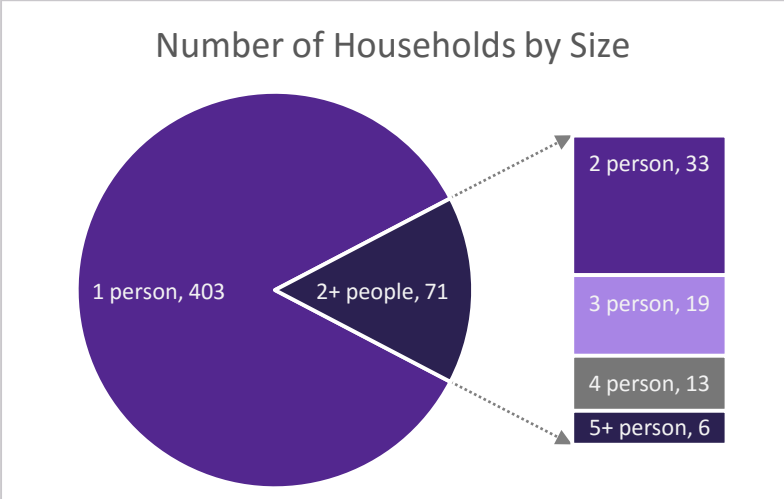
NY-523 - Glen Falls/Saratoga Springs/Saratoga County CoC

10/1/2015-12/31/2015

Overview

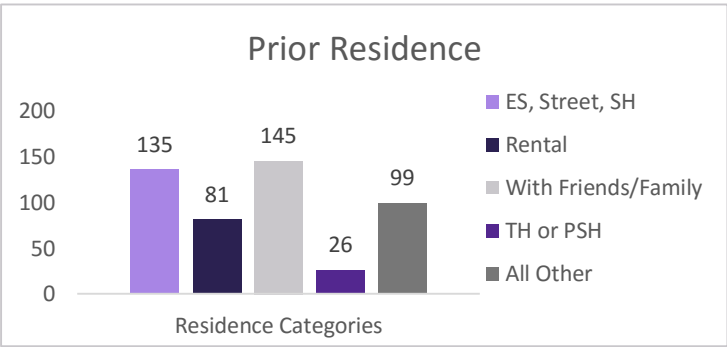
Between 10/1/2015 and 12/31/2015, providers in the Glen Falls/Saratoga Springs/Saratoga County CoC served 609 people experiencing or at risk of experiencing homelessness[i]. 409 people were served in residential programs, with an additional 200 served in supportive services only programs[ii].



There were 355 households without children (containing 365 individuals), 62 households with adults and children (containing 84 adults and 103 children), and 57 households with 57 unaccompanied minors[iii].

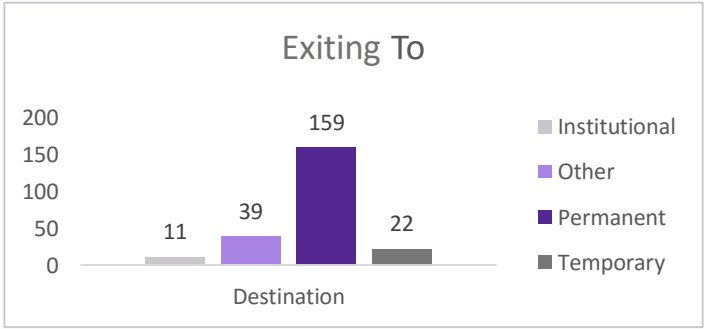
By gender, providers in the CoC served 268 (44%) women, 328 (54%) men and 11 (1.8%) trans-identified individuals.

The racial and ethnic breakdown of those served included 498 (82%) White, 90 (15%) Black or African-American, 2 (0.3%) Asian, 1 (0.2%) Native Hawaiian or Other Pacific Islander, 2 (0.3%) American Indian or Alaskan Native, and 6 (1%) Multiple Races. 38 (6%) individuals identified as Hispanic/Latino regardless of race.



Of 505 adults or heads of household, 135 (27%) indicated a prior residence of Emergency Shelter, the streets or Safe Haven. Of these clients, 68 (50%) reported no previous episodes of homelessness within the last three years while 44 (33%), 22 (16%), and 29 (21%) had been homeless 2, 3, or 4+ times (respectively) during the same time frame. 4 (3%) did not report on this data element.

For those adults or heads of household who were in program a year or more and received an annual assessment (36), 25 (69%) saw an increase in income (cash and cash benefits) between admission and the most recent update. An additional 4 (11%) saw no change in income that was initially higher than zero[iv].

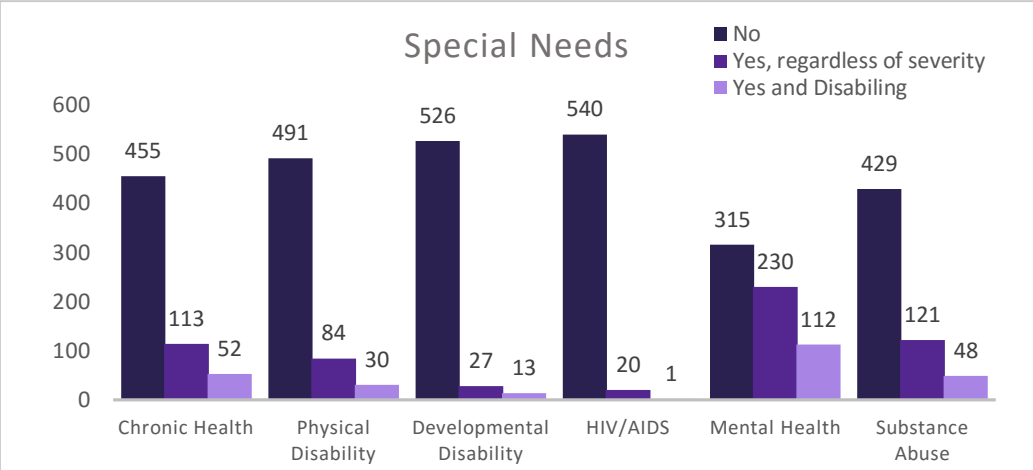


The total number of individuals discharged during the quarter was 234, which included 168 adults and 66 children. Income for 28 (17%)

clients over 18 rose between admission and discharge while 74 (44%) maintained stable income of greater than zero. Of 231 clients with known destinations, 159 (69%) were discharged to a permanent destination.

Special Needs

57% of adults (254/449) and 25% of children (40/160) self-reported at least one physical, emotional, or other health condition *regardless of whether the condition had become serious enough to be disabling*. Among those reporting multiple conditions, the most significant comorbidity was Mental Health and Substance Use (72). When taking severity of condition into account, 176 adults reported conditions that met the criteria to be considered a disability.



Sub-Populations

24 (5%) individuals over 18 met the criteria for chronic homelessness at the time of project entry, which included individuals who were admitted under the previous definition (*the percentage of clients considered chronically homeless is expected to decrease over time due to changes in the definition implemented by HUD which became effective in HMIS as of 10/1/15*).

1 out of every 4 adults receiving services this quarter was a veteran (25%). Out of the 112 veterans served, 39 (35%) reported a disabling condition and 6 (5%) met the criteria for chronic homelessness at admission.

System Performance Measures

On 1/1/16, HUD released 7 new System Performance Measures intended to leverage HMIS data in order to inform planning and track outcomes at the CoC-level. The measures will assist with assessing the overall success of community efforts to address, divert and end homelessness and include: number of homeless persons; number of first-time episodes of homelessness; length of time persons remain homeless; job and income growth during program stays and/or at discharge; placement in permanent destinations; returns to homelessness/recidivism. Additionally, these measures will play an important part in receiving and retaining Federal funding through the CoC Grant Competition.

Data quality and completeness play a major role in ensuring that the System Performance Measures accurately reflect the work being done within the CoC. CARES routinely tracks the health of HMIS data and this information may be found on www.caresny.org.

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[i] Data breakdowns for subsequent categories may total less than this number due to differences in data reporting across funders, as well as data completeness. For more information on data completeness, please see www.caresny.org

[ii] Programs included in this report listed on www.caresny.org. For the purposes of this report, any RRH enrollments are considered residential

[iii] Data based on current age and household composition, which may differ from information reported at admission

[iv] This measure includes individuals across all project types

Projects Included in Report

Emergency Shelter
CAPTAIN -- Malta Youth Center
CAPTAIN STEHP-Wait House STEHP Emergency Shelter
RPC Guardian House Emergency Beds
RPC Vets Emergency Bed Program
SOS Emergency Shelter Shelter
PH - Permanent Supportive Housing
AVH Perm Housing
City of Saratoga Springs Rental Assistance Program
OOCSWWC Community - Chronic
OOCSWWC Community - Families
OOCSWWC Community - Regular
OOCSWWC Community 2011
OOCSWWC Housing First - Chronic
OOCSWWC Housing First - Regular
OOCSWWC Shelter Plus Care 2010
RPC Center Street
RPC Northern Pines
Support Ministries - Ahana House
TSA MICA Supportive Housing
WWAMH Housing First Program
Transitional Housing
AVH Vets House
RPC Guardian House
RPC Vets House Program
Wait House TLP
Homelessness Prevention
Captain STEHP Program Prevention
CAPTAIN STEHP-Wait House Prevention
Legal Aid STEHP - Saratoga Washington Warren Prev
RPC SSVF Prevention
PH - Rapid Re-Housing
Captain STEHP Program
CAPTAIN STEHP-Wait House Rapid Rehousing
Captain STEPH Program Rapid Rehousing
RPC SSVF Program Rapid Rehousing
Services Only Program
HYC-SHP
Street Outreach
CAPTAIN RHY Outreach