



SOAR National Technical Assistance Teleconference
November 3, 2008

“Funding and Sustaining Community-based SSI Outreach”

Deborah Dennis: Welcome everyone. This is our second national SOAR technical assistance call. We have about an hour for this call and we have three presentations today. To get started I want to let you know who is on phone with us today. We have talked to three programs around the country that really have done some amazing things in terms of trying to develop funding resources for their SSI outreach programs and sustaining and growing those programs over time. We thought that each of them had something different to offer in terms of the ways they were able to bring in some funding, the type of funding that they brought in, and the way that they were able to pull that together. With us today we have Michael Brittain from First Step Program in Atlanta, Georgia; Mellani Calvin from the BEST Program in Portland, Oregon; and, if she is able to make it, we will have Edwinna Meister from Welcome House in Covington, Kentucky. Let us start first with Michael Brittain.

Michael Brittain: Hi, good afternoon everyone. My name is Michael Brittain and I work for a nonprofit organization in Atlanta, Georgia, called First Step. We have three divisions in our organization. We have an employment program. We have a benefits division that assists with the SOAR program and assists disabled adults applying for Social Security benefits, and we assist with housing as well. We have 55 housing units. We opened our doors about two years ago, but we did not actually start taking Social Security claims until August 2007. Initially we were started by a philanthropist who funded the project and thus far we have had 93 approvals. We have had about 27 denials and so our success rate is about 77%. The average turnaround time has been about 68 days. We tracked our outcomes from day one. This really helped to generate revenue for the organization.

One of the funding sources we have is United Way. We have a grant of \$222,000 from United Way of Metro Atlanta and \$42,000 of that goes directly towards a benefit specialist, which is what we call case managers in our organization. I'll give you a little background on how we were able to obtain this funding. The mayor of Atlanta created a commission to end chronic homelessness in Atlanta within 10 years. The commission primarily raises money to fund various projects that they deem important in order to accomplish that goal. What we have done basically through attending community meetings and communicating our outcomes to United Way is to get this issue on the forefront of their agenda. So we have really been pushing this to them. I think we have been pretty successful and currently United Way seems gung-ho about SOAR and wanted to raise money for us. They have been asking us to write success stories to get them out to funders. Being vigilant about tracking our outcomes has been really helpful. This has allowed us to show our successes to our funders.

In addition we have a couple of foundations that we're getting money from. We wrote a grant to Cousins Foundation; we were approved for \$150,000 and \$43,000 of that again goes to a benefit specialist. We have smaller grant for \$25,000 from a community foundation, which subsidizes

the program manager salary at our organization. Finally we are getting funding through Department of Community Affairs, the state agency that administers federal HUD dollars. This funding comes through the housing trust fund which is part of HUD's emergency shelter grant program. We have been approved for \$50,000. \$25,000 of that goes to a HUD-subsidized benefits specialist physician. We were at a meeting and a DCA staff person approached us when we are speaking about our program and encouraged us to apply.

So we found that going to different community meetings and presenting our outcomes has really helped us network. We also recently got a contract for \$45,000 with the local hospital, actually a national hospital, St. Joseph Hospital. They have a program called Mercy Care Services here that serves people who are homeless with physical and mental disabilities. So we are going to be hiring a case manager who is only going to be working with cases from St. Joseph Hospital. Our goal is to help them to recoup Medicaid dollars for the hospital by assisting patients who are homeless. The hospital is interested in expanding that relationship and maybe we can get some additional revenue to help support our services.

Finally we have submitted some proposals to a couple of local hospitals. Grady Hospital is a really large state hospital and also Atlanta Medical Center, which is a private for-profit hospital in downtown Atlanta. In both those hospitals we met with CEO of the hospital to propose assisting their homeless patients to obtain Social Security benefits. They are both interested, but Grady Hospital has been lot more challenging because it is a huge bureaucratic system. Atlanta Medical was very easy. Meeting with hospitals may be easier because they are motivated to reduce their uncompensated care. Atlanta Medical told us that they serve a lot of homeless clients and obviously being for profit hospital they are not enthusiastic about that. They want to retrieve some of their fees, so they want us to help the homeless individuals there who are without Medicaid to get Social Security benefits, so they can discharge them quickly. We have not come up with an arrangement yet, but we are working on that. This concludes my presentation on the funding that we have had and I'll be glad to take questions at the end.

Deborah Dennis: Thank you, Michael. Since Michael brought up the whole issue around hospitals, I think what I will do is go through Edwinna Meister's presentation. Edwinna works with the Welcome House, which is a drop-in center for people who are homeless in Covington, Kentucky. Covington is a relatively small community that actually has one hospital in the area that serves folks. Welcome House's mission is to eradicate homelessness and to provide drop-in services and case management for people. They got involved with SOAR and doing SSI applications when Rachel Winters had come to a SOAR Train-the-Trainer program that we had done. Very quickly afterwards she realized that she wanted to be able to do more of this within Welcome House. So her executive director at Welcome House and Rachel went to talk to the patient billing office there at St. Elizabeth. They approached them solely on the basis that Welcome House can stay in better contact with people who had lot of unpaid bills at the hospital and could get them on the benefits that would then enable to hospital to be reimbursed up to 90 days retroactively by Medicare and Medicaid. They decided that the hospital would give them \$18,000 to fund a part-time position and purchase a laptop so that the staff person could go to the hospital and other off-site locations to do some of this work. In the first year that the hospital provided this funding to Welcome House, the hospital was able to recoup \$85,000 in Medicaid and Medicare billing.

By December 2007, St. Elizabeth agreed to fund a new contract for \$45,000 for fiscal year 2008. This allowed the part-time person they had originally hired to go full time, and to hire a part-time person to do some assistance with the program. According to the hospital, the total amount of billing for clients who were approved for SSI as of last week totaled 1.5 million dollars. Of that amount Medicaid had reimbursed the hospital to date for \$217,000 and Medicare has reimbursed St. Elizabeth for \$60,000. So together between Medicare and Medicaid that hospital has recouped \$280,000.

St. Elizabeth has increased their funding for 2009 to anticipate a minimum of \$75,000. This will help fund a full-time administrative staff person, increase the hours from part-time to full-time for the Social Security Outreach system, and provide some office base and equipment, so the program can continue to grow.

In a recent meeting between the Welcome House staff and the person from the fiscal office in the hospital, Joe Ruark, clarified that when St. Elizabeth turns accounts over to collection agencies, it receives only pennies on the dollar from the collection agencies once they have actually done their work. They have used some of these large companies that do assistance with financial benefits, such as Chamberlain Edmonds. When they contract with those folks, the hospital receives 25 cents on the dollar they have invested. However with SOAR their return is \$4 for every dollar they spend. So it's a "no brainer" according to Mr. Ruark. He is so excited about this program that he has become one of the program's biggest cheerleaders. Mr. Ruark is getting press releases written about the program. He is presenting on it at his annual conference of healthcare finance administrators in November and they are working on an article to talk about SOAR and collaboration with hospitals as well. So I think that this shows that in a small community with small hospital they were able to make this work, to provide funding for a program that was much needed, as well as a service to a hospital that was needed as well. So this will work in any size community. It can work with any kind of hospital or any kind of homeless service program. We just wanted to provide this as an example so that people understand some of the connections that can be made with some of the healthcare providers that are out there. So that is the Covington, Kentucky, example. Now I am going to turn over to Mellani Calvin.

Mellani Calvin: I work here in Portland, Oregon, which is a mid-sized city. This is how my program started. Oregon participated in the first SOAR Train-the-Trainer back in December of 2005 and we did about 15 or 16 trainings throughout the state over the last few years. Much like Mike mentioned, specific presentations about how well this works has really brought this to the fore in our community, in addition to the SOAR trainings. We created a SOAR community from lots of different social service agencies with whom we meet monthly to keep SOAR and the expedited benefits plan in the forefront. We also were able to get benefits added to Portland's 10-year plan to end homelessness. It was completely missed for the first three years of our plan.

We worked on creating a proposal for collaboration with the regional Social Security Administration, because we discovered that our neighboring state, Washington, had an excellent SOAR-based relationship with their field offices and their DDS. So after we worked up this plan to basically collaborate with SSA, the city of Portland became a huge supporter of this plan. They really relied on how this could impact the number of homeless on our streets and 10-year plan. Much like Mike's contacts with the Atlanta Coalition, they really got on board with this.

So at that point we did a an hour long presentation to each congressional office and we basically asked for their help to write a letter to Commissioner Astrue, to our region 10 deputy commissioner in Seattle for their support of our plan. We convened a round table discussion with the regional staff of disability program administrator and their director of public relations. We had a large group of community agency participants. We actually had to turn people from nonprofit agencies away because we did not have room in our conference room. There were more than twenty different agencies, which really got Social Security's attention. At that point we received written support from Commissioner Astrue and the Region 10 staff to proceed with our plan.

The plan is that Center City Concern would create a trained team of specialists and non-attorney representatives. We called them disability specialists. We would file everything online and in return we have asked Social Security to designate a liaison at our downtown district office and our Oregon DDS to expedite homeless cases.

We pursued funding for a pilot two-year project and we were able to obtain three different grants. First and foremost was the City of Portland and they gave us a lot of money to start up this team and to pay for own evaluations, our own doctors and psychiatric evaluations and that money that is huge to the success of our program. We also wrote grants to the Kaiser Permanente Foundation here on the West Coast and Provident Medical system too. Kaiser gave us \$164,000. Provident gave us a \$100,000. City of Portland startup money was about \$97,000 and over the next two years they funded another \$500,000. At that point, once we had our funders, we created an MOU with regional staff and we began taking cases.

Our team was completely staffed in 03/08. We have currently reviewed I think about 250 cases. We have accepted about 80. We have 28 approvals with 39 day turnaround time and 87% success rate at the initial level. The media here in Portland actually did several stories on the need to expedite the process in order to keep these cases out of the national hearing backlog. So our plans for sustainability, we have several irons in the fire and, of course, Medicaid reimbursement. Central City Concern has a clinic in downtown Portland here, so Medicaid reimbursement to our clinic is part of how to sustain our team. Our local Housing Authority in Portland had a lot of people using housing vouchers with no income. They have expressed interest in purchasing some of our specialists' time. What they also want to do is include education for their residents, zero-income residents, and to do some screening to see how many of those residents might be eligible for disability.

We also had a recuperation care program at the respite care program where the hospitals refer patients to respite care. While they're there, they work on housing issues. People are referred to the BEST team for getting their benefit applications started. We also have Department of Justice/Corrections pre-release program that is a conduit for referrals to our program. We also had really neat experience couple of weeks ago with Common Ground folks from New York City. They came and did a homeless health survey for the City of Portland and they established a list of the highest risk of homeless people for death. They want to refer cases to our team so that we can get benefits and some housing as soon as possible. There was great data that came from this survey

We'll continue our relationships with hospitals, of course. Here is a little bit of data on Medicaid reimbursement from our program. We have six cases so far that had significant medical bills within the 90-day retroactive period. We have been able to notify these providers of \$220,000 worth of reimbursable funds -- 16 different providers ranging from imaging companies, ambulance companies, and ICUs, all the major hospitals. So that's a summary on benefit and entitlement specialist program in Portland.

Deborah Dennis: Thanks, Mellani. I think you can see from having listened to our three presenters that we have covered a lot of ground in terms of where people are actually finding funding to do this kind of work. It ranges from hospitals, which we have talked about, to the United Way to foundations to state funding, and HUD funding for support services. There has been a variety of things that we heard about.

One of the things that people had asked about prior to this call was whether or not there were any major grant programs that existed to fund SOAR or to fund programs like this. The answer is not yet or not at this time. Basically programs that are looking for funding to do this are looking within their communities and within their state to resources that are as creative as they possibly can be, from looking at the 10-year plan within their city, to looking at foundations and so forth. So it really is a creative process, and we are finding a lot of people relying on variety of different methods to sustain and build these programs.

One of the things I wanted to mention is that at the SOAR Technical Assistance Center we are working on a brief about sustainability and funding for programs that are doing SOAR. Yvonne and I are hoping to complete in the next couple of weeks. I want to turn now and see if you can take some questions that we have been getting.

Yvonne, I think this is question that I would put to you first. The first question is: Do any SOAR programs use the one-quarter representative fee from the SSI applicants' back benefits as the source of funding?

Yvonne Perret: That is a good question. We discourage charging and I understand that is a problem. One of things is that most of the SOAR program staff are not attorneys who are the typical folks who can get that reimbursement. Some folks who are non-attorneys can pay a significant amount of money and pass a training test to charge that fee, but we have not seen anyone doing that yet. I believe that the fee they have to pay is \$1000 for each person who wants to collect the fee, so it is significant and I have not seen any program do that. There is one program in Philadelphia that is staffed by attorneys, but they are not charging at this point because they have a grant from the state to do the SOAR project.

Deborah Dennis: Michael, you want to add to that because you guys are doing something a little different than most of the SOAR projects?

Michael Brittain: Sure. As part of our revenue initially our idea was that we would charge that fee, until we had foundation money or monies from other sources or had agreements with a hospital. We have attempted to do that and, to be quite honest, it is very challenging unless you have been approved to receive a direct fee from Social Security. You can be approved as a non-

attorney representative if you pay \$1000 and take this examination that is offered once a year. You can be approved to receive a direct fee, which is 25% of individuals' back payment. We only recently were approved for that. Most of our approvals have been prior to being approved to be a direct recipient of that fee, so we have to rely on the client or the payee to send us that fee. In most cases they just do not do it. The other issue is that we worked with a lot of local hospitals and while inpatient, in Georgia at least, they only get \$30 per month. We have gotten many approvals from Georgia Regional Hospital which is a local state hospital, so a lot of our clients' payments are only \$90 or \$60 or something.

Deborah Dennis: The whole point of us doing this is really to try and turn these benefits around as quickly as possible so the actual back benefit is going to be relatively small for most people. So we're really trying to get people more reliant on other sources of funding that will be able to provide more of a base.

Michael Brittain: So far we have had 93 approvals and I think we have generated about \$12,000 revenue from fees from that.

Yvonne Perret: I think the other thing to keep in mind is 25% up to maximum, so it is not always 25% for folks. People might already be waiting for a hearing, where the larger sums would come from. You know we're really about avoiding hearings but I know that a number of people already applied, been denied, and now awaiting for a hearing especially in the prototype states that do not have reconsideration.

Deborah Dennis: I have heard a lot of details on the types of programs and on the amount of money, but I have not heard any insight on grants or other funding resources that have been identified or timetables on submission for grant writing. Yvonne, do we have any other sources of funding? And I mentioned that there are no major grant programs that are focused specifically on this.

Yvonne Perret: I'd like to mention that the BEST program grant proposal actually is on our website. We helped put this together with Mellani and they gave us their grant proposal. I do not know if that helps to take a look at that kind of template. Otherwise we have not been able to identify particularly foundations or large grant providers that would support these initiatives. You know one of the things folks might think about in their communities is approaching very large corporations that focus on these areas, if they have them. For example in Baltimore, there are companies that do a lot of philanthropy and gave some grants, I know, to mental health, so this might be something for folks to think about.

Deborah Dennis: Thanks, Yvonne.

Michael Brittain: I am not a primary grant writer for my organization, but I know the focus has been on the fact that an individual obtains medical benefits with SSI. So we have been trying to approach it from the standpoint of improvement in health for our clients. There are a lot of foundations that focus on healthcare. That has been the route we have been trying to argue in terms of grants and increased access to healthcare.

Yvonne Perret: You know we should mention too, and you just reminded me of this, Michael, that there are some folks in California who have put in a proposal to a large foundation there to do SOAR and re-entry from jails and prisons. This particular foundation they have approached really is interested how to improve health, how does this reduce recidivism and how does it help the well-being of the community and some of those kinds of things. So I think you can look more broadly and that can be useful.

Michael Brittain: Financial independence, health. I think Kaiser is focused on that and we also have a grant with Kaiser.

Deborah Dennis: I should just say that lot of folks are out there doing this as a route to greater access to housing. I should say HUD support service funding under McKinney has been very open to funding SOAR as part of their increasing access to housing. The PATH programs within the states are very active participants and have done a lot for so many SOAR programs within a variety of states around the country.

Okay let me turn to the next question. This is a question for Mellani but I bet everyone to on call here could speak to this. The question is from William Hawks in Buffalo, New York: Can you speak to how the SSI applications in Portland were expedited at the state Disability Determination office? What convinced that agency to cooperate with your project?

Mellani Calvin: Great question. Thanks William. Well, the origins of the concept came from the Social Security Administration's HOPE program. There was a very, very successful HOPE program in Denver, Colorado. One of the reasons it was so successful was because the regional staff, I think it is region 8 in Denver, got on board with this. They were so enthusiastic to make this work well that they actually were able to designate an administrative law judge to help expedite these cases. They had tremendous amount of success, 90% success rate I think. So we contacted the region 10 counterpart to the person in region 8. When we did our large presentation to Social Security Administration we got him on the conference call, so that he could speak to region 10 staff in our meeting about how this is again a no-brainer for everybody involved. This collaboration makes Social Security numbers look great. It also reduced so much of the ground work for the disability staff and local field office staff that we are tremendous time savers to them. By doing a lot of outreach to the homeless folks, it minimizes missed appointments; it minimizes lost forms; it streamlines everything. So we became the eyes and ears for the Social Security Administration and I teased them when we first met. I said this is a silly name, the BEST program, but I want to assure you that I do not think we are the best at doing this. I want to make sure you know that we are going to do the very best we can to assist you on doing these tough claims well. I am not sure if that answers your questions, I hope it did.

Michael Brittain: Can I add something to that? I know that your program has some funds to pay for CEs and that makes a huge difference. I think as far as our local DDS office is concerned that also something they like. Frequently we will pay for these evaluations instead of them and that is appreciated. If we feel that we have got strong enough case at that point, we have enough of the medical records and we feel like that CE is going to be warranted, we will go ahead and schedule it ourselves and not wait for the adjudicator. This expedites the case since the adjudicator is judged based on the turnaround time. Again you have to think back on what has

already been said about the fact that we are out on the streets looking for people; we are the ones that have contact with these clients and are able to get forms completed or locate clients quickly. It is immensely helpful to the adjudicators and they really appreciated that because it speeds up their turnaround time.

Yvonne Perret: I think that we need to distinguish between community evaluations that are done to support the claim and CEs because that really has certain connotations and raises questions about why would I pay for CE that DDS could. It seems that you are saying, Michael, you really are getting evaluation strategies to see them being needed to avoid the sort of CE.

Michael Brittain: It speeds up the process and also we have found that certain doctors can be unsympathetic to clients, may not taken enough time with them and we would have better success with certain doctors over others.

Yvonne Perret: The only thing to add about this in terms of getting your DDS to kind of see how this is useful. We have a number of folks in the country at the DDS who are very willing to talk to other DDS medical relations office or administrators about why they like this. So I think this can really be very persuasive.

Mellani Calvin: One of the biggest problems I think is that the general public has with lack of knowledge about the strict criteria for Social Security disability. Another component that we do here, we do a lot of community education. We actually train all of the case managers in three different agencies that refer to us, numerous case managers, training as we go, on what look for at the levels of severity and duration and sustainability and so we are actually doing a bigger service for Social Security Administration in our continued education of what type of cases should be brought to them.

Michael Brittain: We have a local SOAR program at the Department of Human Resources. It is called DHR SOAR and is funded by PATH, just like someone was saying earlier. Kristen Lupfer was largely responsible for establishing this arrangement and partnerships with Social Security and DDS last year when this all was starting in Georgia. She started a SOAR coalition, so we have people who have gone through the SOAR training and are kind of enthusiastic about this, come to these coalition meetings. So now we have this coalition of people that can be kind of advocates for SOAR policies with Social Security and DDS. I think that has been helpful. Actually we have the manager of the homeless department at DDS in Atlanta here and homeless liaisons from Social Security at coalition meetings, so I think that is also really helpful.

Deborah Dennis: Michael, what you are pointing out is something that is really important and I would state that this is part of what is essential in terms of the SOAR program as Yvonne and I have tried to implement this all around the country. This is bringing together the stakeholders who really need to be there to put together a plan for how to make this work. That coalition you described in Georgia is something that we have helped others work out in state after state around the country, now working in the 34 states that we have been working with and in community after community around the country as well. Bringing DDS and SSA to the table along with folks from your Continuum of Care, folks from your state agency that works with temporary and

disability benefits and so forth is really important, so that every body is on the same page about what we were trying to accomplish and how we are going to get there.

Okay, let's see. I think that there is another question. That question came for Mellani but I think that it could be addressed by everyone again. The question is: What information did you present to Congressional offices? I want to make a little broader, Mellani, and that is: what you doing or how much data did you have to have or what did you take to be able to show that what you are doing is effective? I think that in both your case and in Edwinna's case, these programs are not programs that have been around for long periods of time. You were really trying to get something started very quickly and worked with the small amount of data but it was very convincing data. So tell us what you did do to kind of make your case?

Mellani Calvin: Wow. We had no data, actually. We had no local data because there was no team. We used a lot of SOAR data. We used approximately 10% to 15% of homeless cases are approved when, in fact, you know there is really high percentage of disabled people on the streets. I am sorry; I am not remembering exact numbers. We did try to use as much national data as we could but I got to say more than anything else, it boiled down to convincing two people in our group who really knew how to a put this together -- a grant writer and me. I started at a Social Security disability law office and brought all of my knowledge from the field level at hearings to the initial application process. It boiled down to a really passionate sales job with some of the SOAR national data and also we did access some of the street count information. Each community has a mandatory street count that they take every two years something like that, so we had some local data on the numbers of homeless people and the number of the people that say that they have some sort of disability along with it. So I do not have concrete answers. I probably should have pulled out that statement.

Deborah Dennis: That is fine Mellani.

Mellani Calvin: We did do white paper on it and that was mix of local and national data on disabled homeless.

Deborah Dennis: Michael, do you have anything to add to that?

Michael Brittain: We used very similar data from SOAR national numbers and statewide numbers in terms of the percentage of approvals statewide for homeless cases in Georgia. I think was like 18% or something last year. Off the top of my head it was very low, so I think that is pretty compelling and now we finally have some numbers ourselves that we can cite.

Deborah Dennis: I was thinking, Mellani, of the three applicants that you took the data from them to find out how many medical providers they had and you said they had 16 medical providers across the three people. That was very impressive to me in terms of amount of money that was not being reimbursed.

Mellani Calvin: We are up to six cases now that have significant medical bills and \$220,000 among 16 different providers.

Deborah Dennis: Do you actually get the hospital to help to pull that information, those figures together?

Mellani Calvin: We ask our clients to hand over their stack of bills that have been racking up-- just their bills. They have been billed to our claimant directly and they bring us all their bills. We make sure the Medicaid retroactive date is established and in place, and we call all of those 16 different providers and give them that retro Medicaid reimbursement date and let them know that they can turn this bill over to Medicaid and to not bill our client anymore. That \$220,000, that is where that comes from, their own bills that have been handed to us.

Deborah Dennis: That is really crucial. Once you actually get benefits for someone to make sure that you go back to the medical providers and let them know that they can then back bill.

Yvonne Perret: I think a project funded by a hospital in Rhode Island, where the hospital actually tracked it and provided that data. So that the hospital was the reporter of what bills have been paid and that's another approach people can use.

Michael Brittain: Early on we needed some findings to use with some local hospitals. So we started to collect financial records from these hospitals. I just do not see how you can get in the door without having something to be able quote as far as financial data from that particular hospital. So particularly from Grady Hospital, where virtually every homeless individual has gone, we were able to find a wealth of data and that has been really helpful. We have yet to come to an agreement with Grady but these data got us in the door since we are able to quote some financial numbers in terms of what sort of expenses that clients are incurring.

Yvonne Perret: That's a really good point, and most of the hospitals don't know what their income is because it is huge for them.

Mellani Calvin: One person had an \$80,000 bill for problems that got reimbursed and that really got Provident's attention.

Deborah Dennis: I have another question here. What about approaching pharmaceutical companies for assistance with programs like this? Yvonne, any thoughts on that?

Yvonne Perret: I think it is worth a conversation. You want to be really careful about that how that gets negotiated but we know they certainly do have some dollars. The question for me would be that I have not generally seen drug companies finance operational cost. I think you if we get some seed money they probably would be willing to do something like finance some evaluations or something like that.

Mellani Calvin: The reason I think it is a good idea and Yvonne has got so much more experience in all of this, but the biggest beneficiary in the work that we do are the medical providers and the pharmaceuticals. That reimbursement really racks up fast and I do not see any reason why we could not approach pharmacies to bring that to their attention that this small upstream investment can get a lot of people off their needy program.

Yvonne Perret: I think that will be interesting data to see if you can get. See perhaps from a state mental health agency whether or not they have any information on how many of their folks being treated are getting indigent care and then you could say: This is what it costs -- how about if you find a way of doing it differently. It could be interesting.

Deborah Dennis: I have what I think probably will be the last question here and this is a question for Yvonne. It comes from Ron Dudley in Santa Cruz County and Ron says that Santa Cruz County is in the process of becoming a provider for DDS to complete CEs and to receive funding for doing those. It is really more of a comment but I am looking for you to feedback and comment on that.

Yvonne Perret: I think that it will be great if we could get more community providers to do evaluations. The problem with the whole CEs thing is this. If you think about the way CEs work, a CE is not ordered until the DDS determines that it does not have enough information from treating sources or records to make a determination. So the issue I have about the CE is that getting to that point usually takes time. I still think it is a great idea that if a CE is going to be scheduled, it will be done with the community provider who understands the needs of the folks who are in this population, and so I applaud you doing that. I just wish that we could work hard so we can get evaluations in some ways before we get to the CE stage.

Here's an idea that was done by one of SOAR trainers in West Virginia, which I just love and that is she wrote to the West Virginia Medical Association and got a list of the retired doctors and wrote all them explaining what she was doing to assist homeless folks and asked if any of them would be willing to do some pro bono evaluations and she got a great response. So she now has some retired physicians, including psychiatrists, to do some pro bono evaluations before folks get to the CE stage. So I think kudos to you all in Santa Cruz for taking the initiative to do this. I would love to see if we could continue to brainstorm some more strategies for getting an evaluation before the DDS reaches that stage, because it does kind of tend to delay things. But that does not take away anything from your initiative and what you all are doing there, so thank you.

Deborah Dennis: I think that is just about all the time that we have and, before I turn this over to the operator to close the call, I did want say a couple of things. One is that we had mentioned that the BEST application of the proposal was on our website and actually it is not on there but we will be putting that up there shortly. I hope we can get that up there before the end of this week. So let me give you that website address and will put that up and they will put it under "What's New" so that you can find it easily and the website is www.prainc.com/soar. I want to thank everyone for joining us. We expect to have another one of these calls in January. If there are particular topics that people would like to see us address we would be happy to entertain your suggestions and develop a call around topics that you all might be interested in hearing.