behavioral health programs maintain waitlists. Notably, outpatient and intensive outpatient services currently have more than 150 individuals waiting for care. This suggests that, while some providers indicate that they could serve more clients, current capacity for some program types is insufficient to meet community demand, particularly for timely outpatient and intensive outpatient services.

The following are suggested to address waitlists and reduce the amount of time that individuals go without access to needed services.

- Leverage data on waitlists and utilization to guide Washoe County, state partners, and behavioral health providers in strategically allocating public and private resources where demand is highest, ensuring more equitable and efficient service availability across program types.
- Expand intensive outpatient and outpatient service capacity through targeted funding and workforce incentives that attract and retain qualified behavioral health professionals, reducing wait times and improving access to ongoing care.

**Challenge/Gap 4: Exclusions for Individuals with Specific Types of Justice Involvement**

Individuals with specific types of justice involvement—especially those with sex crime or violent convictions—face significant exclusion from the county's behavioral health programs. Nearly a quarter of all interviewed programs preclude individuals convicted of a sex crime from participating, and all four long-term residential programs interviewed disallow sex offenders from participating.

The following are suggested to assist individuals with justice involvement in accessing behavioral health services.

- Pilot specialized residential and outpatient programs designed for individuals with justice involvement, focusing on recovery and reentry rather than exclusion.
- Revisit program eligibility criteria that use blanket exclusions for certain criminal histories and work with providers to develop risk-based, case-by-case admission protocols.
- Strengthen collaboration with the justice system to align behavioral health access with diversion, probation, and reentry support efforts.
- Expand capacity to develop and sustain specialized programs for high-need and justice-involved populations, including individuals with sex crime convictions or complex behavioral health needs, to ensure these groups have meaningful access to appropriate treatment options.

"Address the stigma for individuals involved in the criminal justice system. There are people who need to have a higher level of support and a safer environment. These people continue to cycle through the system, are violent towards staff, and are rearrested. Also [there is a] significant communication breakdown for individuals discharging from jail on holds and being transported to the ERs".

— Behavioral Health Provider Interview Participant

**Challenge/Gap 5: Exclusions for Individuals with Complex Health Conditions**

It was reported that acute psychiatric and/or certain medical conditions could impact client eligibility, as programs may lack the resources or capacity to meet complex needs. Nearly a fifth of interviewed programs indicated that mental health issues or diagnoses could serve as a barrier to entry; this included three of the four long term residential programs, making this program type difficult to access for justice-involved people in the county.

The following are suggested to assist justice-involved individuals with complex health conditions and/or acute mental health issues access behavioral health services.

- Expand integrated behavioral health and primary care models that can manage both mental and physical health needs within one system.
- Create specialized treatment tracks for individuals with dual diagnoses or high medical complexity.
- Invest in crisis stabilization and step-down facilities to bridge the gap between inpatient and outpatient care.

## Housing System Challenges and Gaps

Within Washoe County, there are at least 49 housing programs with some level of supportive services available. While this network of housing providers offer essential supports, access is limited for individuals with justice involvement due to a combination of eligibility restrictions, documentation requirements, long waitlists, and program exclusions.

Interviews with housing providers reflect a system that offers a variety of program options, but that is not immune to barriers that leave many individuals with justice involvement and behavioral health concerns, often those with the highest housing needs, unable to secure stable housing. This can perpetuate cycles of homelessness, incarceration, and recidivism, wherein if individuals are denied housing, they are also denied a safe place to begin making healthier choices.[36]

> "The biggest systemic barrier is the lack of coordination between Department of Corrections and Parole & Probation, with people sitting in prison despite being granted parole because of housing unavailability."
>
> — Housing Provider Interview Participant

[36] National Alliance to End Homelessness. (2022). *Protecting the Use of Housing First*. Accessed on October 2, 2025: https://endhomelessness.org/resources/policy-information/protecting-the-use-of-housing-first

A summary of themes identified through interviews with housing system providers and related suggestions to address the challenges they face is presented below. The suggestions draw upon the insights shared by providers during interviews, as well as supplementary research and analysis conducted by the mapping team.

**Challenge/Gap 1: Documentation Barriers**

The requirement that applicants have certain types of documentation was reported as being a significant barrier to housing program participation by at least a third of interviewed programs. This may be compounded for justice-involved individuals, who may lose access to vital documents during times of incarceration.

The following suggestions are offered to address challenges and gaps related to documentation and reduce the length of time that justice-involved individuals with behavioral health challenges remain without access to housing.

- Work with providers to streamline program entry to change upfront documentation requirements to only those that are essential, with additional documents gathered once tenants are stabilized.
- Promote provider partnerships with the DMV, Social Security Administration, and legal aid providers to help tenants obtain IDs, Social Security cards, and income validation.
- Promote acceptance of flexible documentation (e.g., parole/probation paperwork or affidavits) to remove immediate barriers to participation.

**Challenge/Gap 2: Specific Barriers to Permanent Supportive Housing (PSH) Access**

Permanent supporting housing, which is the most stabilizing type of housing, may also be the least accessible in the county. While the six programs interviewed can serve approximately 278 people in a year, there are reported to be 400 people on the waitlist for just four of those programs. PSH programs also have some of the most significant documentation requirements, and, while not specifically noted in the body of this report, half of the PSH programs surveyed noted that they preclude enrollment of individuals convicted of certain sex and violent crimes and two noted that a history of drug offenses can preclude enrollment.

The following suggestions are offered to address these challenges and gaps and make PSH more accessible for justice-involved individuals in Washoe County.

- Providers could work at a systems-level with funders and policymakers to re-examine restrictive eligibility criteria, especially when PSH is designed for those with the highest needs.
- Pilot PSH units could be created that allow entry for individuals typically excluded such as persons with a drug related felony conviction.
- Providers can expand landlord engagement through incentives like risk mitigation funds or guaranteed rent.

**Challenge/Gap 3: Lack of Housing Options for High-Barrier Populations**

Similar to limitations that all populations face in accessing PSH, Washoe County's supportive housing programs can be out of reach for many individuals with justice involvement due to their backgrounds and personal circumstances.

Although only housing programs who indicated they are open to justice-involved individuals were included in interviews, many limited program eligibility based on the specific criminal history of applicants. At least two-thirds of programs had some preclusion in place, primarily based on sex or violent crime convictions. Some programs also had sobriety, drug and alcohol testing, and/or work and income requirements in place, which conflict with low-barrier approaches such as Housing First models, and which can create barriers for high needs groups such as people exiting incarceration and/or experiencing behavioral health challenges.

The following suggestions were identified to address these challenges or gaps and reduce barriers to accessing stable and supportive housing for justice-involved individuals with behavioral health challenges.

- Work with providers to develop housing tracks tailored for individuals excluded due to conviction history or behavioral health acuity. These tracks could be paired with enhanced supervision, treatment, and support services.
- Promote a Housing First approach, removing sobriety or drug/alcohol testing requirements for admission and continued tenancy. This approach acknowledges that stable housing is an overdose prevention tool.
- Provide intensive case management to assist people moving from congregate living settings to individualized housing succeed as they require ongoing medication management, social and living skills, and support to sustain independence.
- Collaborate with justice agencies, behavioral health providers, and community organizations to co-develop solutions for high-barrier populations and share costs/liability including solutions that accommodate people in both permanent housing and transitional settings.

> "Rent vouchers for people with criminal justice involvement - Washoe County and Clark County used to provide these but discontinued them. Without housing assistance, people end up homeless, and the shelters are full."
>
> — Behavioral Health Provider Interview Participant

# System Strengthening Considerations Offered by Providers

During interviews, all providers were asked to share their insights into how behavioral health and housing systems could be improved. Their responses are synthesized and presented below to represent the provider perspective on how to strengthen the behavioral health and housing systems and better serve persons with behavioral health challenges who are justice-involved. This population is frequently housing insecure, which can further entangle them in the justice system, when their behavioral health needs may be unmet due to housing insecurity. Note that the strategies included in this section were offered directly by the providers interviewed.

## Opportunities Identified by Behavioral Health Providers

In response to the question, *"Is there anything needed from the justice system to help you better serve clients in this program?"* behavioral health providers highlighted the need for stronger communication and coordination between systems, improved continuity of care, and reduced administrative barriers. Based on these insights, the following opportunities were identified:

**Opportunity 1: Strengthen Communication Channels between Behavioral Health and Criminal Justice Systems, including Improved Case Information Sharing**

Persons interviewed noted that information is not shared across systems and as a result, clients may get lost in the process and miss opportunities for accessing behavioral health services. Strategies suggested to enhance collaboration and communication include:

- Create a centralized communication system for sharing client updates, medication information, and treatment progress between courts, probation, and behavioral health providers. This could include the following actions.
    - Establish a protocol across systems to share information on clients, medication management, treatment progress, and other critical information relevant to courts, probation, and behavioral health providers in understanding the clients' unique needs and status.
    - Establish designated justice liaisons—a single point of contact at each major justice partner (e.g., jail, courts, probation) with a shared email address rather than individual staff names.
    - Develop a secure shared data platform to allow authorized access to referral forms, assessment results, and treatment notes while maintaining HIPAA and 42 CFR Part 2 compliance.
- Establish pre-release case summaries from jails that accompany clients upon discharge.
- Integrate case information sharing protocols between probation officers, courts, and behavioral health providers to avoid redundant assessments and delays.

**Opportunity 2: Improve Continuity of Care between Jail and Behavioral Health Providers**

Providers noted that discharge planning for jail release is not effective in ensuring a seamless transition into community care, particularly when access to behavioral health services is needed upon discharge. The following were suggested for enhancing transitions from jail or time of arrest into treatment or upon return to the community:

- Implement a standard process to ensure that individuals leaving jail have several days' worth of medications, treatment referrals, and scheduled follow-ups.
- Establish a rapid notification system when a client under care is arrested or released so providers can coordinate care transitions in real time.

**Opportunity 3: Address Administrative and Procedural Barriers**

Providers described how barriers that routinely delay accessing treatment could be avoided if processes were in place to address administrative or procedural hurdles. They include:

- Streamline Medicaid credentialing for clinicians to reduce delays in service delivery and workforce turnover.
- Accelerate tuberculosis test processing and documentation, as slow testing delays treatment entry.
- Simplify or automate Release of Information (ROI) and record-sharing procedures between correctional facilities and community providers.

**Opportunity 4: Enhance Cross-System Training and Collaboration**

Providers noted that behavioral health program staff could benefit from training with and on other systems serving their clients including the criminal justice system and housing supports, and vice versa. Joint training and enhanced exposure to other systems were perceived as ways to enhance collaboration across systems. Suggestions to support cross-system training efforts include:

- Conduct joint training sessions for behavioral health providers and criminal justice staff on topics like harm reduction, trauma-informed care, and medication for opioid use disorder (MOUD).
- Encourage law enforcement and court staff to visit treatment centers to reduce stigma and build familiarity with behavioral health services.
- Develop a shared understanding of language of care goals—shifting court expectations from "program graduation" to "sustained recovery and wellness."

Washoe County's behavioral health providers and criminal justice partners share the same mission—stability, recovery, and safety. With better coordination, both systems can more effectively serve individuals cycling between incarceration and care, transforming points of crisis into points of connection.

## Opportunities Identified by Housing Providers

When asked, "*What do you need from the justice system to better serve clients in this program?*", housing providers noted the need for better coordination, more resources, and fewer administrative hurdles. Based on this feedback, the following opportunities were identified:

**Opportunity 1: Enhance Coordination and Communication between Court Officials, Law Enforcement, and Behavioral Health with Housing Providers and Case Managers**

Providers described how coordination is needed to implement a system where people with behavioral health concerns who are justice-involved are quickly identified and referred into housing to reduce the likelihood of additional justice involvement. Suggestions to expedite access to housing include:

- Integrate Coordinated Entry (CE) into justice reentry planning to ensure individuals leaving incarceration are assessed and added to the community housing queue before release, rather than after.
- Align housing availability with predictable release dates to reduce mismatches.
- Create systems to share information openly to allow providers to prepare and deliver appropriate support.
- Standardize release-of-information processes so providers receive timely referrals and records.
- Embed housing representatives in specialized courts (e.g., drug court, mental health court, veterans/camo court) to streamline referrals.
- Improve interagency communication (courts, DOC, probation/parole, community living) to ensure consistent, transparent coordination.

**Opportunity 2: Support Medical and Behavioral Health Needs**

Housing providers noted that people in need of housing often have complex medical and behavioral health needs. Supporting those needs as part of their housing plan increases the likelihood clients served will retain housing. The following strategies can help facilitate supporting those medical and behavioral health needs.

- Guarantee continuity of medications, medical records, and assessments during jail discharge.
- Establish multidisciplinary consultations for clients with complex needs.
- Strengthen partnerships with behavioral health services to address issues that can lead to lease violations (e.g., cleanliness, hoarding).
- Accelerate TB test results and access to health documentation.

**Opportunity 3: Reduce Financial and Legal Barriers**

Providers reported that financial and legal barriers often result in people losing housing and can lead to recidivism. The following strategies are suggested to reduce financial and legal barriers and help justice-involved people retain access to stable housing.

- Expand Department of Corrections/state funding to cover prohibitive program fees and stabilize reentry.
- Provide eviction prevention supports and assist with sealing eviction and criminal records.
- Simplify and clarify guardianship processes for clients with justice involvement.

**Opportunity 4: Minimize Administrative Burdens on Providers**

Providers noted that there are some administrative improvements that could reduce duplication of efforts and expedite entry into housing if providers are able to share information and eliminate extra steps. These strategies include:

- Accept existing provider reports instead of requiring duplicate data entry into court systems.
- Ensure compliance with AB236 to improve cross-agency coordination.
- Avoid referring clients with needs beyond a program's capacity without prior consultation.

Taken together, these opportunities highlight the importance of synchronization: aligning justice and housing systems so that clients leaving incarceration can transition smoothly into stable housing with the resources and support needed to succeed.

> "[We need to] develop a full continuum of care for individuals discharging from jail. Patients [are] discharging into a shelter where medication management is not available, needing support in navigating through the criminal justice system, and connecting to resources is challenging."
>
> — Housing Provider Interview Participant

# System Recommendations Based on a Synthesis of All Mapping Activities

The following recommendations were synthesized and informed by the mapping interviews and research on best practices. Three areas are not explicitly addressed in the recommendations although they were raised during the mapping project. They include data sharing, and familiar voices, as these are two active SIM projects underway that are expected to produce their own recommendations. A third area is coordination and communication across court partners, which was already prioritized in the Strategic Framework and is slated to be addressed in 2026.

The following system recommendations, informed by the mapping results, align with provider-identified opportunities to improve service access and reduce barriers to care. They, and the associated goals, objectives, and strategies, are intended for inclusion in the Washoe region's Strategic Framework as outcomes of this mapping initiative.

## Theme: Strengthen Coordination Across Systems

**Goal: Improve communication and integration between behavioral health, housing, and justice systems to reduce delays and ensure continuity of care.**

Objective: Shorten the time from identification to referral and enrollment while eliminating handoff failures.

Strategies:

- Establish a **common intake and warm-handoff process** across crisis, booking, and early court stages (Intercepts 0–2).
- Implement **universal screening** for mental health, substance use, and housing needs, followed by immediate referral to a care navigator who ensures clients are not lost between systems.

## Theme: Remove Policy and Eligibility Barriers

**Goal: Simplify access to services by addressing documentation, insurance, and criminal history restrictions.**

Objective: Remove procedural barriers that delay access and impede continuity of care.

Strategies:

- Create **"documentation-first" reentry protocols** to secure IDs, Social Security cards, and birth certificates before release.
- Use Nevada's **1115 reentry demonstration** to extend pre-release services for up to 90 days, covering case management, medications, and community linkages.
- Partner with Medicaid to **suspend rather than terminate coverage** during incarceration so individuals have active insurance upon release.

## Theme: Expand Housing Options and Treatment Capacity

**Goal: Increase the supply of safe, supportive housing and behavioral health services that stabilize individuals, promotes health, and prevents returns to jail or homelessness.**

Objective: Scale the right mix of units and supportive services including access to treatment to reduce cycling through jail, ED, and shelter.

Strategies:

- Prioritize development of **Permanent Supportive Housing (PSH)** aligned with Housing First principles.
- Create **PSH set-asides** for justice-involved individuals and ensure service rates are adequate to maintain stability.
- Balance the housing portfolio with **transitional and medical-respite options** to support recovery and step-down care.
- Expand **outpatient and intensive outpatient** services for justice-involved individuals.
- Develop **specialized residential and outpatient programs** based on pilot programs that are designed for individuals with justice involvement, focusing on recovery and reentry rather than exclusion.

## Theme: Tailor Services for High-Barrier Populations

**Goal: Ensure that people with serious mental illness (SMI), intellectual or developmental disabilities (I/DD), or complex criminal histories have access to appropriate, effective services.**

Objective: Remove procedural barriers that impede continuity of care.

Strategies:

- Implement **Assertive Community Treatment (ACT) combined with PSH**, ensuring low-barrier entry and continuity of psychiatric care.
- Apply **ADA-aligned screening and crisis protocols** that account for disability-related needs.
- Offer **pre-release document clinics** in collaboration with DMV and SSA to reduce administrative barriers.
- Encourage providers to adopt **individualized eligibility assessments** rather than blanket exclusions based on criminal history.

These coordinated, practical strategies work within the intercepts and across the system as a whole. They aim to close service gaps, reduce recidivism, and create a more integrated behavioral health and housing system that promotes stability and recovery for justice-involved residents in Washoe County.

# Appendix A. Behavioral Health Program Profiles

The following behavioral health providers were interviewed.

Outpatient Services

## Intensive Outpatient



## Long-Term Residential Treatment

## Medication Assisted Treatment and Wraparound Services



## MAT Detox



## Crisis Stabilization Services

## Mobile Crisis Stabilization



## Psychiatric Access



## Inpatient Psychiatric Services



## Case Management Services



## Court Ordered Services

Family Services



The following program profiles summarize information gathered from each provider and are organized by program type.

## Outpatient Services

The following profiles summarize programs offering outpatient services.

### American Comprehensive Counseling Services: Individual Counseling

| | |
|---|---|
| **Website** | https://www.accsnv.com |
| **Contact Name** | Walt Dimitroff |
| **Phone** | 775-356-0371 |
| **Email** | NA |
| **Program Name** | **Individual Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Mental health individual therapy, focuses on domestic violence, substance abuse, and anger management<br>• Licensed Clinical Social Workers (LCSWs) at this organization are utilized whenever resources are needed |
| **Service Duration** | • Determined by court order or based upon client evaluation |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license and court documents<br>• Individuals with acute mental health symptoms may need higher level of care |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Court ordered treatment and assigned case workers |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 800 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• Can serve up to 400 clients at one time |

## Bristlecone Family Resources: Outpatient Substance Use Counseling

| | |
|---|---|
| **Website** | https://bristleconereno.com |
| **Contact Name** | Wendy Easter |
| **Phone** | 775-954-1400 ext. 106 |
| **Email** | admissions@bristleconereno.com |
| **Program Name** | **Outpatient Substance Use Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Individual and substance use disorder group therapy for in-house clients transitioning out of residential and 3.1 level substance use programs<br>• Outpatient clients are welcome to work with peer support specialists |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Criminal history restrictions preclude enrollment<br>• Mental health diagnosis<br>• Continuing insurance coverage after obtaining work: Medicaid does recertifications every six months, which can change a client's eligibility and impact whether an individual can afford treatment |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Being a current client of Bristlecone, or referrals from drug court and close relationships with community partners |
| **Waitlist Information** | • This program does not maintain a waitlist |
| **Program Annual Capacity** | • 90 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 30 clients at one time |

## CBA Healthcare: Outpatient Individual Counseling

| | |
|---|---|
| **Website** | https://CBAhealthcarereno.com |
| **Contact Name** | April Hackett |
| **Phone** | 775-200-8528 |
| **Email** | cbahealthcare@mail.com |
| **Program Name** | **Outpatient Individual Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Counseling services for families and adults, including Eye Movement Desensitization and Reprocessing (EMDR) and talk therapy |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license; face sheets from hospitals can be used for identification<br>• Criminal history restrictions preclude enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Completion of paperwork |
| **Waitlist Information** | • Maintains a waitlist, with six individuals at the time of interview |
| **Program Annual Capacity** | • 450 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• When discharge planning, CBA Healthcare also provides referrals<br>• This program can serve 400 clients at one time |

## Community Health Alliance: Outpatient Counseling - Adults

| | |
|---|---|
| **Website** | https://chanevada.org |
| **Contact Name** | Abril Arguello/Dr. Stephanie Gstettenbauer |
| **Phone** | 775-336-3027 |
| **Email** | aarguello@chanevada.org |
| **Program Name** | **Outpatient Counseling - Adults** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Individual therapy<br>• Does not provide resources for eating disorders or severe intellectual disability; no psychological assessments or couples therapy |
| **Service Duration** | • Individualized with customized treatment plan |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/Driver's License |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Majority of referrals are internal<br>• Accelerating factors for entry: Acuity (emergency referral from primary care provider) |
| **Waitlist Information** | • Maintains a waitlist, with 50 individuals at time of interview |
| **Program Annual Capacity** | • 950 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• When discharge planning, Community Health Alliance has Community Health Workers (CHWs) that support continuity of care<br>• This program can support 530 people at one time |

## Empowerment Center: Outpatient - Level 1

| | |
|---|---|
| **Website** | https://empowermentcenternv.org |
| **Contact Name** | Noelle Gravallese |
| **Phone** | 775-853-5441 |
| **Email** | noelle@empowermentcenternv.org |
| **Program Name** | **Outpatient - Level 1** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Less nine hours of services per week including psychiatric evaluation, substance and mental health evaluations, counseling, group therapy, medication management, and MAT |
| **Service Duration** | • Individualized and open-ended |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Criminal history restrictions preclude enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: If going into a TL program at Empowerment Center, need assessment; if just obtaining outpatient treatment, first come first serve |
| **Waitlist Information** | • Maintains a waitlist, with 10 individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• Provides several pro-bono services<br>• This program can serve 50 clients at one time |

## Inner Solutions: Voluntary Groups

| | |
|---|---|
| **Website** | https://www.innersolutionstherapy.com/ |
| **Contact Name** | Melisa Heckathorn |
| **Phone** | 775-217-0228 |
| **Email** | melisa.heckathorn@yahoo.com |
| **Program Name** | **Voluntary groups** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Dialectical Behavioral Therapy (DBT) group ($20 per session) |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Client motivation |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 40 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• Inner solutions can support individuals with connecting them to individual therapy when discharge planning<br>• This program can serve eight clients at one time |

## Inner Solutions: Outpatient Counseling - Individual

| | |
|---|---|
| **Website** | https://www.innersolutionstherapy.com/ |
| **Contact Name** | Melisa Heckathorn |
| **Phone** | 775-217-0228 |
| **Email** | melisa.heckathorn@yahoo.com |
| **Program Name** | **Outpatient Counseling - Individual** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Families, individuals, and couples |
| **Services Available** | • Traditional counseling serving individuals, families, and couples delivered in person and via telehealth |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Must have insurance or be able to afford sliding scale fee |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 150 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• Inner Solutions can support court-appointed individuals when discharge planning<br>• This program can serve up to 100 clients at one time |

## Northern Nevada Adult Mental Health Services: Medication Clinic

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **Medication Clinic** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Assessment<br>• Medication management<br>• Pharmacy for clients without insurance and those on injections<br>• Psychiatric case worker who will connect people with services |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Outside referral can facilitate connection to services<br>• Walk-in clients are accepted Monday through Friday |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 1,000 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 930 clients at one time |

## Nevada Behavioral Health Systems - Mill Street Care Center: Psycho-Education and Harm Reduction Groups

| | |
|---|---|
| **Website** | https://nvbhs.com/ |
| **Contact Name** | April Lang-Barroga |
| **Phone** | 775-501-8655 |
| **Email** | abarroga@novumhealth.com |
| **Program Name** | **Psycho-Education and Harm Reduction Groups** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Daily psychoeducation and harm reduction groups (held five times a day)—groups are open to anyone to drop in at any time |
| **Service Duration** | • Open ended |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>  ○ *This program will assist individuals needing to obtain documents*<br>• Must have Medicaid or other insurance<br>• Program only accepts Silver Summit Health Plan, Health Plan of Nevada, and Optum Medicare |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 500 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve up to 100 clients at one time |

## Nevada Behavioral Health Systems - Mill Street Care Center: Outpatient Individual Counseling – Adults

| | |
|---|---|
| **Website** | https://nvbhs.com/ |
| **Contact Name** | April Lang-Barroga |
| **Phone** | 775-501-8655 |
| **Email** | abarroga@novumhealth.com |
| **Program Name** | **Outpatient Individual Counseling – Adults** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Mental health assessment<br>• Individual counseling for crisis stabilization<br>• Ongoing therapy |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>  ○ *This program will assist individuals needing to obtain documents*<br>• Must have Medicaid or other eligible insurance<br>• Program only accepts Silver Summit Health Plan, Health Plan of Nevada, and Optum Medicare |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Have contracted MOUs with other providers in area if services are full or client wants to receive therapy elsewhere |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 250 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve up to 60 clients at one time |

## Northern Nevada Adult Mental Health Services: Outpatient Individual and Group Counseling and Peer Support

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **Outpatient Individual and Group Counseling and Peer Support** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health needs |
| **Services Available** | • Mental health counseling<br>• Variety of groups (e.g., DBT/ Cognitive Behavioral Therapy (CBT) group, dual diagnosis)<br>• Peer support can be obtained through a drop-in center<br>• Peer-run groups (e.g., fitness, outing and connecting to the community, gardening, cooking, budgeting) |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Must be stable enough for counseling (some individuals may need to be stabilized through housing and medication management before entering counseling) |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-3 months<br>• Accelerating factors for entry: None currently but working on how to prioritize populations to serve |
| **Waitlist Information** | • Maintains a waitlist, with 26 individuals at time of interview |
| **Program Annual Capacity** | • 300 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 150 clients at one time |

## Northern Nevada HOPES: Adult Groups

| | |
|---|---|
| **Website** | www.nnhopes.org |
| **Contact Name** | Kyle Sundland |
| **Phone** | 775-997-7574 |
| **Email** | ksundland@nnhopes.org |
| **Program Name** | **Adult Groups** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Recovery groups<br>• Peer support-led groups<br>• Grief groups<br>• Spanish speaking groups<br>• MAT-led groups |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 700 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 72 clients at one time |

## Northern Nevada HOPES: Outpatient Individual Counseling - Adult

| | |
|---|---|
| **Website** | www.nnhopes.org |
| **Contact Name** | Kyle Sundland |
| **Phone** | 775-997-7574 |
| **Email** | ksundland@nnhopes.org |
| **Program Name** | **Outpatient Individual Counseling - Adult** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Traditional weekly therapy for individuals, couples, and families |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-3 months<br>• Accelerating factors for entry: If individuals are current clients of HOPES, referrals from existing partnerships with STAR program, diversion courts, DAS |
| **Waitlist Information** | • Maintains a waitlist, with 35 individuals at time of interview |
| **Program Annual Capacity** | • 3,000 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 450 clients at one time |

## Quest: Outpatient Services

| | |
|---|---|
| **Website** | https://questreno.com |
| **Contact Name** | Jolene Dalluhn |
| **Phone** | 775-786-6880 |
| **Email** | jdalluhn@questreno.com |
| **Program Name** | **Outpatient Services** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Individual, peer, and group counseling<br>• MAT and medication management services<br>• Targeted case management<br>• Psychiatric Assessment |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Criminal history of sex crimes and violent crimes preclude enrollment<br>• Cannot serve individuals with high acuity mental health needs or an Autism diagnosis<br>• Vital documents required: ID/driver's license, proof of income, medical records, court documents, and any previous assessments |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: A contract with a court or health provider, experiencing suicidal ideation, case manager requesting expedited access |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 6,500 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end |

## Reno Sparks Tribal Health Center: Individual Substance Use Counseling

| | |
|---|---|
| **Website** | https://www.rsic.org/186/Health-Center |
| **Contact Name** | Michelle Jim-Katenay |
| **Phone** | 775-329-5162 |
| **Email** | mkatenay@rsicclinic.org |
| **Program Name** | **Individual Substance Use Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • All populations in need of behavioral health services who are a part of a tribal community |
| **Services Available** | • Provides counseling for substance use issues |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license, birth certificate, Social Security Card, proof of residence, and court documents<br>• Needs documentation of tribal enrollment or descendance |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Court ordered individuals |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 70 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 50 clients at one time |

## Reno Sparks Tribal Health Center: Mental Health Individual, Couples, and Family Counseling

| | |
|---|---|
| **Website** | https://www.rsic.org/186/Health-Center |
| **Contact Name** | Michelle Jim-Katenay |
| **Phone** | 775-329-5162 |
| **Email** | mkatenay@rsicclinic.org |
| **Program Name** | **Mental Health Individual, Couples, and Family Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • All populations in need of behavioral health services who are a part of a tribal community |
| **Services Available** | • Individual, couples, and family counseling provided by Marriage and Family Therapist (MFT), Clinical professional Counselor (CPC), LCSW, and clinical psychologists |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license, birth certificate, Social Security Card, proof of residence, and court documents<br>• Needs documentation of tribal enrollment or descendance |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Court ordered individuals |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 180 clients at one time |

## Reno Sparks Tribal Health Center: Group Counseling

| | |
|---|---|
| **Website** | https://www.rsic.org/186/Health-Center |
| **Contact Name** | Michelle Jim-Katenay |
| **Phone** | 775-329-5162 |
| **Email** | mkatenay@rsicclinic.org |
| **Program Name** | **Group Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • All populations in need of behavioral health services who are a part of a tribal community |
| **Services Available** | • Talking Circles<br>• Grief groups<br>• The Red Road to Wellbriety (Alternative form AA) |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license, Social Security Card, proof of Residence, and court documents<br>• Needs documentation of tribal enrollment or descendance |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Court ordered individuals |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 100 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 80 clients at one time |

## Renown Behavioral Health: Individual Therapy – Adult

| | |
|---|---|
| **Website** | https://www.renown.org/locations/stacie-mathewson-behavioral-health-and-addiction-institute-at-renown |
| **Contact Name** | Shelly Christenson |
| **Phone** | 775-982-8171 |
| **Email** | shelly.christenson@renown.org |
| **Program Name** | **Individual Therapy – Adult** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • People with behavioral health challenges |
| **Services Available** | • Traditional psychotherapy |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• Must have insurance that is in-network |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 150 individuals |
| **Other Key Information Gathered** | • This program can serve 150 clients at one time |

## Sai Mental Health: Adult Substance Abuse Groups

| | |
|---|---|
| **Website** | https://saimentalhealth.org/ |
| **Contact Name** | Ali Santos |
| **Phone** | 775-800-1136 |
| **Email** | asantos@saimentalhealth.org |
| **Program Name** | **Adult Substance Abuse Groups** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • People with behavioral health challenges |
| **Services Available** | • Substance abuse counseling groups |
| **Service Duration** | • Most clients are court ordered, and the length of time is determined by the court |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Court order |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 50 individuals |
| **Other Key Information Gathered** | • This program can serve 20 clients at one time |

## Sai Mental Health: Youth and Adult Counseling - Mental Health, Substance, and Co-occurring

| | |
|---|---|
| **Website** | https://saimentalhealth.org/ |
| **Contact Name** | Ali Santos |
| **Phone** | 775-800-1136 |
| **Email** | asantos@saimentalhealth.org |
| **Program Name** | **Youth and Adult Counseling - Mental Health, Substance, and Co-occurring** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • All populations in need of behavioral health services |
| **Services Available** | • Adult psychotherapy<br>• Substance abuse counseling |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Acuity |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program can serve 200 clients at one time |

## Sierra Counseling Center: Group Counseling

| | |
|---|---|
| **Website** | https://www.sierracounseling.com/ |
| **Contact Name** | Craig Merrill |
| **Phone** | 775-356-1908 |
| **Email** | craig@sierracounselingcenter.com |
| **Program Name** | **Group Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • People with behavioral health challenges |
| **Services Available** | • Substance use disorder treatment groups<br>• Domestic violence support groups<br>• Anger management groups<br>• Spanish-speaking provider for groups |
| **Service Duration** | • Court ordered clients' length of service depends on sentencing—varies from 3 to 6 to 12 months<br>• Voluntary clients' length of service is individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Cannot serve uninsured individuals or those who are unable to pay sliding scale fee |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program can serve 150 clients at one time |

## Sierra Counseling Center: Individual Counseling

| | |
|---|---|
| **Website** | https://www.sierracounseling.com/ |
| **Contact Name** | Craig Merrill |
| **Phone** | 775-356-1908 |
| **Email** | craig@sierracounselingcenter.com |
| **Program Name** | **Individual Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • People with behavioral health challenges |
| **Services Available** | • Psychotherapy for individuals, families, and couples |
| **Service Duration** | • Depends on clinical evaluation and recommendation for length of time |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Cannot serve individuals who cannot pay the sliding scale fee |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 75 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 35 clients at one time |

## STEP2: Outpatient Counseling - Individual and Group

| | |
|---|---|
| **Website** | https://www.step2reno.org/ |
| **Contact Name** | Jennifer Autry |
| **Phone** | 775-787-9411 |
| **Email** | jautry@step2reno.org |
| **Program Name** | **Outpatient Counseling - Individual and Group** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with substance use disorder |
| **Services Available** | • Treatment services range from eight hours a month (two times a week) to once a month<br>• The program uses the same groups as IOP but is more flexible and less intensive, allowing for more focus on individual needs |
| **Service Duration** | • Individualized based on ASAM |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Criminal history of sex crimes precludes enrollment, but will be reviewed on a case by case basis<br>• Certain acute mental health diagnoses preclude enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Pregnant IV users |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 25 clients at one time |

## The Life Change Center: Outpatient SUD

| | |
|---|---|
| **Website** | https://www.thelifechangecenter.org/ |
| **Contact Name** | John Firestone |
| **Phone** | 775-842-7436 |
| **Email** | john@tlccreno.org |
| **Program Name** | **Outpatient SUD** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • SUD counseling<br>• SUD groups |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license or birth certificate<br>• Must have insurance or be able to pay sliding scale fee |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Pregnancy, IV use, military |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 1,800 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 1,200 clients at one time |

## Vitality Unlimited CCBHC Reno: Outpatient Services

| | |
|---|---|
| **Website** | https://vitalityunlimited.org/ |
| **Contact Name** | Heather Eaton |
| **Phone** | 775-322-3668 |
| **Email** | heather.eaton@vitalityunlimited.org |
| **Program Name** | **Outpatient Services** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Targeted Case Management (TCM)<br>• Psychosocial Rehabilitation (PSR)<br>• Basic Skills Training (BST)<br>• Peer support (PRS)<br>• Primary care services<br>• Therapy for individuals, couples, and groups<br>• Substance use treatment<br>• Crisis services<br>• Psychiatric Medication Management<br>• MAT services |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents are required: ID/driver's license<br>  ○ *Vitality can help individuals obtain ID and information if in need of support*<br>• Criminal history of a sex crime above tier one precludes enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Client is in crisis, court order, acuity |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 3,000 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 1,100 clients at one time |

## Washoe County Housing and Homeless Services: Outpatient Counseling

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/homeless/ |
| **Contact Name** | Ana Huntsberger |
| **Phone** | (775) 325-8210 |
| **Email** | RegionalHomelessServices@washoecounty.gov |
| **Program Name** | **Outpatient Counseling** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Individual counseling |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Must be a current client of Washoe County Housing and Homeless Services |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 500 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 140 clients at one time<br>• This program serves clients who are unable to access mental health treatment in the community for a variety of reasons (e.g., mental health issues, feeling unsafe to leave campus, wrong insurance, need for bridge counseling for immediate support) |

## WC Health: Group Therapy

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Therapy Reception |
| **Phone** | 775-538-6700 |
| **Email** | therapy-reception@wc-health.com |
| **Program Name** | **Group Therapy** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • "Transitions" group that is for individuals who have completed a IOP |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Graduation or completion of WC-Health IOP |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 400 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• There are two groups with a capacity of up to 10 each group |

## WC Health: Individual Therapy

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Therapy Reception |
| **Phone** | 775-538-6700 |
| **Email** | therapy-reception@wc-health.com |
| **Program Name** | **Individual Therapy** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Traditional psychotherapy<br>• Therapy for adults delivered in person or online |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with 10 individuals at time of interview, unless the individual is served by the psychiatric urgent facility (PUF) |
| **Program Annual Capacity** | • 2,021 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 650 individuals at one time |

## Zephyr Wellness - Individual Counseling for Adults

| | |
|---|---|
| **Website** | https://www.zephyrwellness.org/ |
| **Contact Name** | Jake Wiskerchen |
| **Phone** | 775-287-1099 |
| **Email** | jake@zephyrwellness.org |
| **Program Name** | **Individual Counseling for Adults** |
| **Program Type** | • Outpatient Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Outpatient talk therapy |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required; provides assistance in obtaining documents<br>• Cannot treat medical or behavioral indications outside of their level of care, including acute eating disorders |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Community based referrals, e.g., emergency rooms, primary care providers, pediatricians, and church referrals |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 800 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 800 clients at one time |

## Intensive Outpatient

The following profiles summarize programs offering intensive outpatient services.

### Empowerment Center: 2.1 Intensive Outpatient Program

| | |
|---|---|
| **Website** | https://empowermentcenternv.org/ |
| **Contact Name** | Noelle Gravallese |
| **Phone** | 775-853-5441 |
| **Email** | noelle@empowermentcenternv.org |
| **Program Name** | **2.1 Intensive Outpatient Program** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Over nine hours of services per week including:<br>  ○ Psychiatric evaluations<br>  ○ Substance use evaluations<br>  ○ Mental health evaluations<br>  ○ Counseling<br>  ○ Groups<br>  ○ Medication management<br>  ○ MAT |
| **Service Duration** | • Six weeks, depending on client progress. If needed, the client can reapply for additional IOP |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Criminal history of high-level sex crimes and violent crimes preclude enrollment<br>• Medical needs are beyond scope of care |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: If clients already have assessments |
| **Waitlist Information** | • Maintains a waitlist, with 10 individuals at time of interview |
| **Program Annual Capacity** | • 180 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 10 clients at one time |

## Northern Nevada Adult Mental Health Services: Assisted Outpatient Treatment

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **Assisted Outpatient Treatment** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • ACT-based with intensive case management<br>• Medication management<br>• Vocational support<br>• Peer support<br>• Wraparound services<br>• Housing provided through NNAMHS |
| **Service Duration** | • Six months, but can be extended for six-month blocks |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Referral from another provider, staff, or family<br>• Cannot serve individuals who are unable to meet criteria for AOT programs. Eligibility criteria includes multiple past hospitalizations and/or arrests and who have been unsuccessful at lower levels of care |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-3 months<br>• Accelerating factors for entry: Referrals from jail and hospitals; also accepts referrals from other providers, staff, or family |
| **Waitlist Information** | • Maintains a waitlist, with 17 individuals at time of interview |
| **Program Annual Capacity** | • 72 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 36 clients at one time |

## Northern Nevada HOPES: Adult Intensive Outpatient Program

| | |
|---|---|
| **Website** | www.nnhopes.org |
| **Contact Name** | Kyle Sundland |
| **Phone** | 775-997-7574 |
| **Email** | ksundland@nnhopes.org |
| **Program Name** | **Adult Intensive Outpatient Program** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges and substance use disorders |
| **Services Available** | • Offered three times a week for three hours, for a total of nine hours a week<br>• Mental health services<br>• Substance use services<br>• Problem gambling services is starting soon |
| **Service Duration** | • 8-12 weeks |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Insurance approval |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Insurance being verified and prior authorization obtained; Memorandum of Understanding (MOU) with Reno Municipal Court |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 700 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program offers peer support when discharge planning<br>• This program can serve 60 clients at one time |

## Quest Counseling and Consulting, Inc.: Assertive Community Treatment

| | |
|---|---|
| **Website** | https://www.questreno.com/ |
| **Contact Name** | Jolene Dalluhn |
| **Phone** | 775-786-6880 |
| **Email** | jdalluhn@questreno.com |
| **Program Name** | **Assertive Community Treatment** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Treatment for SMI<br>• Wraparound services<br>• Community based treatment<br>• Psychiatric services |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license, medical records, and court documents<br>• Criminal history of violent crimes preclude enrollment<br>• Must have a SMI diagnosis |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Setting up an appointment while client is hospitalized for a psychiatric stay, and having the client consent for discharge and admissions summary |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 30 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 30 clients at one time |

## Reno Behavioral Healthcare Hospital: Dual Diagnosis IOP for Adults

| | |
|---|---|
| **Website** | https://www.renobehavioral.com/ |
| **Contact Name** | Stephanie Brown |
| **Phone** | 775-393-2201 |
| **Email** | s.brown@renobehavioral.com |
| **Program Name** | **Dual Diagnosis IOP for Adults** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Offers three tracks a week, three hours a day<br>• Provide snacks and separate entrance for outpatient clients |
| **Service Duration** | • 10-12 weeks |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• Must participate to stay eligible |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 2,340 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 45 clients at one time |

## Reno Behavioral Healthcare Hospital: CD (Chemical Dependency) IOP for Adults

| | |
|---|---|
| **Website** | https://www.renobehavioral.com/ |
| **Contact Name** | Stephanie Brown |
| **Phone** | 775-393-2201 |
| **Email** | s.brown@renobehavioral.com |
| **Program Name** | **CD (Chemical Dependency) IOP for Adults** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Offers three tracks a week, three hours a day<br>• Provide snacks and separate entrance for outpatient clients |
| **Service Duration** | • 10-12 weeks |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/Driver's license<br>• Sobriety requirement<br>• Must participate to stay eligible |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 2,340 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 45 clients at one time |

## Reno Behavioral Healthcare Hospital: MH (Mental Health) IOP for Adults

| | |
|---|---|
| **Website** | https://www.renobehavioral.com/ |
| **Contact Name** | Stephanie Brown |
| **Phone** | 775-393-2201 |
| **Email** | s.brown@renobehavioral.com |
| **Program Name** | **MH (Mental Health) IOP for Adults** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Offers two groups per week, three hours a day<br>• Snacks provided and separate entrance for outpatient clients |
| **Service Duration** | • 10-12 weeks |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license and/or some form of identification<br>• Must participate to stay eligible |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 1,560 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 30 clients at one time |

## Reno Sparks Tribal Health Center: IOP

| | |
|---|---|
| **Website** | https://www.rsic.org/186/Health-Center |
| **Contact Name** | Michelle Jim-Katenay |
| **Phone** | 775-329-5162 |
| **Email** | mkatenay@rsicclinic.org |
| **Program Name** | **IOP** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges, particularly court ordered individuals |
| **Services Available** | • 9-13 hours of group therapy per week<br>• Able to provide services to individuals with co-occurring disorders<br>• Use culturally based programs |
| **Service Duration** | • 8 weeks |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license, Social Security Card, proof of residence, and court documents<br>• Needs documentation of tribal enrollment or descendance |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Court ordered |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 75 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 15 clients at one time |

## Renown Behavioral Health: IOP - Adult

| | |
|---|---|
| **Website** | https://www.renown.org/locations/stacie-mathewson-behavioral-health-and-addiction-institute-at-renown |
| **Contact Name** | Shelly Christenson |
| **Phone** | 775-982-8171 |
| **Email** | shelly.christenson@renown.org |
| **Program Name** | **IOP - Adult** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Services three days a week, three hours a day<br>• Two tracks: 1) Trauma and PTSD and 2) depression<br>• Individual therapy<br>• Medication management |
| **Service Duration** | • Six weeks |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license and proof of Insurance<br>• Qualifying insurances only |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 258 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program creates discharge plan with available resources for the client<br>• This program can serve 30 clients at one time |

## STEP2: Intensive Outpatient (IOP)

| | |
|---|---|
| **Website** | https://www.step2reno.org/ |
| **Contact Name** | Jennifer Autry |
| **Phone** | 775-787-9411 |
| **Email** | jautry@step2reno.org |
| **Program Name** | **Intensive Outpatient (IOP)** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with substance use disorder |
| **Services Available** | • Treatment services available range from nine-19 hours of group and individual treatment<br>• All clients meet with individual counselors weekly, then attend groups for relapse prevention, living in recovery, anger management, managing emotions, etc. weekly |
| **Service Duration** | • Individualized based on ASAM criteria |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Only need ASAM assessment to get into treatment, which organization provides<br>• Cannot serve individuals with certain acute mental health diagnoses<br>• Criminal history of sex crimes precludes enrollment, but will be reviewed on a case by case basis |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Anyone who is pregnant and an IV user |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 25 clients at one time |

## Vitality Unlimited CCBHC Reno: Intensive Outpatient (IOP)

| | |
|---|---|
| **Website** | https://vitalityunlimited.org/ |
| **Contact Name** | Heather Eaton |
| **Phone** | 775-322-3668 |
| **Email** | heather.eaton@vitalityunlimited.org |
| **Program Name** | **Intensive Outpatient (IOP)** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Vitality offers two tracks of 15 clients to increase capacity because there is such a need (due to Medicaid rules of a limit of 15 clients per group)<br>• Groups run three days a week for three hours a day<br>• Clients also receive individual substance use and mental health counseling, peer support, targeted case management, and medication management<br>• Staff check in on clients frequently |
| **Service Duration** | • 12 weeks |
| **Eligibility and Documentation Criteria** | • Vital documents are required: ID/driver's license<br>  ○ *Vitality can help individuals obtain ID and information if in need of support*<br>• Criminal history of a sex crime above tier one precludes enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Substance use disorder, court order, recommendation for that level of care for ASAM, acuity |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 260 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 30 clients at one time |

## Vitality Unlimited CCBHC Reno: Assertive Community Treatment

| | |
|---|---|
| **Website** | https://vitalityunlimited.org/ |
| **Contact Name** | Heather Eaton |
| **Phone** | 775-322-3668 |
| **Email** | heather.eaton@vitalityunlimited.org |
| **Program Name** | **Assertive Community Treatment** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Substance use and mental health therapy<br>• Targeted Case Management (TCM)<br>• Basic Skills Training (BST)<br>• Psychosocial Rehabilitation Services<br>• Primary care<br>• Crisis support<br>• Group therapy<br>• Psychiatric medication management<br>• Community based support and daily check in |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents are required: ID/driver's license<br>  ○ *Vitality can help individuals obtain ID and information if in need of support*<br>• Criminal history of a sex crime above tier one precludes enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Acuity, court order, diagnosis, providing an assessment that was already completed by the courts |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 50 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 30 clients at one time |

## WC Health: Intensive Outpatient Program

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Therapy Reception |
| **Phone** | 775-538-6700 |
| **Email** | therapy-reception@wc-health.com |
| **Program Name** | **Intensive Outpatient Program** |
| **Program Type** | • Intensive Outpatient |
| **Focus Population** | • Individuals with behavioral health challenges and those experiencing homelessness |
| **Services Available** | • Offers two tracks of IOP groups held three times a week for three hours<br>• Can expand IOP groups in response to demand<br>• A majority of clients in WC-Health housing are offered IOP as deemed appropriate in their assessment |
| **Service Duration** | • 3.5 weeks (10 sessions) |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: If individuals are currently connected with WC - Health Service; based upon therapist recommendation |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 272 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• When discharge planning, case management team provides support to next level of care<br>• This program can serve 30 clients at one time |

## Long-Term Residential Treatment

The following profiles summarize programs offering long-term residential treatment.

### Bristlecone Family Resources: Residential Treatment

| | |
|---|---|
| **Website** | https://bristleconereno.com/ |
| **Contact Name** | Wendy Easter |
| **Phone** | 775-954-1400 ext. 106 |
| **Email** | admissions@bristleconereno.com |
| **Program Name** | **Residential Treatment** |
| **Program Type** | • Long-term Residential |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Individual therapy<br>• Group therapy<br>• Peer support<br>• Art therapy<br>• Connects client with HOPES for mental health and MAT<br>*This program assists individuals in applying for Medicaid, to obtain substance abuse evaluation prior to acceptance. This program also assists with food stamps, getting IDs, and Social Security Cards* |
| **Service Duration** | • Ranges from 30-45 days<br>• Depends on client needs, progress, and Medicaid approval<br>• Sometimes only 21 days due to Medicaid approval |
| **Eligibility and Documentation Criteria** | • Vital documents required: Medical records<br>• Substance abuse evaluation that recommends residential or 3.1 treatment<br>• Must be accepted into residential to access step down services<br>• Criminal history of sex crimes precludes enrollment<br>• Clients must pass a supervised drug screen at intake<br>• Having a substance abuse evaluation is helpful when jails and courts provide one; Bristlecone will help obtain Medicaid to get into services<br>• The most effective way to access this service is via accessing detox at Carson Tahoe Behavioral Health or Reno Behavioral Health. These programs will complete a substance use evaluation and coordinate transport<br>• Cannot support anyone who is experiencing psychosis or a mental health crisis that is not stabilized |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Pregnancy and acuity |
| **Waitlist Information** | • Maintains a waitlist, with six individuals at time of interview |
| **Program Annual Capacity** | • 220 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 26 clients at one time |

## Bristlecone Family Resources: 3.1 Residential Step Down

| | |
|---|---|
| **Website** | https://bristleconereno.com |
| **Contact Name** | Wendy Easter |
| **Phone** | 775-954-1400 ext. 106 |
| **Email** | admissions@bristleconereno.com |
| **Program Name** | **3.1 Residential Step Down** |
| **Program Type** | • Long-term Residential |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Focused on preparing the client to be successful in a TL program or rejoin the community<br>• Individual and group counseling<br>• Program offers passes to use cell phones and leave property<br>• Women receive passes to go to “Dress for Success”<br>• Provides more case management with clients<br>• Life skills via JobConnect, which provides assistance in opening a bank account, financial literacy, a workforce development room with computers, and mock interviews |
| **Service Duration** | • Not to exceed 30 days |
| **Eligibility and Documentation Criteria** | • Vital documents required: Medical records<br>• If an individual is transferred from WellCare, New Frontier, or CCC and they have open beds, need an updated ASAM<br>• Criminal history of sex crimes precludes enrollment<br>• Must successfully complete residential program |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Being a client in other residential treatment at Bristlecone |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 108 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve nine clients at one time |

## Ridge House: Residential Treatment

| | |
|---|---|
| **Website** | https://ridgehouse.org/ |
| **Contact Name** | Nancy Lindler |
| **Phone** | 775-453-5108 |
| **Email** | nlindler@ridgehouse.org |
| **Program Name** | **Residential Treatment** |
| **Program Type** | • Long-term Residential |
| **Focus Population** | • Serves men with a specific focus on prison reentry |
| **Services Available** | • Residential treatment program for substance use disorders and mental health diagnoses<br>• Trauma focused, client-centered, and evidence-based services |
| **Service Duration** | • Individualized, from 3-9 months |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Need to complete and submit application with their release officer<br>• Must be in jail, although criminal history of sex crimes precludes enrollment<br>• Women and individuals without a substance use condition are also precluded<br>• Cannot accept individuals who have SMI with acute symptoms |
| **Referral and Intake Processes** | • Referral-to-intake time: More than 3 months<br>• Accelerating factors for entry: Being eligible for parole and having a substance use disorder |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 40 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 15 clients at one time |

## STEP2: Residential Treatment

| | |
|---|---|
| **Website** | https://step2reno.org |
| **Contact Name** | Jennifer Autry |
| **Phone** | 775-787-9411 |
| **Email** | jautry@step2reno.org |
| **Program Name** | **Residential Treatment** |
| **Program Type** | • Long-term Residential |
| **Focus Population** | • Individuals with substance use disorder |
| **Services Available** | • 3.5 Clinically Managed High-Intensity Residential and 3.1 Clinically Managed<br>• Most clients start at 3.5 and then step down to 3.1<br>• 3.5 provides a 24-hour structured environment designed for people who need 24-hour oversight and are at risk of imminent harm<br>• 3.1 provides 24-hour structure and provides support while clients develop and practice interpersonal skills, strengthen recovery skills |
| **Service Duration** | • Not based on time, but on average about 60 days; ASAM driven |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Participation is required for maintaining eligibility<br>• Criminal history of sex crimes precludes enrollment, but will be reviewed on a case by case basis<br>• Cannot serve individuals with certain acute mental health diagnoses |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Pregnant women who are IV users are the priority, then pregnant women. |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 20 clients at one time |

## Medication Assisted Treatment (MAT) and Wraparound Services

The following profiles summarize programs offering MAT and wraparound services.

### Community Health Alliance: Medication Management

| | |
|---|---|
| **Website** | https://chanevada.org |
| **Contact Name** | Abril Arguello/Dr. Stephanie Gstettenbauer |
| **Phone** | 775-336-3027 |
| **Email** | aarguello@chanevada.org |
| **Program Name** | **Medication Management** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Psychiatric medication management for adults |
| **Service Duration** | • Individualized based upon treatment plan |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• Cannot serve individuals with an eating disorder or severe intellectual disability |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Acuity |
| **Waitlist Information** | • Maintains a waitlist, with 15 individuals at time of interview |
| **Program Annual Capacity** | • 1,200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 150 clients at one time |

## Empowerment Center: Co-occurring Services

| | |
|---|---|
| **Website** | https://empowermentcenternv.org |
| **Contact Name** | Noelle Gravallese |
| **Phone** | 775-853-5441 |
| **Email** | noelle@empowermentcenternv.org |
| **Program Name** | **Co-occurring Services** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Psychiatric, substance use, and mental health evaluations<br>• Individual counseling and groups<br>• Medication management and MAT |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Criminal history of high-level sex crimes and violent crimes preclude enrollment<br>• Cannot serve individuals with complex medical needs |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Assessments, TB tests, and medical documentation |
| **Waitlist Information** | • Maintains a waitlist, with 10 individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 80 clients at one time |

## Inner Solutions: Medication Management

| | |
|---|---|
| **Website** | https://www.innersolutionstherapy.com/ |
| **Contact Name** | Melisa Heckathorn |
| **Phone** | 775-217-0228 |
| **Email** | melisa.heckathorn@yahoo.com |
| **Program Name** | **Medication Management** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Services provided by Advanced Practice Registered Nurses (APRN)—one provides services both in person and telehealth, while the others provide telehealth only<br>• Psychiatric medication management, usually delivered monthly to every three months |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Cannot serve individuals who require higher levels of care due to acuity of symptoms |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Client awareness of program |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 72 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 72 clients at one time |

## Nevada Behavioral Health Systems - Mill Street Care Center: Medication Management (including MAT)

| | |
|---|---|
| **Website** | https://nvbhs.com/ |
| **Contact Name** | April Lang-Barroga |
| **Phone** | 775-501-8655 |
| **Email** | abarroga@novumhealth.com |
| **Program Name** | **Medication Management (Including MAT)** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Psychiatric medication management<br>• MAT supervised by a psychiatrist<br>• Urine analysis tests onsite for drug testing to support compliance |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>  ○ *This program will assist individuals needing to obtain documents*<br>• Medicaid requirement<br>• Program only accepts Silver Summit Health Plan, Health Plan of Nevada, and Optum Medicare |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • Not provided |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end |

## Community Health Alliance: Medication Assisted Treatment

| | |
|---|---|
| **Website** | https://chanevada.org |
| **Contact Name** | Abril Arguello/Dr. Stephanie Gstettenbauer |
| **Phone** | 775-336-3027 |
| **Email** | aarguello@chanevada.org |
| **Program Name** | **Medication Assisted Treatment** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Medication support<br>• Wraparound services<br>• Behavioral health services<br>• Transportation<br>• Emergency dental services<br>• Drug testing |
| **Service Duration** | • Individualized based upon treatment plan |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/Driver's license<br>• Must comply with behavioral contracts and expectations of staff |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 60 clients at one time |

## Northern Nevada HOPES: Medication Assisted Treatment

| | |
|---|---|
| **Website** | www.nnhopes.org |
| **Contact Name** | Kyle Sundland |
| **Phone** | 775-997-7574 |
| **Email** | ksundland@nnhopes.org |
| **Program Name** | **Medication Assisted Treatment** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Individual therapy<br>• Group therapy<br>• Integration sessions during clinic visits<br>• Assessment<br>• Medication management<br>• Urine analysis<br>• Peer support |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 150 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 60 clients at one time |

## Quest Counseling and Consulting, Inc.: MAT

| | |
|---|---|
| **Website** | https://questreno.com |
| **Contact Name** | Jolene Dalluhn |
| **Phone** | 775-786-6880 |
| **Email** | jdalluhn@questreno.com |
| **Program Name** | **MAT** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Full psychiatric evaluation<br>• Drug testing<br>• Counseling |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• Rule compliance<br>• Criminal history of sex crimes precludes enrollment<br>• Must take medication |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: If an individual is using life-threatening substances (fentanyl) or has heavy alcohol use |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 75 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 75 clients at one time |

## Reno Sparks Tribal Health Center: Medication Management

| | |
|---|---|
| **Website** | https://www.rsic.org/186/Health-Center |
| **Contact Name** | Michelle Jim-Katenay |
| **Phone** | 775-329-5162 |
| **Email** | mkatenay@rsicclinic.org |
| **Program Name** | **Medication Management** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Psychiatric medication management (including MAT and injectables) provided by two PMHNPs |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license, birth certificate, Social Security Card, proof of residence, and court documents<br>• Need to provide evidence of tribal enrollment or descendance |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Court ordered individuals are given priority. Having discharge paperwork can assist in process |
| **Waitlist Information** | • Maintains a waitlist with zero individuals at time of interview |
| **Program Annual Capacity** | • 120 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 100 clients at one time |

## Renown Behavioral Health: Medication Assisted Treatment

| | |
|---|---|
| **Website** | https://www.renown.org/locations/stacie-mathewson-behavioral-health-and-addiction-institute-at-renown |
| **Contact Name** | Shelly Christenson |
| **Phone** | Not provided |
| **Email** | shelly.christenson@renown.org |
| **Program Name** | **Medication Assisted Treatment** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • MAT provided by a psychiatrist |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/Driver's license and proof of insurance<br>• Compliance with program<br>• Insurance approval |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 78 individuals |
| **Other Key Information Gathered** | • This program can serve 78 clients at one time |

## Renown Behavioral Health: Medication Management

| | |
|---|---|
| **Website** | https://www.renown.org/locations/stacie-mathewson-behavioral-health-and-addiction-institute-at-renown |
| **Contact Name** | Shelly Christenson |
| **Phone** | Not provided |
| **Email** | shelly.christenson@renown.org |
| **Program Name** | **Medication Management** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Ongoing medication management |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• Insurance approval<br>• Compliance with program |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 260 individuals |
| **Other Key Information Gathered** | • This program can serve 260 clients at one time |

## Sai Mental Health: Youth and Adult Psychiatry

| | |
|---|---|
| **Website** | https://saimentalhealth.org/ |
| **Contact Name** | Ali Santos |
| **Phone** | 775-800-1136 |
| **Email** | asantos@saimentalhealth.org |
| **Program Name** | **Youth and Adult Psychiatry** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Medication management for psychiatry<br>• Medication Assisted Treatment |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Acuity |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 500 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 350 clients at one time |

## The Life Change Center: Peer Recovery Support

| | |
|---|---|
| **Website** | https://thelifechangecenter.org |
| **Contact Name** | John Firestone |
| **Phone** | 775-842-7436 |
| **Email** | john@tlccreno.org |
| **Program Name** | **Peer Recovery Support** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Cultural facilitation of integrating into the Life Change Center and community<br>• Resource coaching, navigation, and case management<br>• Transportation<br>• Harm reduction supplies<br>• Opioid Treatment Induction Support (peers and nurse call client daily/weekly to keep client connected with services) |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license or birth certificate<br>• Harm reduction supplies require some documentation |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Being a patient of the Life Change Center, location, being involved in harm reduction services |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 1,500 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 700 clients at one time |

## The Life Change Center: Medication OUD

| | |
|---|---|
| **Website** | https://thelifechangecenter.org |
| **Contact Name** | John Firestone |
| **Phone** | 775-842-7436 |
| **Email** | john@tlccreno.org |
| **Program Name** | **Medication OUD** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Structured access to and dispensing of medications for OUD |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license or birth certificate |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Pregnancy, IV use, military |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 1,800 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 1,200 clients at one time |

## The Life Change Center: Psychiatric BH

| | |
|---|---|
| **Website** | https://thelifechangecenter.org |
| **Contact Name** | John Firestone |
| **Phone** | 775-842-7436 |
| **Email** | john@tlccreno.org |
| **Program Name** | **Psychiatric BH** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Psychiatrists provide medication management (200-person capacity)<br>• Licensed therapists provide individual counseling (70-person capacity) |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license or birth certificate |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Client of the Life Change Center |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 200 clients at one time |

## Vitality Unlimited CCBHC Reno – MAT

| | |
|---|---|
| **Website** | https://vitalityunlimited.com |
| **Contact Name** | Heather Eaton |
| **Phone** | 775-322-3668 |
| **Email** | heather.eaton@vitalityunlimited.org |
| **Program Name** | **MAT** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Substance use testing<br>• Peer support<br>• Individual counseling [IOP] |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents are required: ID/driver's license<br>  ○ *Vitality can help individuals obtain ID and information if in need of support*<br>• Criminal history of a sex crime above tier one precludes enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Acuity, crisis, court order, clients coming out of residential (have appointment prior to discharge) |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 3,000 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 1,000 clients at one time |

## WC Health: Medication Assisted Treatment

| | |
|---|---|
| **Website** | https://wc-health.com |
| **Contact Name** | Mandel Goodwin |
| **Phone** | 775-538-6700 ext. 4305 |
| **Email** | m.goodwin@wc-health.com |
| **Program Name** | **Medication Assisted Treatment** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Case management<br>• MAT<br>• Ongoing scheduled visits with urine analysis |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 156 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 156 clients at one time |

## WC Health: Psychiatric Medication Management

| | |
|---|---|
| **Website** | https://wc-health.com |
| **Contact Name** | Mandel Goodwin |
| **Phone** | 775-538-6700 ext. 4305 |
| **Email** | m.goodwin@wc-health.com |
| **Program Name** | **Psychiatric Medication Management** |
| **Program Type** | • MAT and Wraparound Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Medication management supervised by psychiatric provider |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 6,424 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 1,000 clients at one time |

## MAT Detox

The following profiles summarize programs offering MAT Detox services.

### Quest Counseling and Consulting, Inc.: Ambulatory Detox

| | |
|---|---|
| **Website** | https://questreno.com |
| **Contact Name** | Jolene Dalluhn |
| **Phone** | 775-786-6880 |
| **Email** | jdalluhn@questreno.com |
| **Program Name** | **Ambulatory Detox** |
| **Program Type** | • MAT Detox |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Services for people who can tolerate withdrawal for 48-72 hours<br>• Clinical Opiate Withdrawal Scale (COWS) screening to evaluate active withdrawal, then providers develop a plan for detox<br>• Medications must be paired with counseling or peer support |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• Need to have substance use disorder diagnosis<br>• Medication and rule compliance |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Lethality and risk |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 40 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 40 clients at one time |

## Crisis Stabilization Services

The following profiles summarize programs offering crisis stabilization services.

### Reno Behavioral Healthcare Hospital: Inpatient Crisis Stabilization

| | |
|---|---|
| **Website** | https://renobehavioral.com |
| **Contact Name** | Stephanie Brown |
| **Phone** | 775-393-2201 |
| **Email** | s.brown@renobehavioral.com |
| **Program Name** | **Inpatient Crisis Stabilization** |
| **Program Type** | • Crisis Stabilization |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Crisis stabilization for individuals experiencing mental health crisis including suicidal ideation with plan, intent, and means, homicidal ideation, psychosis, schizophrenia, bipolar disorder, etc.<br>• Medication management in a locked and safe environment with individual therapy once per week and daily groups<br>• Recreational therapy<br>• Gym access |
| **Service Duration** | • 3-5 days |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• Cannot serve individuals with aggression toward authority figures or individuals who are too medically compromised |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Acuity |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 15,330 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 42 clients at one time |

## Renown Behavioral Health: Renown Crisis Care Center

| | |
|---|---|
| **Website** | https://www.renown.org/locations/stacie-mathewson-behavioral-health-and-addiction-institute-at-renown |
| **Contact Name** | Shelly Christenson |
| **Phone** | Not provided |
| **Email** | shelly.christenson@renown.org |
| **Program Name** | **Renown Crisis Care Center** |
| **Program Type** | • Crisis Stabilization |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Stabilization for individuals in behavioral health crisis<br>• Limited to 23 hours with connection to resources or transfer to an inpatient facility |
| **Service Duration** | • Individualized but cannot exceed more than three days |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/Driver's license |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 3,000 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 25 clients at one time |

## Washoe County Housing and Homeless Services: On-Site Crisis Response

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/homeless/ |
| **Contact Name** | Ana Huntsberger |
| **Phone** | (775) 325-8210 |
| **Email** | RegionalHomelessServices@washoecounty.gov |
| **Program Name** | **On-Site Crisis Response** |
| **Program Type** | • Crisis Stabilization |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Mental health counselors respond to individuals in crisis on the Cares Campus or Our Place<br>• Assessment for acuity, development of a safety plan, and connection with resources<br>• Case management provided to support referrals |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Must already be a client of Washoe County Housing and Homeless Services |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 1,500 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 549 clients at one time |

## WC Health: Psychiatric Urgent Care Facility

| | |
|---|---|
| **Website** | https://wc-health.com |
| **Contact Name** | Mandel Goodwin |
| **Phone** | 775-538-6700 ext. 4305 |
| **Email** | m.goodwin@wc-health.com |
| **Program Name** | **Psychiatric Urgent Care Facility** |
| **Program Type** | • Crisis Stabilization |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Needs assessment<br>• Case management<br>• Housing referral<br>• Background checks<br>• Linkage to services |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 2,016 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 100 clients at one time |

## Mobile Crisis Stabilization

The following profiles summarize programs offering mobile crisis stabilization services.

### Quest Counseling and Consulting, Inc.: Mobile Crisis

| | |
|---|---|
| **Website** | https://questreno.com |
| **Contact Name** | Jolene Dalluhn |
| **Phone** | 775-786-6880 |
| **Email** | jdalluhn@questreno.com |
| **Program Name** | **Mobile Crisis** |
| **Program Type** | • Mobile Crisis Stabilization |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Crisis Stabilization |
| **Service Duration** | • Clinician stays with the client until the crisis is stabilized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Cannot serve individuals in remote locations |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Suicidality with plan and intention<br>• *Not currently receiving external referrals from 988* |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 1,500 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve five clients at one time |

## Vitality Unlimited CCBHC Reno: Mobile Crisis

| | |
|---|---|
| **Website** | https://vitalityunlimited.com |
| **Contact Name** | Heather Eaton |
| **Phone** | 775-322-3668 |
| **Email** | heather.eaton@vitalityunlimited.org |
| **Program Name** | **Mobile Crisis** |
| **Program Type** | • Mobile Crisis Stabilization |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Crisis Response<br>  ○ Responds to individuals in crisis within the community<br>  ○ Connects them to appropriate programs for long-term treatment or support<br>• Assessment & Mental Health Screenings:<br>  ○ *Columbia Suicide Severity Rating Scale (C-SSRS)*<br>  ○ Patient Health Questionnaire-9 (PHQ-9)<br>  ○ Child and Adolescent Needs and Strengths Assessment (CANS)<br>  ○ World Health Organization Disability Assessment Schedule (WHODAS)<br>• Safety Planning<br>  ○ Works with the individual to create a personalized safety plan during or after the crisis<br>• Follow-Up Care<br>  ○ Provides 24-hour follow-up after a crisis intervention to ensure stability and connection to care |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Cannot serve individuals in the community whose environments have not been cleared by law enforcement |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Crisis<br>• Accepts referrals from current clients or partner agencies<br>• *Not currently receiving external referrals from 988* |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 4,700 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 13 clients at one time |

## Psychiatric Access

The following profiles summarize programs offering psychiatric access services.

### Reno Sparks Tribal Health Center: Psychological Evaluations

| | |
|---|---|
| **Website** | https://www.rsic.org/186/Health-Center |
| **Contact Name** | Michelle Jim-Katenay |
| **Phone** | 775-329-5162 |
| **Email** | mkatenay@rsicclinic.org |
| **Program Name** | **Psychological Evaluations** |
| **Program Type** | • Psychiatric Access |
| **Focus Population** | • Any Native Americans from any federally recognized tribe in the community as well as Native Americans in jail with behavioral health challenges |
| **Services Available** | • Conducts screenings for psychological disorders such as ADHD, autism, learning disabilities, bipolar disorder, etc.<br>• Offers services for individuals identified with potential mental health issues in jail<br>• Courts will assist with transport to clinic for needed evaluations |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license, birth certificate, Social Security Card, proof of residence, and court documents<br>• Proof of insurance<br>• Need to have documentation that they are a patient of the clinic<br>• Tribal ID or descendance letter |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Court ordered individuals are prioritized, on parole or probation, or individuals with high acuity |
| **Waitlist Information** | • Maintains a waitlist with 12 individuals at time of interview |
| **Program Annual Capacity** | • 75 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 60 clients at one time |

## Reno Behavioral Healthcare Hospital: PHP for Adults

| | |
|---|---|
| **Website** | https://renobehavioral.com |
| **Contact Name** | Stephanie Brown |
| **Phone** | 775-393-2201 |
| **Email** | s.brown@renobehavioral.com |
| **Program Name** | **PHP for Adults** |
| **Program Type** | • Psychiatric Access |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Services provided five days a week, six hours a day<br>• Nutrition assistance |
| **Service Duration** | • 10 days |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/Driver's license<br>• Must participate to receive services |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 1,825 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 10 clients at one time |

## Northern Nevada HOPES: Behavioral Health Walk-In Clinic

| | |
|---|---|
| **Website** | www.nnhopes.org |
| **Contact Name** | Kyle Sundland |
| **Phone** | 775-997-7574 |
| **Email** | ksundland@nnhopes.org |
| **Program Name** | **Behavioral Health Walk-In Clinic** |
| **Program Type** | • Psychiatric Access |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • People are able to walk in and establish behavioral health services with HOPES<br>• Low barrier access to receiving services<br>• Serves as a funnel into the organization's services<br>• Clinicians also carry a case load of short-term therapy as a stop gap until long term services are available |
| **Service Duration** | • As needed |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 150 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 12 clients at one time |

## St. Mary's Behavioral Health: St. Mary's Behavioral Health

| | |
|---|---|
| **Website** | https://saintmarysreno.com/our-services/behavioral-health-mental-health/ |
| **Contact Name** | Christin Uccelli |
| **Phone** | 775-770-3049 |
| **Email** | cuccelli@primehealthcare.com |
| **Program Name** | **St. Mary's Behavioral Health** |
| **Program Type** | • Psychiatric Access |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Inpatient psychiatric services (adult and geriatric) for individuals who need medical detox<br>• Able to accept patients with co-morbidities such as wound care, dialysis, speech therapy, assistance with activities of daily living (ADLs), and physical disabilities |
| **Service Duration** | • Nine days |
| **Eligibility and Documentation Criteria** | • Vital documents required: Medical records and copy of legal hold<br>• Cannot serve individuals in custody, who have dementia without change in behaviors, who have an eating disorder as primary diagnosis, or those who are violent |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Individuals are prioritized if they are on a hold (due to acuity) and where they are located (prioritize St. Mary's system patients in the emergency department (ED) or medical floor where individuals can get medical clearance right away). If from community, patients need to go to ED for medical clearance whether on hold or not |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 6,200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 23 clients at one time<br>• Coordinate with managed care case managers (e.g., at Silver Summit (Novum) and Anthem) |

## Inpatient Psychiatric Services

The following profiles summarize programs offering inpatient psychiatric services.

### Northern Nevada Adult Mental Health Services: Inpatient Psychiatric Services

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **Inpatient Psychiatric Services** |
| **Program Type** | • Inpatient Psychiatric Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Acute psychiatric care for individuals with a mental health crisis hold |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: Medical records, court documents, records showing medical clearance, and record showing court petition initiated<br>• Individuals must be medically stable enough to be treated<br>• Certain medical conditions preclude enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Mental health crisis hold<br>• Accepts clients directly from Washoe County jail |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 300 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 30 clients at one time |

## Northwest Specialty Hospital: Inpatient Psych - Adult Behavioral Health

| | |
|---|---|
| **Website** | https://northernnevadahealth.com/locations/northwest-specialty-hospital/ |
| **Contact Name** | Teresa Whitfield |
| **Phone** | 775-683-4221 |
| **Email** | teresa.whitfield@uhsinc.com |
| **Program Name** | **Inpatient Psych - Adult Behavioral Health** |
| **Program Type** | • Inpatient Psychiatric Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Psychiatric evaluations<br>• Medication management<br>• Group therapy |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • Vital documents required: Medical records<br>  ○ Must receive a medical record from referral source<br>• Cannot serve Individuals reporting or exhibiting homicidal tendencies |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Individuals on legal holds and are medically cleared<br>• Accepts transfers from ERs and Free-Standing ERs (FEDs) |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 4,800 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• Collaboration with case managers with health plans<br>• This program can serve 48 clients at one time, 22 of these spaces are designated for geriatric clients<br>• There is generally a 2-6 person waitlist |

## Reno Behavioral Healthcare Hospital: Inpatient Rehab for Adults

| | |
|---|---|
| **Website** | https://renobehavioral.com |
| **Contact Name** | Stephanie Brown |
| **Phone** | 775-393-2201 |
| **Email** | s.brown@renobehavioral.com |
| **Program Name** | **Inpatient Rehab for Adults** |
| **Program Type** | • Inpatient Psychiatric Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Provides ASAM Level 3.5 services for individuals experiencing substance use disorder<br>• Medication management in a locked and safe environment with individual therapy once per week<br>• Daily groups<br>• Recreation therapy<br>• Gym access |
| **Service Duration** | • 30 days |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/Driver's license<br>• Acceptance depends on insurance |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 7,655 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 21 clients at one time |

## Reno Behavioral Healthcare Hospital: Inpatient Detox - Adults

| | |
|---|---|
| **Website** | https://renobehavioral.com |
| **Contact Name** | Stephanie Brown |
| **Phone** | 775-393-2201 |
| **Email** | s.brown@renobehavioral.com |
| **Program Name** | **Inpatient Detox - Adults** |
| **Program Type** | • Inpatient Psychiatric Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Inpatient detox (ASAM level 3.7) for individuals experiencing substance use disorder<br>• Medication management in a locked and safe environment with individual therapy once per week and daily groups<br>• Recreational therapy<br>• Gym access |
| **Service Duration** | • 5-7 days |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• This program does not provide detox services for individuals using methamphetamine, cocaine, methadone, marijuana, or inhalants |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 9,450 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 26 clients at one time |

## Case Management Services

The following profiles summarize programs offering case management services.

### Nevada Behavioral Health Systems - Mill Street Care Center: Care Coordination Services

| | |
|---|---|
| **Website** | https://nvbhs.com/ |
| **Contact Name** | April Lang-Barroga |
| **Phone** | 775-501-8655 |
| **Email** | abarroga@novumhealth.com |
| **Program Name** | **Care Coordination Services** |
| **Program Type** | • Case Management |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Care coordination<br>• Peer support specialists<br>• Embedded care coordinators go to psychiatric hospitals and provide connections to resources<br>• Supports scheduling appointments, provides transportation, assists in obtaining documents, and coordinates care with local shelters and food resources<br>• Laundry, shower, and hot lunch daily<br>• Access to limited sober living resources |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>  ○ *This program will assist individuals needing to obtain documents*<br>• Medicaid requirement<br>• Program only accepts Silver Summit Health Plan, Health Plan of Nevada, and Optum Medicare |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: None |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 500 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 200 clients at one time |

## Northern Nevada Adult Mental Health Services: Intensive and Regular Service Coordination

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **Intensive and Regular Service Coordination** |
| **Program Type** | • Case Management |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Intensive service coordination<br>• Peer support services<br>• Medical clinic services<br>• Limited residential services |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Acuity; if a client is discharged from hospital, jail, or unhoused, they are prioritized over stably housed individuals |
| **Waitlist Information** | • Maintains a waitlist, with six individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 150 clients at one time |

## WC Health Case Management: Case Management

| | |
|---|---|
| **Website** | https://wc-health.com |
| **Contact Name** | Mandel Goodwin |
| **Phone** | 775-538-6700 ext. 4305 |
| **Email** | m.goodwin@wc-health.com |
| **Program Name** | **Case Management** |
| **Program Type** | • Case Management |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Provide case management for Anthem Medicaid members<br>• Assist with employment, housing resources, and appointments |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Individual needs to have Anthem Blue Cross Blue Shield Medicaid |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Has Anthem Blue Cross Blue Shield Medicaid |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 2,322 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 100 clients at one time |

## Court Ordered Services

The following profiles summarize programs offering court ordered services.

### CBA Healthcare: Court Group

| | |
|---|---|
| **Website** | https://CBAhealthcarereno.com |
| **Contact Name** | April Hackett |
| **Phone** | 775-200-8528 |
| **Email** | cbahealthcare@mail.com |
| **Program Name** | **Court Group** |
| **Program Type** | • Court Ordered Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Group (limited to ten) once per week, funded through insurance, cash pay, and the courts |
| **Service Duration** | • Based on court requirements |
| **Eligibility and Documentation Criteria** | • Vital documents required: ID/driver's license<br>• Guided by court referral<br>• Criminal history of sex crimes precludes enrollment<br>• Can accept domestic violence cases as long as male counselor is available |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Court referrals and evaluations |
| **Waitlist Information** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 50 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• Program provides referrals to different levels of care as needed<br>• This program can serve 10 clients at one time |

## Empowerment Center: Drug Court Services

| | |
|---|---|
| **Website** | https://empowermentcenternv.org |
| **Contact Name** | Noelle Gravallese |
| **Phone** | 775-853-5441 |
| **Email** | noelle@empowermentcenternv.org |
| **Program Name** | **Drug Court Services** |
| **Program Type** | • Court Ordered Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Provides court ordered services depending on level of care client is eligible for<br>• Six court contracted beds through Second Judicial Specialty Court<br>• Court requires communication from providers for updates on client progress |
| **Service Duration** | • Typically stay in services until they graduate court |
| **Eligibility and Documentation Criteria** | • Vital documents required: Court documents<br>• Cannot serve individuals who need a higher level of care, i.e., medically complex individuals<br>• Criminal history of high-level sex crimes and violent crimes preclude enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Assessment |
| **Waitlist Information** | • Maintains a waitlist, with five individuals at time of interview |
| **Program Annual Capacity** | • 50 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 10 clients at one time |

## Inner Solutions: Court Ordered (Appointed) Groups (DBT)

| | |
|---|---|
| **Website** | https://www.innersolutionstherapy.com/ |
| **Contact Name** | Melisa Heckathorn |
| **Phone** | 775-217-0228 |
| **Email** | melisa.heckathorn@yahoo.com |
| **Program Name** | **Court Ordered (Appointed) Groups (DBT)** |
| **Program Type** | • Court Ordered Services |
| **Focus Population** | • Individuals with behavioral health challenges |
| **Services Available** | • Individual therapy and weekly DBT groups which help people develop skills to control impulsive behavior |
| **Service Duration** | • Usually involved in the program for a year depending on the individual's progress |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• Cannot serve individuals who do not have comprehensive insurance or who cannot afford the sliding scale |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Court order<br>• The program has a relationship with Reno Justice Court and also receives referrals from Reno Municipal Court and Veterans Court |
| **Waitlist Information** | • Maintains a waitlist, with five individuals at time of interview |
| **Program Annual Capacity** | • 50 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• Case management is available if the client continues individual therapy<br>• This program can serve 48 clients at one time |

## Northern Nevada Adult Mental Health Services: Justice-Involved Diversion

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **Justice-Involved Diversion** |
| **Program Type** | • Court Ordered Services |
| **Focus Population** | • Individuals with behavioral health challenges in the Competency Court |
| **Services Available** | • ACT-type model<br>• Medication management<br>• Peer support<br>• Residential services<br>• Counseling<br>• Wraparound services |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required<br>• History of substance use precludes enrollment |
| **Referral and Intake Processes** | • Referral-to-intake time: 1-4 weeks<br>• Accelerating factors for entry: Lakes Crossing staff goes into jail to assess for appropriateness for program |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 90 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 60 clients at one time |

## Northern Nevada Adult Mental Health Services: Mental Health Court

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **Mental Health Court** |
| **Program Type** | • Court Ordered Services |
| **Focus Population** | • Individuals with behavioral health challenges who are sentenced from District Court to Mental Health Court instead of jail for low level felonies and gross misdemeanors |
| **Services Available** | • Medication management<br>• Case management<br>• Individual therapy<br>• Group therapy for individuals who are competent but pled guilty |
| **Service Duration** | • One year |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: 2-7 days<br>• Accelerating factors for entry: Individuals discharged from jail with a month supply of medication(s) |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 100 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 100 clients at one time |

## Family Services

The following profiles summarize programs offering family services.

### The Life Change Center: High Risk Pregnancy and Neonatal

| | |
|---|---|
| **Website** | https://thelifechangecenter.org |
| **Contact Name** | John Firestone |
| **Phone** | 775-842-7436 |
| **Email** | john@tlccreno.org |
| **Program Name** | **High Risk Pregnancy and Neonatal** |
| **Program Type** | • Family Services |
| **Focus Population** | • Individuals who are pregnant and/or are parenting |
| **Services Available** | • Pre-and-post pregnancy services<br>• Case management<br>• Provide baby and child equipment (strollers, cribs, diapers)<br>• Group counseling and supports |
| **Service Duration** | • Individualized, limited to approximately 1.5 years |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Pregnancy, having a child under one year old, and being a patient of Life Change Center |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 100 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 50 clients at one time |

## The Life Change Center Family Services: Family Services

| | |
|---|---|
| **Website** | https://thelifechangecenter.org |
| **Contact Name** | John Firestone |
| **Phone** | 775-842-7436 |
| **Email** | john@tlccreno.org |
| **Program Name** | **Family Services** |
| **Program Type** | • Family Services |
| **Focus Population** | • Individuals who are pregnant and/or are parenting |
| **Services Available** | • Parenting support<br>• Prevention activities<br>• Provide clothing, food, diapers, funding for after school activities based on the Strengthening Families curriculum<br>• Group work (families and neonatal) |
| **Service Duration** | • Individualized |
| **Eligibility and Documentation Criteria** | • No vital documents required |
| **Referral and Intake Processes** | • Referral-to-intake time: Immediate (same day)<br>• Accelerating factors for entry: Being involved with the Life Change Center and being the caregiver of children |
| **Waitlist Information** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 300 individuals |
| **Other Key Information Gathered** | • This program provides resource navigation services in connecting a client to community resources or the next level of care as services end<br>• This program can serve 100 clients at one time |

# Appendix B. Housing Program Profiles

The following housing providers were interviewed.

The following program profiles summarize information gathered from each provider and are organized by program type.

## Community Based Living Arrangements

The following profiles summarize programs categorized as Community Based Living Arrangements.

### Rising Star LLC: Community-Based Living Arrangement

| | |
|---|---|
| **Website** | https://Risingstarllc.com |
| **Contact Name** | Vicki Lynn Winfield |
| **Phone** | 775 224 5940 |
| **Email** | risingstarNV@yahoo.com |
| **Program Name** | **Community-Based Living Arrangement** |
| **Program Type** | • Community-Based Living Arrangement |
| **Focus Population** | • Individuals with mental health challenges and substance use disorders |
| **Supports Available** | • Life skills training<br>• Transportation support<br>• Health care services<br>• Mental health services |
| **Eligibility Criteria** | • Sobriety requirement<br>• Medication compliance<br>• Willingness to comply with state statutes<br>• Vital documents required: ID/driver's license, Social Security Card, proof of income, proof of residence, medical records, and court documents |
| **Referral and Acceptance** | • Referrals received through Coordinated Entry[1] |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 75 individuals |
| **Other Key Information Gathered** | • Facility and voucher or tenant-based; does not accept Medicaid<br>• Individualized length of stay |

[1] Participation in coordinated entry system not verified with NNCoC, as noted previously.

## WC-Health: Coronado

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Katherine Westfall |
| **Phone** | 775-538-6700 ext. 4304 |
| **Email** | k.westfall@wc-health.com |
| **Program Name** | **Coronado** |
| **Program Type** | • Community-Based Living Arrangement |
| **Focus Population** | • People with a disability |
| **Supports Available** | • Life skills training<br>• Transportation support<br>• Health care services<br>• Mental health services |
| **Eligibility Criteria** | • Some criminal history restrictions preclude enrollment, including a history of all sex crimes. History of violent crimes is considered on a case-by-case basis<br>• No vital documents required |
| **Referral and Acceptance** | • Referral and assessment received from Northern Nevada Adult Mental Health Services (NNAMHS) |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 34 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• Individualized length of stay |

## WC-Health: Maine Street

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Katherine Westfall |
| **Phone** | 775-538-6700 ext. 4304 |
| **Email** | k.westfall@wc-health.com |
| **Program Name** | **Maine Street** |
| **Program Type** | • Community-Based Living Arrangement |
| **Focus Population** | • People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Education assistance<br>• Health care services<br>• Mental health services |
| **Eligibility Criteria** | • Criminal history restrictions may preclude enrollment, including a history of sex crimes; history of violent crimes is considered on a case-by-case basis<br>• No vital documents required |
| **Referral and Acceptance** | • Referral and assessment received from Northern Nevada Adult Mental Health Services (NNAMHS) |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 28 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• Individualized length of stay |

## Permanent Supportive Housing

The following profiles summarize programs categorized as permanent supportive housing.

### Reno Housing Authority: Dick-Scott Manor

| | |
|---|---|
| **Website** | https://www.renoha.org/ |
| **Contact Name** | Hettie Read |
| **Phone** | 775.329.3630 ext. 221 |
| **Email** | hread@renoha.org |
| **Program Name** | **Dick-Scott Manor** |
| **Program Type** | • Permanent Supportive Housing |
| **Focus Population** | • Veterans who are unhoused or at risk of homelessness |
| **Supports Available** | • Case management |
| **Eligibility Criteria** | • Must be a veteran with required service level (determined by VA)<br>• Meet HUD income requirements<br>• Criminal history restrictions preclude enrollment (arson and certain felonies)<br>• Vital documents required: ID/driver's license and proof of income |
| **Referral and Acceptance** | • Referrals received from the VA |
| **Waitlist** | • Has a waitlist maintained by the VA |
| **Program Annual Capacity** | • 12 individuals |
| **Other Key Information Gathered** | • Voucher or tenant based; does not accept Medicaid<br>• Permanent, as long as individuals remain eligible |

## Reno Housing Authority: Carvill Court

| | |
|---|---|
| **Website** | https://www.renoha.org/ |
| **Contact Name** | Hettie Read |
| **Phone** | 775.329.3630 ext. 221 |
| **Email** | hread@renoha.org |
| **Program Name** | **Carvill Court** |
| **Program Type** | • Permanent Supportive Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Transportation support<br>• Mental health services |
| **Eligibility Criteria** | • Maintain lease agreements with their housing provider<br>• Some criminal history restrictions preclude enrollment, including certain felonies related to sex and violent offenses<br>• Vital documents required: ID/driver's license, Social Security Card, and proof of income |
| **Referral and Acceptance** | • Referrals received through Coordinated Entry |
| **Waitlist** | • Through Coordinated Entry, participants are placed on the Community Queue |
| **Program Annual Capacity** | • 15 individuals |
| **Other Key Information Gathered** | • Voucher or tenant based; does not accept Medicaid<br>• Individuals receive a lifetime voucher, as long as they meet requirements and are housed on site. They may progress to other housing and keep their voucher |

## Accessible Space, Inc.: Butterworth

| | |
|---|---|
| **Website** | https://www.accessiblespace.org/ |
| **Contact Name** | Jerry Kappeler |
| **Phone** | Not available |
| **Email** | JKappeler@accessiblespace.org |
| **Program Name** | **Butterworth** |
| **Program Type** | • Permanent Supportive Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People who are exiting incarceration<br>• People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Mental health services<br>• Other: Comprehensive therapy services |
| **Eligibility Criteria** | • Must be able to pay rent<br>• Some criminal history restrictions preclude enrollment, including certain felonies related to sex, drug, or violent offenses<br>• Vital documents required: ID/driver's license, birth certificate, Social Security Card, proof of income, and proof of residency |
| **Referral and Acceptance** | • Referrals come from word of mouth, jails, hospitals, and community partners |
| **Waitlist** | • Maintains a waitlist, with 140-200 individuals at time of interview |
| **Program Annual Capacity** | • 24 individuals |
| **Other Key Information Gathered** | • Facility and voucher or tenant based; accepts Medicaid<br>• Permanent |

## Accessible Space, Inc.: Raggio

| | |
|---|---|
| **Website** | https://www.accessiblespace.org/ |
| **Contact Name** | Jerry Kappeler |
| **Phone** | Not available |
| **Email** | JKappeler@accessiblespace.org |
| **Program Name** | **Raggio** |
| **Program Type** | • Permanent Supportive Housing |
| **Focus Population** | • Anyone under the federal poverty line |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Mental health services<br>• Other: physical therapy, occupational therapy, speech therapy, cognitive therapy and counseling |
| **Eligibility Criteria** | • Must be able to pay rent<br>• Some criminal history restrictions preclude enrollment, including certain felonies related to sex, drug, or violent offenses<br>• Vital documents required: ID/driver's license, birth certificate, Social Security Card, and proof of income |
| **Referral and Acceptance** | • Referrals come from word of mouth, jails, hospitals, and community partners |
| **Waitlist** | • Maintains a waitlist with 140-200 individuals at time of interview |
| **Program Annual Capacity** | • 24 individuals |
| **Other Key Information Gathered** | • Facility and voucher or tenant based; accepts Medicaid<br>• Permanent |

## Volunteers of America: ReStart PSH

| | |
|---|---|
| **Website** | https://voa-ncnn.org |
| **Contact Name** | Julianna Glock |
| **Phone** | (775) 324-2622 |
| **Email** | JGlock@voa-ncnn.org |
| **Program Name** | **ReStart PSH** |
| **Program Type** | • Permanent Supportive Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Transportation support<br>• Mental health services<br>• Other: SSI/SSDI Outreach, Access and Recovery (SOAR), connections to other services |
| **Eligibility Criteria** | • HUD PSH requirements<br>• Vital documents required: ID/driver's license, Social Security Card, proof of income |
| **Referral and Acceptance** | • Referrals received through Coordinated Entry |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 110 individuals |
| **Other Key Information Gathered** | • Voucher or tenant based; does not accept Medicaid<br>• As long as needed |

## Washoe County Housing and Homeless Services: Washoe County Human Services PSH

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/homeless/ |
| **Contact Name** | Catrina Peters |
| **Phone** | 775-530-9772 |
| **Email** | CPeters@washoecounty.gov |
| **Program Name** | **Washoe County Human Services PSH** |
| **Program Type** | • Permanent Supportive Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and Vocational Supports<br>• Legal assistance<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Mental health services<br>• Other: Offers referrals for legal assistance; some bus passes and some transport to appointments; not a high level of Education Assistance is available, but some are provided; support navigation of health care |
| **Eligibility Criteria** | • No conditions or requirements that participants must meet to receive housing or services in this program<br>• Vital documents required: ID/driver's license, birth certificate |
| **Referral and Acceptance** | • Referrals received through Coordinated Entry |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 110 individuals |
| **Other Key Information Gathered** | • Voucher or tenant based; accepts Medicaid<br>• Participants can remain housed as long as needed and funding remains available<br>• Cannot serve individuals who are undocumented |

## Rapid Rehousing

The following profiles summarize programs categorized as rapid rehousing.

### Volunteers of America: Rapid Rehousing Program in Partnership with Reno Housing Authority and City of Reno

| | |
|---|---|
| **Website** | https://voa-ncnn.org |
| **Contact Name** | Devin McFarland |
| **Phone** | 775-499-5198 |
| **Email** | dmcfarland@voa-ncnn.org |
| **Program Name** | **Rapid Rehousing Program in Partnership with Reno Housing Authority and City of Reno** |
| **Program Type** | • Rapid Rehousing |
| **Focus Population** | • Low-income individuals under 30% Annual Median Income (AMI)<br>• Individuals experiencing homelessness/housing instability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Legal assistance<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Peer to peer support<br>• Mental health services<br>• Other: Referrals are made to education assistance and legal assistance through community providers |
| **Eligibility Criteria** | • Community Housing Assessment Tool (CHAT) must be completed<br>• Background clearance<br>• Income under $1200/month<br>• Active on the Reno Housing Authority waiting list<br>• Vital documents required: ID/driver's license, Social Security card, and proof of income |
| **Referral and Acceptance** | • Referrals from City of Reno, RISE, community case managers |
| **Waitlist** | • Maintains a waitlist, with 20 individuals at time of interview |
| **Program Annual Capacity** | • 40 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• 18-month program |

## Volunteers of America: VOA Rapid Rehousing

| | |
|---|---|
| **Website** | https://voa-ncnn.org |
| **Contact Name** | Julianna Glock |
| **Phone** | (775) 324-2622 ext. 101 |
| **Email** | JGlock@voa-ncnn.org |
| **Program Name** | **VOA Rapid Rehousing** |
| **Program Type** | • Rapid Rehousing |
| **Focus Population** | • People who are literally experiencing homelessness<br>• People actively fleeing domestic violence |
| **Supports Available** | • Case management<br>• Life skills training<br>• Transportation support<br>• Mental health services<br>• Other: SOAR, care coordination, referrals to employment and vocational supports to increase income and independently sustain rent |
| **Eligibility Criteria** | • Income at or below 50% Annual Median Income (AMI)<br>• Vital documents required: proof of income<br>• Other documents are typically required by landlords; support is provided to obtain documents |
| **Referral and Acceptance** | • Referrals received through Coordinated Entry |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 60 individuals |
| **Other Key Information Gathered** | • Voucher or tenant based; does not accept Medicaid<br>• 12-month program |

## Nation's Finest: SSVF

| | |
|---|---|
| **Website** | https://nationsfinest.org/locations/reno/ |
| **Contact Name** | Kim Molten |
| **Phone** | 775-544-4719 |
| **Email** | kmolter@nationsfinest.org |
| **Program Name** | **SSVF** |
| **Program Type** | • Rapid Rehousing |
| **Focus Population** | • Veterans and their families |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Transportation support<br>• Education assistance<br>• Other: Other services and financial supports are offered (e.g., support for supplies for a new job), the program prioritizes housing support (e.g., first and last month's rents, deposit) with its limited funding |
| **Eligibility Criteria** | • Participate in case management, have an eviction letter, or be experiencing homelessness<br>• Background check clearance<br>• VA card<br>• Vital documents required: ID/driver's license, proof of income, and Social Security Card; will accept birth certificate or passport as well |
| **Referral and Acceptance** | • Referrals received through Coordinated Entry |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 400 individuals, including those who receive case management services and who are not necessarily housed |
| **Other Key Information Gathered** | • Voucher or tenant based; does not accept Medicaid<br>• Individualized length of stay, dependent on the client needs, and client is evaluated every month to understand their needs using a housing stability plan |

## Specialized Reentry Housing

The following profiles summarize programs categorized as specialized reentry housing.

### Life Changes, Inc.: New Beginnings Reentry

| | |
|---|---|
| **Website** | https://lifechangesinc.solutions |
| **Contact Name** | Lisa Moore |
| **Phone** | 775 685 8145 |
| **Email** | lifechangesinc@yahoo.com |
| **Program Name** | **New Beginnings Reentry** |
| **Program Type** | • Specialized Reentry Program |
| **Focus Population** | • People experiencing chronic homelessness<br>• People who are exiting incarceration<br>• People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Transportation support<br>• Peer to peer support<br>• Other: have community health workers and employment specialist onsite; provide referrals to clinical services |
| **Eligibility Criteria** | • Sobriety and work requirements<br>• Some criminal history restrictions preclude enrollment, including a history of arson, sex crimes, and crimes against minors, seniors, or disabled persons; a history of violent offenses is considered on a case-by-case basis<br>• Vital documents required: ID/driver's license, birth certificate, Social Security Card |
| **Referral and Acceptance** | • Preferred: Department of Corrections referral<br>• Word of mouth and walk ins |
| **Waitlist** | • Maintains a waitlist, with 30 individuals at time of interview |
| **Program Annual Capacity** | • 300 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• Individualized length of stay; typically, this is a 90-day program that can be extended for a year or more |

## Ridge House: Transitional Housing

| | |
|---|---|
| **Website** | https://ridgehouse.org/ |
| **Contact Name** | Nancy Lindler |
| **Phone** | 775-453-5108 |
| **Email** | nlindler@ridgehouse.org |
| **Program Name** | **Transitional Housing** |
| **Program Type** | • Specialized Reentry Program |
| **Focus Population** | • People who are exiting incarceration |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Legal assistance<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Peer to peer support<br>• Mental health services<br>• Other: assist clients in meeting court requirements |
| **Eligibility Criteria** | • Sobriety<br>• Must fill out application in prison and pass interview<br>• No vital documents required |
| **Referral and Acceptance** | • Referred from prison |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 60 individuals |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• Length of stay is individualized and open-ended |

## Transitional Living/Transitional Housing

The following profiles summarize programs categorized as transitional living/transitional housing.

### Battleborn: Transitional Living/Transitional Housing

| | |
|---|---|
| **Website** | https://ccsnn.org/ |
| **Contact Name** | Judy Kroshus |
| **Phone** | 775-870-4050 ext. 804 |
| **Email** | jkroshus@ccsn.org |
| **Program Name** | **Transitional Living/Transitional Housing** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People with substance use disorders |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Legal assistance<br>• Transportation support<br>• Education assistance<br>• Peer to peer support<br>• Mental health services<br>• Other: financial literacy and workforce development |
| **Eligibility Criteria** | • Sobriety and work requirements<br>• Complete 30-day treatment program before admission<br>• Must independently manage medications<br>• Some criminal history restrictions preclude enrollment, including a history of arson, sex crimes, violent crimes, and gun charges<br>• Vital documents required: ID/driver's license, birth certificate, and Social Security Card |
| **Referral and Acceptance** | • Referrals received from Nevada Department of Corrections, faith-based communities, word of mouth, jail, other community programs, and self-referrals |
| **Waitlist** | • Maintains a waitlist with six individuals at time of interview |
| **Program Annual Capacity** | • 250 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• Length of stay is individualized; successful completion is considered to be 6-months, but participants are able to stay "as long as they want"<br>• This is a sober living facility<br>• Certified by the National Association of Recovery Residences/California Consortium of Addiction Programs and Professionals<br>• Mental health and substance use services are provided on site by Vitality |

## Bristlecone: Transitional Living

| | |
|---|---|
| **Website** | https://bristleconereno.com |
| **Contact Name** | Wendy Easter |
| **Phone** | 775-954-1400 ext. 106 |
| **Email** | admissions@bristleconereno.com |
| **Program Name** | **Transitional Living** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People with substance use disorder stepping down from residential treatment |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Peer to peer support |
| **Eligibility Criteria** | • Sobriety and work requirements<br>• Ability to pay for two weeks up front and $50 deposit ($350)<br>• Criminal history of sex crimes precludes enrollment<br>• No vital documents required |
| **Referral and Acceptance** | • Referrals received from Nevada Department of Corrections |
| **Waitlist** | • Maintains a waitlist, with one individual at time of interview |
| **Program Annual Capacity** | • 36 individuals |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• 6-month program |

## Eddy House: Transitional Living

| | |
|---|---|
| **Website** | https://eddyhouse.org |
| **Contact Name** | Ryan Sexton and Xavier Gonzalez |
| **Phone** | 775-384-1129 |
| **Email** | Ryan@eddyhouse.org |
| **Program Name** | **Transitional Living** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • 18–25-year-olds experiencing chronic homelessness<br>• 18–25-year-olds who are exiting incarceration<br>• 18–25-year-olds who are aged out of foster care |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Mental health services |
| **Eligibility Criteria** | • Work or education requirement<br>• Must have income for program fee, which starts at $300, increases by $150 every three months, and caps at $1,200 for last six months<br>• Vital documents required: ID/driver's license, birth certificate, Social Security Card, and proof of income |
| **Referral and Acceptance** | • Referrals received from Eddy House programs and partnering agencies |
| **Waitlist** | • Maintains a waitlist with four individuals at time of interview |
| **Program Annual Capacity** | • 36 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• Length of participation is 24-months or until participant reaches age 25, whichever comes first |

## Heaven Bound Lifestyle Center: Heaven Bound Transitional Housing

| | |
|---|---|
| **Website** | https://hblcreno.com |
| **Contact Name** | Patty Derosa |
| **Phone** | 775-297-1338 |
| **Email** | Not available |
| **Program Name** | **Heaven Bound Transitional Housing** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People who are exiting incarceration |
| **Supports Available** | • Transportation support<br>• Other: Faith-based services |
| **Eligibility Criteria** | • Sobriety and work requirements<br>• Bible study and church attendance<br>• House chore requirements<br>• Complete required parole/probation appointments, and follow all parole/probation requirements<br>• Criminal history of sex crimes precludes enrollment<br>• Vital documents required: ID/driver's license, birth certificate, and Social Security Card |
| **Referral and Acceptance** | • Pre-approved facility from DOC facility list |
| **Waitlist** | • Maintains a waitlist with two individuals at time of interview |
| **Program Annual Capacity** | • 20 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• 90-day program |

## Hosanna Home: Transitional Living/Transitional Housing

| | |
|---|---|
| **Website** | https://hosannahome.org/ |
| **Contact Name** | Linda Schmitt |
| **Phone** | 775-232-5416 |
| **Email** | hosannahome7@gmail.com |
| **Program Name** | **Transitional Living/Transitional Housing** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • Women over 18 experiencing homelessness |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Other: recreational activities, celebration of recovery, offers referrals or support if required by court-order, anger management and boundary education |
| **Eligibility Criteria** | • Sobriety and work requirements<br>• Abide by 6:00 p.m. curfew<br>• Attend Christian-centered services<br>• Criminal history of sex or violent crimes precludes enrollment<br>• Cannot serve women taking anti-psychotics<br>• No vital documents required |
| **Referral and Acceptance** | • Program conducts in-reach in the jail once a month<br>• Referrals are also received from Reno Behavioral Health, churches, Our Place, Vitality, and other community based providers |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 25-30 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• 9-month program<br>• Participant finances are monitored |

## Nation's Finest: Behavioral Health Center on Montello-Veterans

| | |
|---|---|
| **Website** | https://nationsfinest.org/locations/reno/ |
| **Contact Name** | Kim Molter |
| **Phone** | 775-544-4719 |
| **Email** | kmolter@nationsfinest.org |
| **Program Name** | **Behavioral Health Center on Montello-Veterans** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • Male veterans experiencing homelessness |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Transportation support<br>• Education assistance<br>• Peer to peer support<br>• Mental health services |
| **Eligibility Criteria** | • Must be a veteran with no dishonorable discharge and no bad conduct<br>• Must be screened by the VA or other veteran organizations for services<br>• Vital documents required: ID/driver's license, Social Security card, and proof of income (will accept birth certificate or passport); A DD214 or VA card also required |
| **Referral and Acceptance** | • Referrals received through VA Healthcare |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 100 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• 90-day program, but can stay up to one year with recertification of need every 90 days |

## Northern Nevada HOPES: Hope Springs

| | |
|---|---|
| **Website** | https://www.nnhopes.org/programs/hope-springs/ |
| **Contact Name** | Julie Gwinn |
| **Phone** | 775-786-4673 |
| **Email** | Not provided |
| **Program Name** | **Hope Springs** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People who are exiting incarceration |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational support<br>• Transportation support<br>• Health care services<br>• Peer to peer support<br>• Mental health services |
| **Eligibility Criteria** | • Sobriety requirement<br>• Ability to do chores and clean home<br>• Must work toward achieving employment and securing housing<br>• Criminal history of sex crimes or violent crimes precludes enrollment<br>• Vital documents required: medical records and court documents |
| **Referral and Acceptance** | • Self-referrals |
| **Waitlist** | • Maintains a waitlist with two individuals at time of interview |
| **Program Annual Capacity** | • 56 individuals |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• 6-9-month program |

## STAR: Transitional Living Home

| | |
|---|---|
| **Website** | N/A |
| **Contact Name** | Sgt. Chesa Adams |
| **Phone** | 775.484.6569 |
| **Email** | cflickinger@washoecounty.gov |
| **Program Name** | **Transitional Living Home** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • Men who are exiting incarceration<br>• Male participants in the STAR program<br>• Men with opioid use |
| **Supports Available** | • Case management<br>• Peer to peer support<br>• Mental health services<br>• Other: care coordination, men's support group |
| **Eligibility Criteria** | • Sobriety and work requirements<br>• Participation in STAR programming<br>• Some criminal history precludes enrollment, including history of all sex crimes; history of violent crimes is considered on a case-by-case basis<br>• No vital documents required; provide support to acquire these items through case management |
| **Referral and Acceptance** | • Referrals are received through STAR Program or from CrossRoads |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 14 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• 12-month program that can be extended if necessary |

## Step 1: Men's Transitional Housing Program

| | |
|---|---|
| **Website** | https://step1inc.org |
| **Contact Name** | Rachelle Pellissier |
| **Phone** | 775-329-9830 |
| **Email** | rachelle@step1inc.org |
| **Program Name** | **Men's Transitional Housing Program** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • Men who are exiting incarceration<br>• Men with SUD diagnosis |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Other: provide substance use groups and treatment and refer clients out for mental health counseling as needed |
| **Eligibility Criteria** | • Sobriety and work requirements<br>• SUD diagnosis<br>• Participate in one meeting a day and in outpatient individual and group counseling<br>• Criminal history of sex and violent crimes precludes enrollment<br>• Unable to serve individuals with high acuity mental health needs<br>• No vital documents required |
| **Referral and Acceptance** | • Referrals received from:<br>  ○ Probation and Parole<br>  ○ Washoe County Jail and Washoe County courts (Drug Court)<br>  ○ Higher level providers such as residential rehabs including New Frontier, Carson Counseling Center, and Vitality<br>  ○ Inpatient psychiatric services<br>• Individuals can also self-refer |
| **Waitlist** | • Maintains a waitlist, with 15 individuals at time of interview |
| **Program Annual Capacity** | • 100 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• 90–120-day program, can be up to six months for housing; outpatient services are available for 6 months up to a year |

## STEP2: Transitional Housing

| | |
|---|---|
| **Website** | https://step2reno.org |
| **Contact Name** | Jennifer Autry |
| **Phone** | 775-787-9411 |
| **Email** | jautry@step2reno.org |
| **Program Name** | **Transitional Housing** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • Individuals with substance use disorder |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Education assistance<br>• Mental health services<br>• Other: facilitates community referrals, transportation for health for health care services, and continues to provide mental health services |
| **Eligibility Criteria** | • Sobriety and work requirements<br>• SUD diagnosis<br>• Participation in IOP/OP program<br>• Criminal history of sex crimes precludes enrollment, but will be reviewed on a case by case basis<br>• Unable to serve individuals with high acuity mental health needs<br>• No vital documents required |
| **Referral and Acceptance** | • Must complete residential treatment at STEP2 |
| **Waitlist** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 200 individuals |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• Program length is determined on a case by case basis, but on average lasts 6-9 months |

## Steps to New Freedom: Transitional Living/Transitional Housing

| | |
|---|---|
| **Website** | N/A |
| **Contact Name** | Cheri Hadsel, Bob Hemenway |
| **Phone** | 775-322-4003 |
| **Email** | steps.tonewfreedom@yahoo.com |
| **Program Name** | **Transitional Living/Transitional Housing** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • Men experiencing chronic homelessness<br>• Men who are exiting incarceration<br>• Male veterans experiencing homelessness and significant others |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Mental health services<br>• Other: facilitates community referrals |
| **Eligibility Criteria** | • Attend Agape Psychological Services at least once a month; veterans attend once a week<br>• Completed application and interview process<br>• Unable to serve individuals with a physical disability, or individuals with high acuity mental health needs<br>• Vital documents required: ID/driver's license, birth certificate, and Social Security card |
| **Referral and Acceptance** | • Referrals received from:<br>  ○ Veteran services<br>  ○ Prison system<br>• Clients refer other clients |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 68 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• 90-day program with an extension of 30 days, not to exceed 4 months<br>• Some designated beds for veterans |

## The Empowerment Center: Transitional Living

| | |
|---|---|
| **Website** | https://empowermentcenternv.org |
| **Contact Name** | Noelle Gravallese |
| **Phone** | 775-853-5441 |
| **Email** | noelle@empowementcenternv.org |
| **Program Name** | **Transitional Living** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People who are exiting incarceration<br>• People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Legal assistance<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Peer to peer support<br>• Mental health services |
| **Eligibility Criteria** | • Sobriety and work requirement<br>• Criminal history restrictions preclude enrollment (high level sex offenders and violent crimes)<br>• No vital documents required |
| **Referral and Acceptance** | • Self-referral<br>• Other agencies |
| **Waitlist** | • Maintains a waitlist with 20 individuals at time of interview |
| **Program Annual Capacity** | • 180 individuals |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• 5-7-month program |

## Volunteers of America: Anthem Housing

| | |
|---|---|
| **Website** | https://voa-ncnn.org |
| **Contact Name** | Devin McFarland |
| **Phone** | 775-499-5198 |
| **Email** | dmcfarland@voa-ncnn.org |
| **Program Name** | **Anthem Housing** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Legal assistance<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Peer to peer support<br>• Mental health services<br>• Other: access to a SOAR certified case manager |
| **Eligibility Criteria** | • Pass background check<br>• Must be high utilizers with mental health/physical health needs<br>• Some criminal history restrictions preclude enrollment; no felonies of person or property within last three years<br>• No vital documents required by the program; Anthem manages the documentation requirements |
| **Referral and Acceptance** | • Referrals are accepted from Anthem |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 20 individuals |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• 18-month program, up to three years as long as residents work towards goals<br>• Anthem supports treatment |

## Vitality Unlimited: Vitality Housing

| | |
|---|---|
| **Website** | https://vitalityunlimited.org/ |
| **Contact Name** | Judith Ricketts-Stookey |
| **Phone** | 775-461-0025 |
| **Email** | judith.stookey@vitalityunlimited.org |
| **Program Name** | **Vitality Housing** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • Men with mental health challenges and/or substance use disorders |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Peer to peer support<br>• Mental health services<br>• Other: clients go to CBBHC for case management and other services listed above |
| **Eligibility Criteria** | • Sobriety requirement<br>• Must participate in treatment<br>• Payment requirement<br>• Compliance with rules and regulations<br>• Some criminal history precludes enrollment, including Tier 2 and 3 sex offenders; history of violent crimes is considered on a case-by-case basis<br>• No vital documents required; require TB and drug test results |
| **Referral and Acceptance** | • Referrals received from the Vitality residential program<br>• Also accept overflow from CrossRoads and Battleborn (have an MOU)<br>• Referrals from specialty courts and Second Judicial Court (have an MOU) receive priority for beds |
| **Waitlist** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • 30 individuals |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• 1–2-year housing program through Vitality<br>• 90 days for “VA referrals” |

## WC Health: Parole and Probation Program

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Mandel Goodwin |
| **Phone** | 775-538-6700 ext. 4305 |
| **Email** | m.goodwin@wc-health.com |
| **Program Name** | **Parole and Probation Program** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People who are exiting incarceration |
| **Supports Available** | • Case management<br>• Employment and vocational supports<br>• Transportation support<br>• Health care services<br>• Mental health services |
| **Eligibility Criteria** | • Sobriety requirement<br>• Must comply with parole and probation requirements<br>• Criminal history restrictions preclude enrollment (sex crimes and history of aggression on a case-by-case basis)<br>• No vital documents required |
| **Referral and Acceptance** | • Referrals received from Parole and Probation and NDOC |
| **Waitlist** | • Maintains a waitlist, with 10 individuals at time of interview |
| **Program Annual Capacity** | • 1,200 individuals |
| **Other Key Information Gathered** | • 14-day program that parole and probation funds through indigent funding or clients may self pay; accepts Medicaid |

## WC Health: Pathways Forward

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Mandel Goodwin |
| **Phone** | 775-538-6700 ext. 4305 |
| **Email** | m.goodwin@wc-health.com |
| **Program Name** | **Pathways Forward** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People who are exiting incarceration |
| **Supports Available** | • Case management<br>• Employment and vocational supports<br>• Transportation support<br>• Health care services<br>• Mental health services |
| **Eligibility Criteria** | • Sobriety requirement<br>• Criminal history restrictions preclude enrollment (Tier 3 sex offenders and history of extreme violence)<br>• No vital documents required |
| **Referral and Acceptance** | • Referrals received from Parole and Probation and NDOC |
| **Waitlist** | • Maintains a waitlist, with 20 individuals at time of interview |
| **Program Annual Capacity** | • 48 individuals |
| **Other Key Information Gathered** | • 60-day Anthem-funded program at a WC-Health facility; accepts Medicaid |

## WC Health: Anthem Behavioral Health Housing

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Mandel Goodwin |
| **Phone** | 775-538-6700 ext. 4305 |
| **Email** | m.goodwin@wc-health.com |
| **Program Name** | **Anthem Behavioral Health Housing** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People with behavioral health issues who are unhoused or at risk of homelessness |
| **Supports Available** | • Case management<br>• Employment and vocational supports<br>• Transportation support<br>• Health care services<br>• Mental health services |
| **Eligibility Criteria** | • Sobriety requirement<br>• Have a co-occurring disorder diagnosis<br>• Must make progress on care plan<br>• Have Anthem Medicaid<br>• History of Tier 3 sex offenses precludes enrollment<br>• No vital documents required; assist clients with obtaining these documents |
| **Referral and Acceptance** | • People with Anthem Medicaid walk in or are referred to from local hospitals, psychiatric inpatient programs, or jail |
| **Waitlist** | • Maintains a waitlist, with 15 individuals at time of interview |
| **Program Annual Capacity** | • 360 individuals |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• 90-day program |

## WC Health: Transitional Living

| | |
|---|---|
| **Website** | https://www.wc-health.com/ |
| **Contact Name** | Mandel Goodwin |
| **Phone** | 775-538-6700 ext. 4305 |
| **Email** | m.goodwin@wc-health.com |
| **Program Name** | **Transitional Living** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People experiencing chronic homelessness |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Health care services<br>• Mental health services |
| **Eligibility Criteria** | • Sobriety requirement<br>• Engagement with care plan<br>• Criminal history of sex crimes and recent violent crimes precludes enrollment<br>• No vital documents required |
| **Referral and Acceptance** | • Referrals received from hospitals and Anthem<br>• Self-referrals and walk-ins to PUF |
| **Waitlist** | • Maintains a waitlist, with zero individuals at time of interview |
| **Program Annual Capacity** | • Not provided |
| **Other Key Information Gathered** | • Facility based; accepts Medicaid<br>• 60-90-day program |

## WestCare: Veterans Program

| | |
|---|---|
| **Website** | https://westcare.com |
| **Contact Name** | Irma Magrdichian |
| **Phone** | Not provided |
| **Email** | Not provided |
| **Program Name** | **Veterans Program** |
| **Program Type** | • Transitional Living/Transitional Housing |
| **Focus Population** | • People experiencing chronic homelessness<br>• People who are exiting incarceration<br>• People with a disability<br>• Veterans<br>• People with behavioral health challenges and substance use disorders |
| **Supports Available** | • Case management<br>• Other: services are coordinated with community partners; program coordinates directly with VA to connect individuals to service-connected benefits |
| **Eligibility Criteria** | • Sobriety requirement<br>• VA compliance<br>• Some criminal history precludes enrollment, including arson; history of sex crimes is considered on a case-by-case basis<br>• No vital documents required |
| **Referral and Acceptance** | • Referrals received through Coordinated Entry |
| **Waitlist** | • Not provided |
| **Program Annual Capacity** | • Not provided |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• Length of program is individualized; contingent upon compliance with VA stipulations |

## Other Housing with Service Coordination or Referrals

The following profiles summarize housing programs offering service coordination or referrals.

### Eddy House: Eddy House Community Living

| | |
|---|---|
| **Website** | https://eddyhouse.org |
| **Contact Name** | Ryan Sexton |
| **Phone** | 775 384 1129 ex 214 |
| **Email** | Ryan@eddyhouse.org |
| **Program Name** | **Eddy House Community Living** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • 18–25-year-olds experiencing chronic homelessness<br>• 18–25-year-olds who are exiting incarceration<br>• 18–25-year-old aged out foster youth |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Mental health services<br>• Other: services are coordinated with community partners; works directly with VA to connect individuals to service-connected benefits |
| **Eligibility Criteria** | • Work or education requirement<br>• No drugs on premises<br>• Vital documents required: ID/driver's license, birth certificate, Social Security Card, and proof of income |
| **Referral and Acceptance** | • Referrals received from other Eddy House programs and partnering agencies |
| **Waitlist** | • Maintains a waitlist, with 4 individuals at time of interview |
| **Program Annual Capacity** | • 60 individuals |
| **Other Key Information Gathered** | • Facility based; does not accept Medicaid<br>• Flexible, 6-month program; clients age out at 25<br>• Free program |

## Heaven Bound Lifestyle Center: Heaven Bound Aging and Disability Services

| | |
|---|---|
| **Website** | https://hblcreno.com |
| **Contact Name** | Patty Derosa |
| **Phone** | 775 297 1338 |
| **Email** | NA |
| **Program Name** | **Heaven Bound Aging and Disability Services** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Legal assistance<br>• Employment and vocational supports<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Mental health services<br>• Other: services are coordinated with community partners; coordinates directly with VA to connect individuals to service-connected benefits |
| **Eligibility Criteria** | • Determined by the state<br>• Criminal history of sex crimes precludes enrollment<br>• Vital documents required: ID/driver's license, birth certificate, and Social Security Card, and Medicaid/insurance documents |
| **Referral and Acceptance** | • Referrals received from Coordinated Entry |
| **Waitlist** | • Maintains a waitlist managed by the state; at the time of the interview, the wait was two years long |
| **Program Annual Capacity** | • 20 individuals |
| **Other Key Information Gathered** | • Independent living with a family member or on their own; rent is paid by Social Security or the state<br>• Accepts Medicaid<br>• Program length is indefinite |

## Northern Nevada Adult Mental Health Services: NNAMHS Board and Care

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **NNAMHS Board and Care** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People with a serious mental illness diagnosis<br>• People who are unable to live independently |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Mental health services<br>• These services are provided by NNAMHS, not necessarily the Board and Care facility itself |
| **Eligibility Criteria** | • Determined by the house/licensing<br>• Sobriety requirement<br>• Some criminal history restrictions may preclude enrollment, depending on landlord<br>• No vital documents required |
| **Referral and Acceptance** | • Internal referrals only |
| **Waitlist** | • Maintains an informal waitlist; works with clients to identify housing to meet their needs |
| **Program Annual Capacity** | • 7 individuals |
| **Other Key Information Gathered** | • Facility based program that is similar to a CBLA with different licensing process; does not accept Medicaid<br>• Program length is indefinite |

## Northern Nevada Adult Mental Health Services: NNAMHS Homes for Individual Residential Care (HIRC)

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **NNAMHS Homes for Individual Residential Care (HIRC)** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People with a serious mental illness diagnosis |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Health care services<br>• Peer to peer support<br>• Mental health services<br>• Other: hands-on, intensive case management; meals provided |
| **Eligibility Criteria** | • Participation in case management<br>• HCQC requirements (e.g., curfew, chores)<br>• Sobriety requirement<br>• Criminal history restrictions preclude enrollment depending on landlord<br>• No vital documents required |
| **Referral and Acceptance** | • Referrals received from NNAMHS and Dini Townsend Psychiatric Hospital |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 6 individuals |
| **Other Key Information Gathered** | • Facility based program with 24-hour support and monitoring and intensive services; does not accept Medicaid<br>• Longer-term care situation |

## Northern Nevada Adult Mental Health Services: NNAMHS Independent Placement

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **NNAMHS Independent Placement** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People with a serious mental illness diagnosis |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Mental health services<br>• Other: referrals can be provided to other services |
| **Eligibility Criteria** | • Participation in case management<br>• Each unit has its own rules<br>• SMI diagnosis required<br>• Must be able to do ADLs<br>• Vital documents required: ID/driver's license (required by landlords) |
| **Referral and Acceptance** | • Discharge from Dini Townsend Psychiatric Hospital prioritized<br>• Referrals also received from courts<br>• Walk-ins to medical clinic to establish with NNAMHS may be accepted |
| **Waitlist** | • Maintains a waitlist, with 10 individuals at time of interview |
| **Program Annual Capacity** | • Costs are variable so there is not a set capacity for this program |
| **Other Key Information Gathered** | • Voucher or tenant based independent living program; does not accept Medicaid<br>• No limit to the length of stay |

## Northern Nevada Adult Mental Health Services: NNAMHS Independent Supportive Placement

| | |
|---|---|
| **Website** | https://dpbh.nv.gov/about/overview/nnamhs_overview/ |
| **Contact Name** | Julie Lindesmith |
| **Phone** | 775-688-2010 |
| **Email** | jlindesmith@health.nv.gov |
| **Program Name** | **NNAMHS Independent Supportive Placement** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People with a serious mental illness diagnosis |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Mental health services<br>• Other: medication and ADL and IADL prompts |
| **Eligibility Criteria** | • Must be a NNAMHS client<br>• Participation in case management<br>• Each unit has its own rules<br>• SMI diagnosis required<br>• Criminal history restrictions preclude enrollment depending on landlord<br>• Vital documents required: ID/driver's license (required by landlords) |
| **Referral and Acceptance** | • Referrals accepted from courts<br>• Walk-ins to medical clinic to establish with NNAMHS may be accepted |
| **Waitlist** | • Maintains an informal waitlist; works with clients to identify housing to meet their needs |
| **Program Annual Capacity** | • Costs are variable so there is not a set capacity for this program |
| **Other Key Information Gathered** | • Voucher or tenant based program with CBLA-type services within an independent apartment; does not accept Medicaid<br>• No limit to the length of stay |

## Reno-Sparks Gospel Mission: Christian Addiction Recovery Education (Care) Program

| | |
|---|---|
| **Website** | https://rsgm.org/ |
| **Contact Name** | Luis Santoni |
| **Phone** | 775-323-0386 ext. 11 |
| **Email** | luis@rsgm.org |
| **Program Name** | **Christian Addiction Recovery Education (Care) Program** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People experiencing chronic homelessness<br>• People who are exiting incarceration<br>• People with a disability |
| **Supports Available** | • Case management<br>• Life skills training<br>• Transportation support<br>• Peer to peer support<br>• Other: Christ-based education that incorporates living skills and preparation to reenter community |
| **Eligibility Criteria** | • Must participate in program<br>• Cannot be on medication or receiving MAT services (Wellbutrin okay)<br>• Criminal history of sex or violent crimes precludes enrollment<br>• No vital documents required |
| **Referral and Acceptance** | • Self-referral<br>• Courts<br>• Word of mouth |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 100 individuals |
| **Other Key Information Gathered** | • Facility based drug and alcohol residential recovery program that is faith-based; does not accept Medicaid<br>• 12-month, four-phased program (3 months each)<br>• Clothing and food are provided if participant complies with program requirements |

## Volunteers of America: Affordable Senior Housing (HUD)

| | |
|---|---|
| **Website** | https://voa-ncnn.org |
| **Contact Name** | Heather Bolen |
| **Phone** | 775-331-4166 |
| **Email** | hbolen@voa-ncnn.org |
| **Program Name** | **Affordable Senior Housing (HUD)** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People who are 62-years-old and older |
| **Supports Available** | • Other: Service coordinator can support residents in connection to other services available in the community |
| **Eligibility Criteria** | • Criminal background check<br>• No money can be owed to previous landlord<br>• Criminal history of sex crimes precludes enrollment<br>• Vital documents required: ID/driver's license, Social Security Card, proof of income; proof of assets, and verified living history with addresses |
| **Referral and Acceptance** | • Self-referral<br>• Word of mouth<br>• Other agencies |
| **Waitlist** | • Maintains a waitlist, with 220 individuals at time of interview |
| **Program Annual Capacity** | • 245 individuals |
| **Other Key Information Gathered** | • Facility based HUD-subsidized housing for those 62 and older; does not accept Medicaid<br>• Indefinite stay; must get annual recertification |

## Volunteers of America: Community-Based Emergency Residential Services (Veterans)

| | |
|---|---|
| **Website** | https://voa-ncnn.org |
| **Contact Name** | Devin McFarland |
| **Phone** | 775-499-5198 |
| **Email** | dmcfarland@voa-ncnn.org |
| **Program Name** | **Community-Based Emergency Residential Services (Veterans)** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • Veterans experiencing homelessness |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Legal assistance<br>• Transportation support<br>• Health care services<br>• Peer to peer support<br>• Mental health services<br>• Other: services are offered in collaboration with the VA and there is a specific case manager for the program; VOA will schedule medical appointments and offer therapy through the ReStart Program |
| **Eligibility Criteria** | • Honorably discharged veterans<br>• Established with the VA healthcare system<br>• TB test clearance<br>• Criminal history restrictions preclude enrollment, including certain felonies in the past three years<br>• No vital documents required; VA helps clients get a DD214 and other documentation |
| **Referral and Acceptance** | • Referrals accepted from VA or Healthcare for Homeless Veterans |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 40 individuals |
| **Other Key Information Gathered** | • Facility based emergency housing program; accepts Medicaid<br>• 90-day program<br>• All units are ADA accessible |

## Volunteers of America: Village on Sage

| | |
|---|---|
| **Website** | https://voa-ncnn.org |
| **Contact Name** | Devin McFarland |
| **Phone** | 775-499-5198 |
| **Email** | dmcfarland@voa-ncnn.org |
| **Program Name** | **Village on Sage** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People experiencing chronic homelessness<br>• People on a fixed income |
| **Supports Available** | • Life skills training<br>• Employment and vocational supports<br>• Health care services<br>• Peer to peer support<br>• Participation in services is not mandated<br>• Other services offered onsite by other community providers (e.g., mobile outreach by doctors, NA/AA meetings) |
| **Eligibility Criteria** | • Income requirement of $1,200-$3,545 per month<br>• Pass criminal background check<br>• Criminal history restrictions preclude enrollment, including a history of certain felonies in the past three years<br>• Vital documents required: ID/driver's license, birth certificate, Social Security card, and proof of income |
| **Referral and Acceptance** | • Case managers from other VOA programs<br>• Community providers<br>• Self-referral |
| **Waitlist** | • Maintains a waitlist with 30 individuals at time of interview |
| **Program Annual Capacity** | • 400 individuals |
| **Other Key Information Gathered** | • Facility based bridge housing program (considered a boarding house in regulation); does not accept Medicaid<br>• Indefinite stay that is month-to-month<br>• Monthly rent payments; shared community living |

## Washoe County Housing and Homeless Services: Emergency Housing Vouchers with Tenancy Supports

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/homeless/ |
| **Contact Name** | Catrina Peters |
| **Phone** | 775-530-9772 |
| **Email** | CPeters@washoecounty.gov |
| **Program Name** | **Emergency Housing Vouchers with Tenancy Supports** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People experiencing chronic homelessness and on the community queue |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Mental health services<br>• Other: will refer out for legal assistance |
| **Eligibility Criteria** | • Criminal history precludes enrollment, including a history of sex crimes and convictions of manufacturing drugs in a public housing facility<br>• Vital documents required: ID/driver's license and proof of income |
| **Referral and Acceptance** | • Referrals received from Coordinated Entry |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 83 households |
| **Other Key Information Gathered** | • Voucher or tenant based program that is "somewhere between a RRH and PSH"; accepts Medicaid<br>• Landlords must accept clients in a voucher based program<br>• Indefinite length of stay<br>• Program sunsets in 2030 |

## Washoe County Housing and Homeless Services: Tenancy Supports with Shallow Subsidy (TSSS)

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/homeless/ |
| **Contact Name** | Catrina Peters |
| **Phone** | 775-530-9772 |
| **Email** | CPeters@washoecounty.gov |
| **Program Name** | **Tenancy Supports with Shallow Subsidy (TSSS)** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • People experiencing chronic homelessness |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Legal assistance<br>• Transportation support<br>• Education assistance<br>• Health care services<br>• Mental health services<br>• Other: will refer out for legal assistance |
| **Eligibility Criteria** | • Current emergency shelter program participant on the Reno Housing Authority waitlist<br>• Income requirement<br>• Vital documents required: ID/driver's license and proof of income |
| **Referral and Acceptance** | • Referrals are received from case managers working at the emergency shelter |
| **Waitlist** | • Does not maintain a waitlist |
| **Program Annual Capacity** | • 75 individuals |
| **Other Key Information Gathered** | • Voucher or tenant based program that is similar to RRH and an emergency housing voucher program; accepts Medicaid<br>• Shallow subsidy and case management are available until placement in a Housing Authority Unit<br>• Program sunsets in December 2026 |

## Washoe County Human Services Agency: CrossRoads Men's Program

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/hsa/adult_services/crossroads/index.php |
| **Contact Name** | Frankie Lemus |
| **Phone** | 775-328-7200 |
| **Email** | crossroads@washoecounty.gov |
| **Program Name** | **Washoe County HSA Men's CrossRoads Program** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • Men experiencing chronic homelessness (and homelessness)<br>• Men with SUD/co-occurring disorders |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Other: targeted intensive case management; evidence-based behavior change curricula; linkage to health care services; collaboration with behavioral health providers; recreation and leisure-based activities; self-help and peer led and facilitated meetings; workshops and seminars; assistance with child visitation or reunification; parenting skills; other linkages and services |
| **Eligibility Criteria** | • Washoe residents prioritized<br>• Admission criteria based off of ASAM<br>• Interview required<br>• Work collaboratively with case workers to seek stable income and housing<br>• Attend behavioral health services and case management services<br>• Attendance in evidence-based behavior change curricula<br>• Some criminal history precludes enrollment, including a history of sex crimes and a pattern of violence<br>• Vital documents required: Proof of residency and medical records; will provide assistance in obtaining any needed documentation |
| **Referral and Acceptance** | • Referrals received via word of mouth, contracts with SJDC Specialty Courts/Reno Justice Court Specialty Court/Reno Municipal Court Specialty Court/DAS STAR program, Detention Services Unit and Inmate Assistance Program, local treatment programs, detox centers and emergency shelters, and other Washoe County programs and agencies |
| **Waitlist** | • Maintains a waitlist, with 10 individuals at time of interview (can vary) |
| **Program Annual Capacity** | • 150-200 individuals |
| **Other Key Information Gathered** | • Facility based, structured living community using Community as Method (CAM) approach<br>• Individualized length of stay; average stay is between 9 to 10 months but there is no upper limit<br>• Program addresses criminogenic risks and needs |

## Washoe County Human Services Agency: CrossRoads Women's Program

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/hsa/adult_services/crossroads/index.php |
| **Contact Name** | Frankie Lemus |
| **Phone** | 775-328-7200 |
| **Email** | crossroads@washoecounty.gov |
| **Program Name** | **Washoe County HSA Women's CrossRoads Program** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • Women experiencing chronic homelessness<br>• Women with SUD/co-occurring disorders |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Other: targeted intensive case management (weekly); evidence-based behavior change curricula; linkage to health care services; collaboration with behavioral health providers; recreation and leisure-based activities; self-help and peer led and facilitated meetings; workshops and seminars; assistance with child visitation or reunification; parenting skills; other linkages and services |
| **Eligibility Criteria** | • Washoe residents prioritized<br>• Admission criteria based off of ASAM<br>• Interview required<br>• Work collaboratively with case workers to seek stable income and housing<br>• Attend behavioral health services and case management services<br>• Attendance in evidence-based behavior change curricula<br>• Some criminal history precludes enrollment, including a history of sex crimes and a pattern of violence<br>• Vital documents required: Proof of residency and medical records; will provide assistance in obtaining any needed documentation |
| **Referral and Acceptance** | • Referrals received via word of mouth, contracts with SJDC Specialty Courts/Reno Justice Court Specialty Court/Reno Municipal Court Specialty Court/DAS STAR program, Detention Services Unit and Inmate Assistance Program, local treatment programs, detox centers and emergency shelters, and other Washoe County programs and agencies |
| **Waitlist** | • Maintains a waitlist, with 10 individuals at time of interview (can vary) |
| **Program Annual Capacity** | • 100 individuals |
| **Other Key Information Gathered** | • Facility based, structured living community using Community as Method (CAM) approach<br>• Individualized length of stay; average stay is between 9 to 10 months but there is no upper limit<br>• Program addresses criminogenic risks and needs |

## Washoe County Human Services Agency: CrossRoads Families Program

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/hsa/adult_services/crossroads/index.php |
| **Contact Name** | Frankie Lemus |
| **Phone** | 775-328-7200 |
| **Email** | crossroads@washoecounty.gov |
| **Program Name** | **Washoe County HSA CrossRoads Families Program** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • Individuals or couples experiencing chronic homelessness (and homelessness)<br>• Individuals or couples with SUD/co-occurring disorders<br>• *This program serves individuals or couples with dependent minor children* |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Other: targeted intensive case management (weekly); evidence-based behavior change curricula; linkage to health care services; collaboration with behavioral health providers; recreation and leisure-based activities; self-help and peer led and facilitated meetings; workshops and seminars; assistance with child visitation or reunification; parenting skills; other linkages and services |
| **Eligibility Criteria** | • Washoe residents prioritized<br>• Admission criteria based off of ASAM<br>• Interview required<br>• Work collaboratively with case workers to seek stable income and housing<br>• Attend behavioral health services and case management services<br>• Attendance in evidence-based behavior change curricula<br>• Some criminal history precludes enrollment, including a history of sex crimes and a pattern of violence<br>• Vital documents required: Proof of residency and medical records; will provide assistance in obtaining any needed documentation |
| **Referral and Acceptance** | • Referrals received via word of mouth, contracts with SJDC Specialty Courts/Reno Justice Court Specialty Court/Reno Municipal Court Specialty Court/DAS STAR program, Detention Services Unit and Inmate Assistance Program, local treatment programs, detox centers and emergency shelters, and other Washoe County programs and agencies |
| **Waitlist** | • Maintains a waitlist, with 10 individuals at time of interview (can vary) |
| **Program Annual Capacity** | • 12 to 15 families |
| **Other Key Information Gathered** | • Facility based, structured living community using Community as Method (CAM) approach<br>• Individualized length of stay; average stay is between 9 to 10 months but there is no upper limit<br>• Program addresses criminogenic risks and needs |

## Washoe County Human Services Agency: CrossRoads Women and Children's Program

| | |
|---|---|
| **Website** | https://www.washoecounty.gov/hsa/adult_services/crossroads/index.php |
| **Contact Name** | Cara Paoli & Frankie Lemus |
| **Phone** | 775-328-7200 |
| **Email** | crossroads@washoecounty.gov |
| **Program Name** | **Washoe County HSA Women and Children's CrossRoads Program** |
| **Program Type** | • Other Housing with Services Coordination or Referrals |
| **Focus Population** | • Women experiencing chronic homelessness (and homelessness)<br>• Women with SUD/co-occurring disorders<br>• *This program serves women with dependent minor children* |
| **Supports Available** | • Case management<br>• Life skills training<br>• Employment and vocational supports<br>• Transportation support<br>• Peer to peer support<br>• Other: targeted intensive case management (weekly); evidence-based behavior change curricula; linkage to health care services; collaboration with behavioral health providers; recreation and leisure-based activities; self-help and peer led and facilitated meetings; workshops and seminars; assistance with child visitation or reunification; parenting skills; other linkages and services |
| **Eligibility Criteria** | • Washoe residents prioritized<br>• Admission criteria based off of ASAM<br>• Interview required<br>• Work collaboratively with case workers to seek stable income and housing<br>• Attend behavioral health services and case management services<br>• Attendance in evidence-based behavior change curricula<br>• Some criminal history precludes enrollment, including a history of sex crimes and a pattern of violence<br>• Vital documents required: Proof of residency and medical records; will provide assistance in obtaining any needed documentation |
| **Referral and Acceptance** | • Referrals received via word of mouth, contracts with SJDC Specialty Courts/Reno Justice Court Specialty Court/Reno Municipal Court Specialty Court/DAS STAR program, Detention Services Unit and Inmate Assistance Program, local treatment programs, detox centers and emergency shelters, and other Washoe County programs and agencies |
| **Waitlist** | • Maintains a waitlist, with 10 individuals at time of interview (can vary) |
| **Program Annual Capacity** | • 24 women with children |
| **Other Key Information Gathered** | • Facility based, structured living community using Community as Method (CAM) approach<br>• Individualized length of stay; average stay is between 9 to 10 months but there is no upper limit<br>• Program addresses criminogenic risks and needs |

# Appendix C. Housing Programs in Development

The following four housing programs, three of which are PSH. were in development when interviews were conducted. A brief summary of each of these programs is provided below to support a general understanding of housing resources that may be available in the future.

## Volunteers of America: Highway 40 Project

The Highway 40 project is a facility based, 26-unit PSH option. It is expected to serve 26 individuals at a time (no families or unaccompanied youth). Half of the service population will be accepted through Coordinated Entry.

Its focus populations are people experiencing homelessness and people with a disability. There are no known conditions or requirements that participants must meet to receive housing or services in this program.

Vital documentation requirements are still under discussion; for now, proof of income will be required.

The program is expected to offer the following supportive services: case management, life skills training, transportation support, peer to peer supports, and mental health services. Medicaid is not accepted.

## Accessible Space, Inc.: Lane Drive

Lane Drive is a facility and voucher or tenant based PSH option. It will serve up to 50 individuals at a time. 20 of those individuals will be accepted through Coordinated Entry. The program is expected to have low turnover and likely, a waitlist.

Its focus populations are people experiencing homelessness, people who are exiting incarceration, and people with a disability. Participants must be able to maintain the income requirements to receive housing or services in this program. The program will be unable to serve individuals with certain felony convictions related to drugs, sex, or violence.

Vital documentation requirements will be an ID/driver's license, birth certificate, Social Security Card, proof of income, and proof of residence.

The program is expected to offer the following supportive services: case management, life skills training, employment and vocational supports, transportation support, education assistance, health care services, and mental health services. Medicaid is accepted.

## Washoe County Housing and Homeless Services: Cares Campus Permanent Supportive Housing

Cares Campus Permanent Supportive Housing is a facility based PSH option. It will serve up to 75 individuals at a time (i.e., 50 units, 15 of which are double occupancy), with an expected low turnover rate. The program will participate in Coordinated Entry, and five of the units will be reserved for veterans and require a referral from the VA.

Its focus populations are people experiencing homelessness and people with a disability. Participants must have an SMI diagnosis or physical disability for entry.

Vital documentation requirements will include ID/driver's license and medical records.

The program will offer the following supportive services: case management, life skills training, employment and vocational supports, legal assistance, transportation support, education assistance, health care services, peer to peer supports, and mental health services. Planned supportive services are based on the ACT model and will include access to a psychiatrist, registered nurse, behavioral health clinicians, peer mentors, and an employment specialist on site. Medicaid is accepted.

## Chrysalis Light: Recovery Homes

Chrysalis Light is a faith-based, facility based recovery home option modeled after Transitional Living programs. It will initially serve up to eight women at a time and eventually add an additional 16 spaces. This program will maintain a waitlist, and it is available at the following link: https://tinyurl.com/3n2pzy56.

Its focus populations are women experiencing homelessness, women who are exiting incarceration, and women with substance use disorders. Participants must be able to maintain a job between 32 and 40 hours a week, pay $475/month beginning in the third month, and follow all program rules and requirements to receive housing or services in this program. This program will support participants in obtaining vital documentation.

This program is expected to offer the following supportive services: case management, life skills training, employment and vocational supports, transportation support, and peer to peer support. It will also facilitate connections to community resources. Medicaid is not accepted.