Critical Time Intervention (CTI)
Core Components & CTI Forms* "Cheat Sheet"

**CTI forms are intentionally designed to assist with documenting CTI core components and reinforcing CTI practice*

CTI Core Components & Essential CTI Forms				
CTI Core Components & CTI Forms	**Description & Rationale**	**Phase 1 Months 1 & 2 (Transition)**	**Phase 2 Months 3 & 4 (Try-out)**	**Phase 3 Months 5 & 6 (Transfer)**
Active Service Linkages	*> Working collaboratively with Veterans, the case manager creates meaningful, engaging linkages to VA and community resources that promote the Veteran's continuity of care, stability and social integration.*	> Establish Veteran's resource & support networks at their local VA facilities and in their communities. > Attend service appointments to advocate on Veteran's behalf and model help-seeking behaviors and skills to achieve goals. Follow up with Veteran about their satisfaction with each linkage.	> Monitor the impact of resources on goal attainment and adjust as necessary. > Empower Veterans to maintain resources independently, assisting when challenges arise and continuing to teach Veteran how to self-advocate.	> Consult on Veteran's goal achievement (rather than a direct helping role). > Transition support to established linkages in final meetings with Veteran's resources and supports. Plan for the future, including how to navigate ongoing threats to housing stability.
Time-limited & Phase Date Form	*> The initial 6 months in housing are a critical time for establishing skills, resources, and supports needed to achieve long-term housing stability.* *> Veterans' expectations for the program are managed up front and throughout the 6 months of CTI.* *> The Phase Date Form tracks case manager's caseload across Phases* *> This form helps to ensure case manager's activities for a Veteran are consistent with their current Phase.*	> Remind Veteran what work together will look like in this Phase and program length > Update the Phase Date Form during each supervision session	> Remind Veteran what work together will look like in this Phase and time remaining in the program > Update the Phase Date Form during each supervision session	> Remind Veteran what work together will look like in this Phase and time remaining in the program > Update the Phase Date Form during each supervision session

Transitioned support & Case / Progress Notes	> *The intensity of the case manager's support is reduced over time as the care is transitioned from the case manager to the Veterans' support and resource network, as these connections are made and established.* > *Case notes are completed for every interaction (e.g., phone, in-person, etc.) or attempted interaction with the Veteran.* > *Case notes capture how interactions and meetings with the Veteran supports their current goals for that Phase.* > *Provides documentation of reduced support over time and helps case managers plan for the next Phase*	> Weekly in-person meetings at minimum > Document every interaction or attempted interaction w/ Veteran	> Two times per month in-person meetings > Document every interaction or attempted interaction w/ Veteran	> Monthly in-person meetings > Document every interaction or attempted interaction w/ Veteran
Focused Goals & Phase Plan Form	> *1 – 3 focused goals (i.e.,* Specific, Measurable, Achievable, Relevant and Timely [SMART]*) per phase.* > *Goals are connected to Veteran's reason for becoming homeless.*	> Phase Plan is completed at beginning of Phase 1 *and* end of Phase 1 (goal summary)	> Phase Plan is completed at beginning of Phase 2 (fresh version of form) *and* end of Phase 2 (goal summary)	> Phase Plan is completed at beginning of Phase 3 (fresh version of form) *but* NOT end of Phase 3 (use Closing Note instead)
Weighted Caseloads & Caseload Tracker	> *Caseloads are weighted to account for the intensity of services across phases.* >*The weighted caseload tracker ensures manageable caseload of no more than 20 weighted cases.*	> Update Weighted Caseload Tracker 1-2 times per month	> Update Weighted Caseload Tracker 1-2 times per month	> Update Weighted Caseload Tracker 1-2 times per month

Weekly Supervision & CTI Supervision Form	*> Supervision is conducted weekly. Each case manager's entire caseload is discussed at least once per month with a supervisor.* *> The CTI Supervision Form is used to guide discussion between supervisor and case manager, of Veterans' progression through CTI.*	> Weekly supervision > Each case manager's entire caseload is discussed at least once per month	> Weekly supervision > Each case manager's entire caseload is discussed at least once per month	> Weekly supervision > Each case manager's entire caseload is discussed at least once per month
Minimal Extensions / No Early Discharges & Closing Note Form	*> Extensions are granted in rare cases, typically when a linkage or support is imminent, but cannot be solidified before the 6 months of CTI ends.* *> Early discharges from the program are not permitted, even if Veteran is doing well – this ensures Veterans can get support within the initial 6 months in housing, should it be needed.* *> Upon discharge, the Closing Note is used to summarize what occurred during the six months of CTI, and plan for maintaining housing stability after CTI.*	> No early discharges > The Closing Note is NOT used until Phase 3	> No early discharges > The Closing Note is NOT used until Phase 3	> No early discharges > Examples of circumstances that may require extensions include pending benefits, employment, relocation, a hospitalization or other health-related crisis. > The Closing Note is completed in 2nd to last or last meeting with Veteran

Additional CTI Forms (to use "as needed")				
CTI Core Components & CTI Forms	**Description & Rationale**	**Phase 1 Months 1 & 2 (Transition)**	**Phase 2 Months 3 & 4 (Try-out)**	**Phase 3 Months 5 & 6 (Transfer)**
CTI Informed Veteran Assessment	> *Assesses biopsychosocial histories & assessment domains relevant to the CTI model.* > *If organization has a similar intake form, it is recommended to review the CTI Informed Assessment and make additions or adjustments to the organization's form to align with CTI.*	> At intake/ beginning of Phase 1 > The "Independent Living Skills Checklist" (page 9) assesses Veterans' independence upon program entry	> The "Independent Living Skills Checklist" can be used to assess Veteran's progress to live independently	> The "Independent Living Skills Checklist" can be used to assess Veteran's progress to live independently
Veteran Resource List	> *List of documents and contacts aligned with recovery goal domains.* > *Serves as a source for documenting the support and resource network, personalized to each Veteran.*	> Ongoing/ as needed throughout Phases	> Ongoing/ as needed throughout Phases	> Ongoing/ as needed throughout Phases
Harm Reduction Plan	> *Plan to reduce harm associated with any risk behavior or threat to Veteran's housing stability.*	> As needed	> As needed	> As needed
CTI Self-Assessment	> *Tool for highlighting areas of strength and identifying challenges related to applying CTI. Meant to be a method for reinforcing CTI core components and identifying strategies to align with CTI.*	> Recommended to complete quarterly or biannually and monthly/bimonthly for new staff	> Recommended to complete quarterly or biannually and monthly/bimonthly for new staff	> Recommended to complete quarterly or biannually and monthly/bimonthly for new staff

CTI Recourses and Processes Workbook	*> This workbook helps organizations document resources and processes available through their local VA and community partners.* *> Since VAs and communities vary in services and resources and ways of accessing them, documenting resources and processes creates an information hub for each organization to refer to and orient new staff to.*	> As needed	> As needed	> As needed
CTI SMART Goals Worksheet	*> The SMART Goals Worksheet is a tool designed to help case managers teach Veterans how to develop and achieve SMART goals on their own.* *> Also a helpful tool for case managers that are new to using SMART goals within their practice.*	> As needed	> As needed	> As needed
Primary Care Provider Visit & Mental Health Provider Visit Forms	*>These forms are designed to help case managers support Veterans in obtaining key points of contact (e.g., names, numbers, roles) for commonly used providers and services.* *> Helps to clarify who the Veteran should contact in different health-related situations. Additionally, it includes information to register for MyHealtheVet.*	> As needed	> As needed	> As needed