# Saratoga-North Country Continuum of Care
# Strategic Plan

## Contents

## Executive Summary

The Saratoga-North Country (SNC) Continuum of Care (CoC) is a group of providers and community members dedicated to preventing and reducing homelessness in the Saratoga-North Country region. SNC is the Continuum of Care for Saratoga, Warren, Washington, and Hamilton Counties in New York State, a Housing and Urban Development (HUD) designated local planning body that coordinates housing and services funding for homeless families and individuals. In order to collectively address homelessness in the most efficient and effective ways, SNC embarked on a strategic planning process between 2017 and 2018. The resulting Strategic Plan will guide the work of the SNC over the next three years (2019 – 2021).

In order to create the Strategic Plan, SNC created a Strategic Planning Committee that worked to implement a community-based and data-informed process. The Strategic Planning Committee hosted forums with a variety of local service providers and community stakeholders to determine the most pressing local homelessness needs, and how SNC can best move forward to address those needs. The Strategic Planning Committee analyzed data from the Homeless Management Information System (HMIS), which captures information on those who are homeless and access programs throughout the SNC catchment area, as well as from providers who do not enter their data into HMIS.

The results of the strategic planning process led the SNC to focus on the following key areas to address homelessness in the local community:

> Goal #1: Increase awareness among homeless housing and service providers and clients of necessary support services available in the community.
> Goal #2: End chronic homelessness in the community.
> Goal #3: Swiftly and successfully connect those who are homeless and have mental illnesses to housing and support services, reducing homelessness among those with mental illnesses.
> Goal #4: Swiftly and successfully connect homeless families and unaccompanied youth to housing and support services, reducing homelessness among these populations.
> Goal #5: Increase transportation options and accessibility for those who are homeless or at-risk of homelessness to improve access to housing and employment opportunities.
> Goal #6: Engage existing and new partners in the SNC Continuum of Care in order to creatively and successfully as a community implement the Strategic Plan.

The SNC Strategic Plan will largely be carried out by SNC committees and members, with an effort to inclusively engage community partners and stakeholders. By implementing specific action items related to each of these goals, SNC feels it will make significant strides towards realizing its vision of a community that has ended homelessness in the four-county region by providing a continuum of housing and support services for those at-risk of homelessness and to those who are chronically homeless.

## Description of Saratoga-North Country CoC

The Saratoga-North Country (SNC) Continuum of Care (CoC) is the CoC for Saratoga, Warren, Washington, and Hamilton Counties in New York State, a Housing and Urban Development (HUD) designated local planning body that coordinates housing and services funding for homeless families and individuals. SNC is dedicated to preventing and reducing homelessness by ensuring an effective system of care and services is in place for the area. SNC has an open membership policy and actively welcomes and recruits stakeholders who seek to collaboratively address homelessness. SNC members include emergency shelters and housing providers, municipal representatives, systems of care stakeholders, community members, and persons who are or who have been homeless. Together, each member brings their expertise and talents to the conversation as the SNC strives to educate our community on homelessness and connect persons in need to necessary supports.

SNC operates with a Board of Directors, is supported by a lead planning agency/Collaborative Applicant (CARES of NY, Inc.), and hosts two full membership meetings a year. As the local CoC, SNC annually applies for and is awarded CoC funding from HUD. In 2017, the CoC was awarded over $1.3 million for homeless housing, services, planning, and data collection. In addition to annually applying for CoC funding, in order to carry out the SNC purpose to prevent and reduce homelessness, , seven committees currently operate:

1. **Saratoga County Housing Committee:** This committee is responsible for conducting an annual Point in Time (PIT) count, assisting the Collaborative Applicant in preparing and submitting the Continuum of Care (CoC) application, conducting homeless awareness activities, participating in local planning, and any other activities identified and voted on by the membership, specific to the Saratoga County region. This committee meets monthly and membership is open.
2. **Warren/Washington/Hamilton County Housing Committee:** This committee is responsible for conducting an annual Point in Time (PIT) count, assisting the Collaborative Applicant in preparing and submitting the Continuum of Care (CoC) application, conducting homeless awareness activities, participating in local planning, and any other activities identified and voted on by the membership, specific to the Warren, Washington, and Hamilton Counties region. This committee meets monthly and membership is open.
3. **Coordinated Entry Committee:** This committee is responsible for implementing and monitoring the coordinated entry system. This system prioritizes the most vulnerable persons in need of housing, and connects them with the most appropriate housing to meet their needs. This committee meets monthly.
4. **NOFA Committee**: This committee manages the annual local CoC rank and review process to prioritize homeless housing and service projects for CoC funding, as part of the annual HUD CoC application.
5. **Data and Goals Committee:** This committee monitors and evaluates program performance of CoC-funded agencies, encourages participation among members in the Homeless Management Information System (HMIS), and monitors to ensure quality data.
6. **Strategic Planning Committee:** This committee is responsible for reviewing, preparing, and overseeing implementation of the SNC Strategic Plan.
7. **HMIS Advisory Committee:** This committee works with the Homeless Management Information System (HMIS) system administrator to ensure proper and effective HMIS policies and procedures.

The SNC also participates on the **Capital Region Advisory Committee on Youth Homelessness**, which spans multiple CoC's and has a mission to provide leadership, develop, advocate, and coordinate community strategies to accurately count homeless youth.

## SNC Mission and Vision

The mission of the Saratoga-North Country (SNC) Continuum of Care (CoC) is to engage our community (Saratoga, Warren, Washington, and Hamilton Counties) in addressing homelessness by: 1) identifying gaps and needs that contribute to housing instability, 2) implementing programs to address identified needs, 3) collecting and analyzing data to better understand homelessness and the impact of interventions, and 4) increasing awareness about homelessness, housing instability and issues of poverty throughout the community. The vision of the SNC is a community that has ended homelessness in the four-county region by providing a continuum of housing and support services for those at-risk of homelessness to those who are chronically homeless. SNC will know the community has ended homelessness once the community reaches "functional zero." SNC defines functional zero in accordance with the national strategic plan to prevent and end homelessness, *Home Together*. As such, SNC will know it has ended homelessness when the community has a comprehensive response in place that ensures homelessness is prevented whenever possible, or if it can't be prevented, it is a rare, brief, and non-recurring experience. Specifically, the community will have the capacity to:

- Quickly identify and engage people at risk of and experiencing homelessness.
- Intervene to prevent the loss of housing and divert people from entering the homelessness services system.
- When homelessness does occur, provide immediate access to shelter and crisis services, without barriers to entry, while permanent stable housing and appropriate supports are being secured.
- Quickly connect people to housing assistance and services—tailored to their unique needs and strengths—to help them achieve and maintain stable housing.

## Purpose of the SNC Strategic Plan

The purpose of the Saratoga-North Country (SNC) Strategic Plan is to guide the work of the SNC to address homelessness in the most efficient and effective ways over the next three years (2019 – 2021). The plan is specific, yet flexible, and will be a living and breathing action plan, adjusted as needs in the community change.

In addition, SNC pursued strategic planning for the following reasons:

- To ensure the diverse group of independent organizations who make up the Continuum of Care (CoC) are on the same page about what CoC goals the CoC is collectively working towards.
- The plan will hold Membership, Committees and agencies accountable. It will have in writing who agreed to do what.
- HUD recommends that CoCs have a local planning document to guide their work.

- The Strategic Plan can be used to write grant applications and promote the work of the CoC to funders and outside stakeholders.
- The process of developing the Strategic Plan can engage new stakeholders to participate in the CoC, and existing stakeholders to participate in new ways.

## Strategic Planning Process

The Saratoga-North Country (SNC) Continuum of Care (CoC) started its strategic planning process in May 2017. The SNC Board, with support from CARES, led a forum during the semi-Annual Membership meeting to identify initial ideas about needs and assets related to homelessness in the community. From there, a Strategic Planning Committee was formed, made up of a variety of CoC members[1]. The Strategic Planning Committee began by reviewing local community plans to identify needs related to homelessness. The Strategic Planning Committee then utilized the information collected during the semi-Annual Membership meeting and from local plans to establish four focus points moving forward:

1. Support Services
2. Chronic Homelessness
3. Youth and Family Homelessness
4. Transportation

The Strategic Planning Committee then planned and hosted two public community forums in January 2018 – one in Saratoga Springs, and one in Glens Falls. The purpose of these forums was to gather feedback on needs and assets related to homelessness as it relates to each of the above four focus areas. Together there were over 100 people in attendance. Attendees included homeless housing and service providers, health care providers, housing authorities, faith-based organizations, community centers, state and local governments, universities, libraries, community members, and persons with lived homelessness experience. Attendees worked through four stations – one on each topic – and discussed the following questions at each:

1. What are gaps/barriers in the community related to the topic area and homelessness?
2. What are assets in the community related to the topic area and homelessness?
3. Keeping in mind the assets listed, what are solutions to the gaps/barriers identified?

The Strategic Planning Committee utilized this feedback to prioritize needs and solutions the CoC can prioritize over the next three years to most efficiently and effectively address homelessness. The Strategic Planning Committee developed goals, strategies and action items based on these priorities. The Strategic Planning Committee then utilized data on homelessness from the Homeless Management Information System (HMIS), Point-In-Time (PIT) Count, Housing Inventory Chart (HIC), and quantitative and qualitative information from agencies who do not enter into HMIS to confirm the goals, strategies, and action items.. The Strategic Planning Committee settled on six overarching themes to focus on in the plan:

1. Support Services
2. Chronic Homelessness

[1] See Appendix II, *SNC Strategic Planning Committee Members*

3. Persons who are Homeless and have Mental Illnesses
4. Youth and Family Homelessness
5. Transportation
6. Growing the SNC CoC to carry out the Strategic Plan

The Strategic Planning Committee completed the Strategic Plan by adding measures of progress and responsible parties to complete the work outlined in the plan. The Strategic Planning Committee finished the draft Strategic Plan in January 2019. The Strategic Plan was presented to the CoC Board in January 2019. The Plan was sent to Membership for open comment and adopted by Membership during the semi-Annual Membership meeting in March 2019.

## Overarching Picture of Homelessness in Saratoga – North Country

The Saratoga-North Country (SNC) Continuum of Care (CoC) covers Saratoga, Warren, Washington, and Hamilton counties, covering a vast area of Northeastern New York that includes some small city centers, but mostly suburban and rural areas. In fact, much of Hamilton County extends into the Adirondack Mountains. Many of the city centers in the area suffer from a high rental market, making it challenging for middle-income workers to find housing, and nearly impossible for those who are low-income or homeless without the support of housing vouchers and/or programs. The rural nature of the area and high market rents are two of the primary characteristics that make addressing homelessness in this area unique and challenging.

### Overall Homelessness in SNC

According to the 2018 Point-In-Time Count[2], 257 persons in 237 households were homeless in the SNC area on a given night. While this is a significant number of homeless persons, this is likely an undercount due to the rural nature of the area. Of those homeless persons counted on the night of the count, 24 were children (under the age of 18), 14 were youth (ages 18-24), and 16 were chronically homeless. A majority of these households were sheltered, with 23 persons counted as unsheltered, or not living in a place meant for human habitation, on the night of the count[3].

### Sheltered Homelessness in SNC

The community has a total of 78 year-round emergency shelter beds and approximately 73 seasonal emergency shelter beds[4]. Of those year-round emergency shelter beds, the following number of beds were dedicated to specific subpopulations:

- Victims of Domestic Violence: 18 (23% of all year-round emergency shelter beds)
- Veterans: 14 (18%)
- Youth: 8 (10%)
- Persons with Serious Persistent Mental Illness: 2 (3%)

[2] The Point-In-Time (PIT) Count is a HUD mandated count of everyone who presents as homeless on one day of the year in January. The Count consists of both a Sheltered PIT Count (those who are staying in shelters or hotels/motels) and an Unsheltered PIT Count (those staying in places not meant for human habitation). SNC conducts the Unsheltered PIT Count by hosting outreach teams who conduct surveys with those on the street.
[3] Saratoga-North Country 2018 Point-In-Time Count
[4] Saratoga-North Country 2018 Housing Inventory Chart

Agencies that currently provide year-round or seasonal emergency shelter beds include:

- CAPTAIN Youth and Family Services
- Catholic Charities of Warren, Washington & Saratoga Counties
- Shelters of Saratoga
- Open Door
- Veterans & Community Housing Coalition
- WAIT house
- Warren-Washington Association for Mental Health
- Wellspring

Local Departments of Social Services also provide vouchers for emergency shelter in hotels/motels. During the 2018 Point-In-Time Count, 75 people were provided emergency housing in hotels/motels[5].

The average length of time a person remained homeless in the SNC area in 2017 while in shelter was 41 days[6]. Almost 30% of persons who exited Emergency Shelter in 2015 returned to homelessness at some point by 2017[7].

## Transitional and Permanent Housing for those Previously Homeless in SNC

According to the 2018 Housing Inventory Chart (HIC), the community currently has 32 transitional housing beds, 71 rapid rehousing beds, and 236 permanent supportive housing beds. Of those permanent housing beds (rapid rehousing and permanent supportive housing), the following number of beds were dedicated to specific subpopulations:

- Veterans: 106 beds (35% of all permanent housing beds)
- Victims of Domestic Violence: 49 beds (16%)
- Youth: 25 (8%)
- Persons with Serious Persistent Mental Illness: 18 (6%)

Agencies that currently provide permanent housing dedicated to homeless persons include:

- Adirondack Vets House
- CAPTAIN Youth and Family Services
- Glens Falls Housing Authority
- Support Ministries
- Transitional Services Associates
- Veterans & Community Housing Coalition
- Veterans Administration
- WAIT House
- Warren-Washington Association for Mental Health
- Wellspring

[5] Saratoga-North Country 2018 Housing Inventory Chart
[6] HMIS System Performance Measures, NY-523 – Glens Falls/Saratoga Springs/Saratoga County CoC for the operating year 01/01/2017 to 12/31/2017, Metric 1b, Person sin ES, SH and PH.
[7] HMIS System Performance Measures, NY-523 – Glens Falls/Saratoga Springs/Saratoga County CoC for the operating year 01/01/2017 to 12/31/2017, Metric 2b, Return to Homelessness within 24 months.

Of those who accessed permanent supportive housing in 2017, 92% percent retained housing or successfully moved to another permanent housing destination upon discharge[8]. While almost 30% of persons who exited Emergency Shelter at a point in time returned to homelessness within two years[9], only one person who was housed in permanent housing returned to homelessness within two years[10]. These statistics exemplify the success and importance of SNC's permanent housing program in supporting housing stability for those who were previously homeless. As such, with additional permanent housing, SNC anticipates the ability to decrease the average length of stay in shelter and returns to homelessness.

## Making the Case for the Selected SNC Strategic Plan Goals

In reviewing the picture of homelessness in the community, including both data, outcomes of community forums, and discussing Strategic Planning Committee members' experiences addressing homelessness, the Strategic Planning Committee identified the six most pressing needs the CoC will focus on addressing over the next three years:

> Goal #1: Increase awareness among homeless housing and service providers and clients of necessary support services available in the community.
> Goal #2: End chronic homelessness in the community.
> Goal #3: Swiftly and successfully connect those who are homeless and have mental illnesses to housing and support services, reducing homelessness among those with mental illnesses.
> Goal #4: Swiftly and successfully connect homeless families and unaccompanied youth to housing and support services, reducing homelessness among these populations.
> Goal #5: Increase transportation options and accessibility for those who are homeless or at-risk of homelessness to improve access to housing and employment opportunities.
> Goal #6: Engage existing and new partners in the SNC Continuum of Care in order to creatively and successfully as a community implement the Strategic Plan.

The purpose behind prioritizing each of these goals is described in the following sections.

### Increasing Awareness of Support Services

One of the areas identified for prioritization by SNC in order to best address homelessness is increasing awareness of support services available for those who are at-risk of or who are homeless. Exemplifying this need, Shelters of Saratoga conducted a survey of 51 homeless persons in January 2017; 62% of those surveyed reported they did not receive government money,[11] and thus were not connected to resources such as the Department of Social Services Shelter Allowance, Supplemental Security Income (SSI), or Social Security Disability Insurance (SSDI). Moreover, during the Strategic Planning community forums , participants reiterated the need to better promote access to existing support services. For example, participants reported support services are often siloed, and there is a need for a centralized source of information on support services available to potential clients – particularly services provided during irregular hours. It was also recommended the CoC engage ad hoc or informal support service programs that offer valuable resources, such as faith-based organizations and schools. During the Strategic Planning community

[8] HMIS System Performance Measures, NY-523 – Glens Falls/Saratoga Springs/Saratoga County CoC for the operating year 01/01/2017 to 12/31/2017, Metric 7b.2, % successful exits/retention.
[9] HMIS System Performance Measures, NY-523 – Glens Falls/Saratoga Springs/Saratoga County CoC for the operating year 01/01/2017 to 12/31/2017, Metric 2b, Return to Homelessness within 24 months.
[10] HMIS System Performance Measures, NY-523 – Glens Falls/Saratoga Springs/Saratoga County CoC for the operating year 01/01/2017 to 12/31/2017, Metric 2b, Return to Homelessness within 24 months.
[11] Shelters of Saratoga Registry Week Results.

forums, it was also noted that SNC can pursue enlisting volunteers in a more robust way. For example, members of faith-based communities have been participating in CoC meetings and identifying areas where the faith-based community could provide necessary supports – such as transportation to support services or health appointments. The community also reported the need for increasing support services such as a place to receive mail and keep personal belongings, employment training, financial literacy, mental health services, coordination of care, and transportation.

### Ending Chronic Homelessness

Another area identified by SNC for prioritization in order to best address homelessness is ending chronic homelessness. Chronic homelessness is defined as a household who has been homeless for twelve consecutive months or who has been homeless on four or more occasions totaling twelve months over three years. The head of household must also have a disabling condition in order for the household to be considered chronically homeless. According to the 2018 Point-In-Time (PIT) Count, 16 persons were chronically homeless in the community on the night of the count. The Homeless Management Information System (HMIS) showed that in 2017 4% of homeless persons in emergency shelters were chronically homeless (18 persons)[12], likely an undercount given local Departments of Social Services do not enter into HMIS. While a majority of homeless persons in the community are not chronically homeless, the CoC believes prioritizing those with the highest needs and longest histories of homelessness will benefit the community for a number of reasons. First, it is important to focus on serving this population as the chronically homeless are among the most vulnerable of all those experiencing homelessness in the community. Given the cost and scarcity of permanent supportive housing, the community must be deliberate in targeting these intensive programs to those in greatest need. Second, those experiencing chronic homelessness tend to cycle in and out of emergency departments, detox programs, jails, prisons, and psychiatric institutions, costing taxpayers as much as $30,000 to $50,000 per person per year[13]. Similarly, those who are chronically homeless tend to utilize more community and program services and resources than other populations. Thus, focusing on serving this population initially will allow the community to free valuable resources for a greater number of homeless individuals in the future. Finally, prioritizing the chronically homeless aligns with HUD priorities and directives, as noted in the federal plan to end homelessness, *Home Together.*

### Reducing Homelessness Among Those with Mental Illnesses

Another area identified by SNC for prioritization in order to best address homelessness is reducing homelessness among those with mental illnesses. Both quantitative and qualitative data show that a preponderance of singles in the shelter system have a serious mental illness. According to the Homeless Management Information System (HMIS), of those who were served in the emergency shelter system in 2017, 47% had a serious mental illness – the highest percentage among any subpopulation tracked in HMIS[14]. Moreover, those with serious mental illnesses stayed an average of 43 days in shelter and 50% exited to unstable/negative housing destinations[15]. Part of the reason for this length of stay and exits to negative housing destinations is the lack of supportive housing dedicated to persons with serious mental illnesses in the community. Transitional Services Association (TSA) provides 51 permanent housing beds for persons with mental illnesses. While these units are not dedicated to persons who are homeless, those who are homeless are prioritized

[12] See Appendix IV, *HMIS Data*.
[13] *Ending Chronic Homelessness in 2017,* United States Interagency Council on Homelessness, https://www.usich.gov/resources/uploads/asset_library/Ending_Chronic_Homelessness_in_2017.pdf
[14] See Appendix IV, *HMIS Data*.
[15] See Appendix IV, *HMIS Data*.

for housing. Currently only 6% of permanent housing beds for the homeless in the community are dedicated to persons with severe and persistent mental illnesses[16], and these programs have long waitlists. Providers have reported that often while homeless persons with mental illnesses wait for housing placement, they suffer from decompensation and, as a result, leave emergency housing.

In addition to this data, during the Strategic Planning community forums the community verified the need to focus on serving those with mental illnesses. Specifically, during the community forum with CoC Membership, numerous providers reported the lack of mental health providers (both therapists and psychiatrists/prescribers) who accept Medicaid in the region. As a result, some providers have driven hours with their clients in order to connect them with a mental health provider who can prescribe necessary medication[17]. Lack of access to mental health providers not only puts clients at risk, it also makes it challenging for providers to support clients in gaining disability documentation, a necessity for entering permanent supportive housing. Access to permanent supportive housing is essential for this population, as often this population requires ongoing support services for mental health treatment, physical health care, education and employment opportunities, peer support, daily living skills and money management training. Without these supportive services the ability of this population to gain and stay in effective treatment programs, maintain their housing and migrate into the community is unlikely.

### Reducing Homelessness Among Families and Unaccompanied Youth

Two additional areas identified by SNC for prioritization in order to best address homelessness are reducing homelessness among families and unaccompanied youth.

***Homeless Unaccompanied Youth***

For the purposes of this plan, "unaccompanied youth" are those individuals that are not in the direct custody of a parent or guardian; and "homeless youth" are those individuals, aged 13-24, with no adequate nighttime residence, who are staying in a nighttime residence that was designed for temporary living, who are living in a shelter or residential Runaway and Homeless Youth (RHY) programs, and/or who are staying in public or private places not meant for accommodating human beings. Gaining an accurate picture of youth homelessness is notoriously challenging, as homeless unaccompanied youth are hard to track; many homeless youth do not engage in services and bounce from location to location. However, by assessing utilization of current youth housing and service programs in the community, it is evident there is a significant need for additional housing and services specific to homeless unaccompanied youth. In the SNC area, there are currently 16 emergency housing beds dedicated to homeless unaccompanied youth (8 through CAPTAIN Community Human Services in Saratoga County for youth ages 13-17; and 8 through WAIT House in Warren County that serves youth ages 16-20[18]). There are currently only two Transitional Living Programs (TLPs) in the entire Capital District, a 7,228 mile region, and only 8% (25 beds) of all permanent housing in SNC is dedicated to youth[19]. By contrast, in 2017, CAPTAIN had 79 and WAIT House had 73 unduplicated admissions to their youth shelters[20]. It is estimated that approximately 12 – 20 youth are placed on the waitlist for these programs annually using program data from the last three years, showing a need to more quickly connect youth with permanent housing. Moreover, the 2017 Youth Point-In-Time (PIT) Count showed there were 59 unaccompanied youth ages 18-24

[16] Saratoga-North Country 2018 Housing Inventory Chart
[17] See Appendix III, *Community Forums Summaries*.
[18] Saratoga-North Country 2018 Housing Inventory Chart
[19] Saratoga-North Country 2018 Housing Inventory Chart
[20] Homeless Management Information System (HMIS), CAPTAIN and WAIT House Youth Shelters Reports, unduplicated admissions within each program.

in shelters throughout the Capital District on the night of the count[21]. This count also showed that on a single night there are as many as 60 homeless or unstably housed youth according to survey results. New York State Education data shows that during the 2016-2017 school year, 1,027 students were homeless or unstably housed in Saratoga, Warren, and Washington Counties[22]. Finally, utilization of CAPTAIN's street outreach program also exemplifies a need for housing dedicated to homeless youth in the community. Specifically, in 2017 CAPTAIN made contact with homeless, runaway, or at-risk of becoming homeless, street-involved and/or disenfranchised youth 4,738 times.

In addition to the number of homeless youth in the region, SNC is prioritizing homeless unaccompanied youth as this population has specific, specialized needs that require ongoing, tailored services. For example, homeless unaccompanied youth are more susceptible to exploitation, human trafficking, and participating in "survival sex" as a means to find housing. In 2017 in Saratoga County alone, there were 229 referrals to the Safe Harbor Anti-Trafficking Program for information, possible cases, and victim assistance for youth less than 18 years old. These youths routinely suffer from persistent, unregulated mental health issues, physical health issues, or other co-occurring issues that make maintaining stable housing a challenge.

***Homeless Families***

Another area identified by SNC as a prioritized need is family homelessness. Between January and June of 2017, Washington County provided emergency housing to 86 people in families – accounting for over 70% of clients to whom Washington County DSS provided emergency housing[23]. Over the same time period, Warren County provided emergency housing to 59 people in families[24]. Over the course of 2017, Family Services Association provided housing assistance to 20 families at risk of homelessness[25], and North Country Ministry supported 29 families in staying in hotels/motels for a week at a time[26]. Homeless families face unique challenges in the SNC region, as there are no family shelters. As a result, families are housed in hotels/motels by Departments of Social Services (DSS), and provided varying levels of support in moving on. Families housed in hotels/motels face challenges meeting DSS requirements, such as performing apartment and job searches, as often families don't have access to childcare, transportation, or computers. Once a family finds appropriate housing that is within the DSS budget, they must collect funding to suffice the security deposit, and few agencies in the area have funding to support security deposits. In addition, without designated family shelters, families tend to access community or faith-based organizations that provide housing and support services, such as Family Service Association, Hamilton Warren Community Action, and North Country Ministry. While these organizations play a vital role in preventing and reducing homelessness among families, the demand for services and funding outweighs resources of community organizations.

Another reason for prioritizing family homelessness is the interrelationship between family homelessness and domestic violence. According to Wellspring, one of two domestic violence service

[21] The Capital Region Advisory Board on Youth Homelessness hosted a Point-in-Time Count in October, 2018. The count consisted of three distinct data sources: a locally developed survey tool to capture homeless and unstably housed youth on the street; the Homeless Management Information System (HMIS) to capture youth in shelter on the night of the count; and data from school McKinney-Vento Homeless Liaisons.

[22] NYS Technical and Education Assistance Center for Homeless Students

[23] Washington County Department of Social Services reported to the SNC Strategic Planning Committee that they housed 123 persons, 86 of whom were in families, between January and June 2017.

[24] Warren County Department of Social Services reported to the SNC Strategic Planning Committee that they housed 271 persons, 59 of whom were in families, between January and June 2017.

[25] Family Services Association reported to the SNC Strategic Planning Committee.

[26] North Country Ministry reported to the SNC Strategic Planning Committee.

providers in the area, families account for 35%[27] of households served by the agency. Domestic violence is the number one cause of homicide in Saratoga County, exemplifying the importance of focusing on this issue.

While the numbers on family housing presented above report a smaller overall picture of homelessness than that depicted of singles, these numbers are also unscientific. Without a family shelter, and without family providers participating in a single data collection system, such as HMIS, it is impossible to quantify the number of homeless families in the region. It is from this lack of clear quantitative data that the CoC fears, pulling on experience, that the need is much greater than the numbers reflect. For this reason, the CoC will prioritize addressing family homelessness in the community, as well as gaining a more accurate picture of family homelessness over the next three years.

### Increasing Transportation Options

An additional area identified by SNC for prioritization in order to best address homelessness is increasing transportation options for those who are homeless or at-risk of homelessness. During the CoC's Strategic Planning community forums, lack of access to transportation was an issue repeatedly brought-up, even when focusing on the other priority areas in the plan. As noted above, towns and villages in the area are spread out and separated by great distances, making it hard to access necessary support services, housing, and employment opportunities. Further, there is no public transportation in outlying communities. Housing that is located on a bus line have higher rents, and Medicab scheduling was reported as being onerous and unreliable[28]. For these reasons, pursuing creative ways to increase access to transportation for those who are homeless or at-risk of becoming homeless is essential to reducing homelessness.

## Engage existing and New Partners in the SNC Continuum of Care

In order to achieve any of the above goals, it is important that the SNC CoC continue to grow in membership. As noted above, during the CoC Strategic Planning community forums, it was noted that there are many important, informal providers throughout the community who the CoC could better connect with to problem-solve, such as the faith-based community and schools. Moreover, implementation of this plan will require the ongoing and new participation of community members dedicated to ending homelessness. The CoC Strategic Planning community forums showed engaging new partners to help implement the plan is a possibility, as the forums were attended by a variety of stakeholders, community members and persons with lived homelessness experience, all of whom were eager to continue the conversation. What's more, throughout this planning process the CoC grappled with accessing data from numerous providers in order to inform the most pressing needs related to homelessness. As such, it became clear that engaging partner providers in participating in the Homeless Management Information System (HMIS) will allow the community to more easily and accurately identify needs related to homelessness in the future. Finally, the CoC will need to engage other systems of care, including the criminal justice, foster care, health, and mental health systems, all of which have the opportunity to reduce homelessness in the community by decreasing discharges to homelessness. Finally, engaging affordable housing providers will create more housing opportunities for homeless and previously homeless persons the SNC seeks to serve.

[27] Wellspring reported to the SNC Strategic Planning Committee.
[28] See Appendix III, *Community Forums Summaries*.

## Implementation of the Plan

The Saratoga-North Country (SNC) Strategic Plan will largely be carried out by SNC committees and members, with an effort to inclusively engage community partners and stakeholders. In order to carry out such work, SNC is aware that committees will need to grow in membership and attendance, and the first action item for every committee in implementing the addendum will be to engage new staff members and agencies throughout the community to get involved with SNC in a strategic way. The CoC will also pursue development of an Affordable Housing Committee, engaging affordable housing partners to discuss and promote this important community resource in a coordinated fashion; and an Outreach Committee, which will pursue action items related to engaging new partners, such as those in the criminal justice, foster care, health, and mental health systems. Committees will develop timeframes/target completion dates for each action item tasked to them.

It is important to note that in carrying out the SNC Strategic Plan, SNC Committees will promote meeting the needs of those least likely to access services and/or who have historically faced discrimination in accessing services. Specifically, the SNC work will align with HUD's Equal Access to Housing Final Rule and Equal Access in Accordance with Gender Identity Final Rule, ensuring clients are able to access housing in accordance with client-choice, regardless of sexual orientation or gender identity. In addition, SNC will work to ensure there are not disparities in service provisions related to race or ethnicity.

The SNC Strategic Planning Committee will monitor the work associated with each goal every six months, ensuring that SNC is working towards its goal to end homelessness. The Strategic Planning Committee will provide a report on progress to the SNC Board semi annually as well. The Strategic Plan will be a living and breathing document, and will be edited by the Strategic Planning Committee as changes in the community or realizations through implementation occur.

# Workplan

## Goal #1: Increase awareness among homeless housing and service providers and clients of necessary support services available in the community.

Measure of Progress: Providers feel more aware of necessary resources in the community, according to a CoC survey.

Context: During the Strategic Planning community forums, participants reiterated the need to better promote access to existing support services. While participants also reported the need for increasing support services in the community, SNC will focus on promoting access to existing support services as a more realistic and achievable goal. Any increase of support services will be accomplished through promotion of volunteer opportunities.

| Strategy | Action Item | Responsible Party | Timeframe |
|---|---|---|---|
| 1. Ensure providers and clients are aware of all resources in the community. | a. Ensure creation of a Resource Guide that is easy to access and update.<br>i. Warren/Washington/Hamilton: work with Crandall Library to ensure SANG is accurate and comprehensive. Provide feedback on accessibility and user-ability after it is rolled out.<br>ii. Saratoga: consider fundraising/partnering to create a system similar to SANG. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| | b. Promote community Resource Guides to providers, neighboring CoCs, United Way 211, police/sheriff, library staff, volunteers, schools, Departments of Social Services, etc. by sending to contact lists, creating postcards, and purchasing TV and Radio PSA's. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| 2. Increase capacity of agencies to provide necessary resources. | a. Incorporate into Resource Guides opportunities to and eligibility for volunteering. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |

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| | b. Promote volunteer opportunities to the faith-based community, retirees, etc. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |

## Goal #2: End chronic homelessness in the community.

Measures of Progress:

(1) Number of chronically homeless persons in shelter over the course of three years reduces from 18[29] to 5 persons according to HMIS data[30].
(2) Length of stay for chronically homeless persons in shelter reduces from 55 days[31] to 40 according to HMIS data.
(3) Successful placement from shelter to housing for previously chronically homeless persons increases from 56%[32] to 60% according to HMIS data.

Context: While a majority of homeless persons in the community are not chronically homeless (in 2018 4% of those reported in shelter were chronically homeless, as reported in HMIS[33]), prioritizing those with the highest needs and longest histories of homelessness will benefit the community by freeing valuable resources for a greater number of homeless individuals in the future. SNC will end chronic homelessness in the community by continuing to improve the Coordinated Entry System, promoting Housing First among permanent housing providers, promoting development of housing dedicated to those who are chronically homeless, and ensuring ongoing support services are available for those who have been chronically homeless.

| Strategy | Action Item | Responsible Party | Timeframe |
|---|---|---|---|
| 1. Continue to develop the Coordinated Entry System to prioritize the most vulnerable persons based on community need. | a. Reallocate CoC funding or apply for foundation funding to create a paid Coordinated Entry Coordinator position.<br>1. Work with United Way to identify potential funders for a Coordinated Entry Position and write application.<br>2. Reallocate funding to a Coordinated Entry position through the CoC Rank & Review process. | Board, CE Committee | |
| | b. Identify a lead agency to manage the Coordinated Entry Coordinator. | Board | |
| | c. Consider utilizing HMIS to manage Coordinated Entry applications and waitlist. | CE Committee | |

[29] See Appendix IV, *HMIS Data*.
[30] SNC strives to create a community with 0 chronically homeless persons within five years.
[31] See Appendix IV, *HMIS Data*.
[32] See Appendix IV, *HMIS Data*.
[33] See Appendix IV, *HMIS Data*.

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| | d. Update and implement the Marketing Plan to ensure Coordinated Entry is promoted and accessible to those least likely to apply. | CE Committee | |
| | e. Identify and implement methods to create more flow on the Coordinated Entry waitlist. | CE Committee | |
| 2. Identify specific needs and increase shelter opportunities/capacity for those who are chronically homeless. | a. Identify specific chronic homeless housing needs utilizing HMIS and Coordinated Entry data. | Data and Goals Committee (collect and assess data)<br><br>Warren-Washington-Hamilton Housing Committee (review data and brainstorm)<br><br>Saratoga Housing Committee (review data and brainstorm) | |
| | b. Engage faith-based organizations to identify resources for increasing shelter beds (i.e. Pine Hills Alliance Church is creating an 8-bed shelter for men). | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| 3. Engage the criminal justice, health, and mental health systems to prevent discharges to homelessness, or when discharges to homelessness are inevitable, create a planned path to emergency housing and services. | a. See Goal #6, Strategy #3. | Outreach Committee | |

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| 4. Promote utilizing a Housing First approach among homeless housing providers. | a. Host trainings on the Housing First model. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| | b. Monitor CoC- and ESG-funded agencies to ensure implementation of the Housing First Model using HUD's Housing First Assessment Tool. | Data and Goals Committee | |
| 5. Develop more Permanent Housing and/or Affordable Housing with a set-aside for those who are chronically homeless. | a. Encourage agencies to apply for state funding (HCR, ESSHI, HHAP) to increase the number of permanent housing and affordable housing beds. | Board | |
| | b. Partner with existing support service resources (i.e. Health Homes, Managed Care Organizations) to provide support services onsite at affordable housing developments. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee<br><br>(In communication with CE Committee) | |
| | c. Identify ways to increase public understanding and acceptance of homelessness and permanent housing and affordable housing programs in order to prevent NIMBYism during development. For example, promote data in ALICE report. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| 6. Support those who are chronically homeless with funding for security deposits. | a. Explore opportunities for increasing funding to support security deposits, including engaging landlords to repay security deposits once clients have moved and educating clients about the need to save for security deposits. Educate tenants, landlords and providers on the security deposit refund process, timeframe, billable items, and the court process for acquiring those funds back should they not be returned. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |

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| | b. Explore development of a tool to prioritize prevention funding. | CE Committee | |
| | c. Explore all avenues for potential prevention funding, including federal, state (i.e. STEHP), local, and foundations. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| | d. Advocate at the state and federal level for additional funding for prevention services. | Board | |
| 7. Research and consider alternative housing options for the chronically homeless. | a. Research and consider alternative housing options for the chronically homeless, including: identifying specific campsites for those who are homeless and providing necessities such as sewer/water line; creating tiny houses. | Glens Falls Housing Authority, who will report to Membership semi-annually. | |

## Goal #3: Swiftly and successfully connect those who are homeless and have mental illnesses to housing and support services, reducing homelessness among those with mental illnesses.

Measures of Progress:

(1) Number of homeless persons with severe and persistent mental illnesses (SMI) in shelter over the course of a year reduces from 236[34] to 200 persons according to HMIS data.
(2) Length of stay for homeless persons with SMI in shelter does not increase from 42 days[35] according to HMIS data.
(3) Successful placement from shelter to housing for previously homeless persons with SMI increases from 50%[36] to 60% according to HMIS data.

Context: Both quantitative and qualitative data show that a preponderance of singles in the shelter system have a serious mental illness. According to the Homeless Management Information System (HMIS), of those who were served in the emergency shelter system in 2017, 47% had a serious mental illness – the highest percentage among any subpopulation tracked in HMIS[37]. That being said, currently only 6% of permanent housing beds for the homeless in the community are dedicated to persons with severe and persistent mental illnesses[38], and these programs have long waitlists. Moreover, access to mental health services in the region is scarce. As such, SNC will address the needs of those who are homeless with a serious mental illness by reducing discharges to homelessness from health and mental health facilities, increasing housing dedicated to homeless persons with severe mental illnesses, and supporting increased accessibility of mental health services in the community.

| Strategy | Action Item | Responsible Party | Timeframe |
|---|---|---|---|
| 1. Engage the health and mental health systems to prevent discharges to homelessness, or when discharges to homelessness are inevitable, create a planned path to emergency housing and services. | a. See Goal #6, Strategy #3. | Outreach Committee | |

[34] See Appendix IV, *HMIS Data*.
[35] See Appendix IV, *HMIS Data*.
[36] See Appendix IV, *HMIS Data*.
[37] See Appendix IV, *HMIS Data*.
[38] Saratoga-North Country 2018 Housing Inventory Chart

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| 2. Increase the amount of Rapid Rehousing targeted to persons with serious mental illnesses (SMI). | a. Prioritize CoC Bonus funding for Rapid Rehousing dedicated to persons with SMI. | Board, Rank and Review Committee | |
| | b. Support applications for funding for Rapid Rehousing dedicated to persons with SMI (i.e. NYSSHP). | Board | |
| 3. Increase the amount of Permanent Supportive Housing targeted to persons with serious mental illness (SMI). | a. Encourage agencies to apply for state funding (HCR, ESSHI, HHAP) to increase the number of permanent housing and affordable housing beds dedicated to those with SMI. | Board<br><br>Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| | b. Partner with affordable housing developers and existing support services resources (i.e. Health Homes, Managed Care Organizations) to provide support services to those with SMI accessing affordable housing. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee<br><br>(In communication with CE Committee) | |
| 4. Support National Alliance on Mental Illness – New York's advocacy efforts to increase availability and accessibility of mental health services in the region. | a. Present community concerns to NAMI- New York on an annual basis. | Board | |
| | b. Work with NAMI to identify ways the CoC can support advocacy efforts to increase availability and accessibility of mental health services in the region. | Board | |

## Goal #4: Swiftly and successfully connect homeless families and unaccompanied youth to housing and support services, reducing homelessness among these populations.

Measures of Progress:

Families: The number of homeless families in the community over the course of a year reduces by 10% according data reported by Departments of Social Services.

Unaccompanied Youth:

(1) Number of homeless unaccompanied youth in shelter does not increase from 103[39] persons according to HMIS data[40].
(2) Length of stay for homeless unaccompanied youth in shelter does not increase from t 21 days[41]according to HMIS data[42].
(3) Successful placement from shelter to housing for previously homeless unaccompanied youth increases from 50%[43] to 65% according to HMIS data[44].

Context: Both families and youth were identified by the SNC as homeless populations to prioritize due to the lack of housing dedicated to these populations compared to the presenting need. Specifically, in the SNC area, there are currently 16 emergency housing beds dedicated to homeless unaccompanied youth[45], while in 2017, CAPTAIN had 79 and WAIT House had 73 unduplicated admissions to their youth shelters[46]. It is clear there is a significant need for homeless families in the area when analyzing data provided by local Departments of Social Services. Moreover, with no family shelter in the region, there is a need to provide support services to families residing in hotels/motels on an emergency housing basis. As such, SNC will focus on increasing prevention funding to provide families at-risk of homelessness; providing support services to families in hotels/motels; preventing discharges to homelessness from the foster care system; and increasing housing options specific to homeless youth and families.

| Strategy | Action Item | Responsible Party | Timeframe |
|---|---|---|---|
| 1. Increase the amount of prevention funding available to provide | a. Explore all avenues for potential prevention funding, including federal, state (i.e. STEHP), local, and foundations. | Board | |

[39] See Appendix IV, *HMIS Data*.
[40] Please note, SNC set this measure with the understanding that a change in state policy defining youth as ages 24 or under and increased street outreach (including the Safe Harbor program) will likely increase the number of unaccompanied homeless youth accessing shelters.
[41] See Appendix IV, *HMIS Data*.
[42] A goal of 21 days in shelter for unaccompanied youth is a best practice.
[43] See Appendix IV, *HMIS Data*.
[44] This increase is likely given WAIT House, CAPTAIN, and Warren Washington Association for Mental Health are all adding permant housing beds dedicated to youth in the community (estimated 24 RRH and 14 PSH).
[45] Saratoga-North Country 2018 Housing Inventory Chart
[46] Homeless Management Information System (HMIS), CAPTAIN and WAIT House Youth Shelters Reports, unduplicated admissions within each program.

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| financial and prevention services to families. | b. Systematically promote prevention resources and services to families, including job readiness programs, workforce development, and budgeting workshops. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| | c. Advocate at the state and federal level for additional funding for prevention services. | Board | |
| 2. Develop and coordinate outreach services to at least 25 homeless families residing in hotels/motels to support households in navigating system resources. | a. Support agencies in applying for funding to coordinate outreach services to families in hotels/motels. | CE Committee | |
| | b. Work with Departments of Social Services (DSSs) to identify homeless families in hotels/motels. | CE Committee | |
| | c. Work with the Departments of Social Services to track families residing in hotels/motels by encouraging DSS's to enter into the Homeless Management Information System (HMIS). | Board, HMIS Lead | |
| 3. Engage the foster care system to prevent discharges to homelessness, or when discharges to homelessness are inevitable, create a planned path to emergency housing and services. | a. See Goal #6, Strategy #3. | Outreach Committee | |
| 4. Continue to partner with the Capital Region Advisory Committee on Youth Homelessness to identify the number of youth who are homeless in the region. | a. Participate on the Capital Region Advisory Committee on Youth Homelessness and report back to the SNC Board. | CAPTAIN, WAIT House | |
| | b. Engage youth in planning and participating in the annual Youth PIT Count. | CAPTAIN, WAIT House | |

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| c. Develop additional or expand upon an existing Transitional Living Program (TLP) for youth. | a. Encourage and support applications for funding to develop additional TLP beds. | Board | |
| d. Increase the amount of Rapid Rehousing targeted to families and youth. | a. Prioritize CoC Bonus funding for Rapid Rehousing dedicated to families and/or youth. | Board, Rank and Review Committee | |
| | b. Support applications for funding for Rapid Rehousing dedicated to families and/or youth (i.e. NYSSHP). | Board | |
| e. Work with affordable housing providers to develop affordable housing for families – both for rental and ownership. | a. Identify and build partnerships with affordable housing providers, community land trusts, and foreclosure prevention providers. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| | b. Support applications for funding for affordable housing dedicated to families. | Board | |
| | c. Research and consider alternative homeownership options for families, such as mobile homes and tiny homes. | New Affordable Housing Committee | |
| | d. Explore best practices in how Public Housing Authorities can adopt a homeless admission preference. | Glen Falls Housing Authority, who will report to Membership semi-annually. | |

## Goal #5: Increase transportation options and accessibility for those who are homeless or at-risk of homelessness to improve access to housing and employment opportunities.

Measure of Progress: Clients who are homeless or at-risk of homelessness report more access to transportation options, according to a client survey.

Context: Given the area's rural nature, transportation is an issue that impacts all other priority areas in this plan. As such, SNC will coordinate with existing Transpiration Roundtables and Transit Authorities to improve access to transportation for those who are homeless or at-risk of homelessness.

| Strategy | Action Item | Responsible Party | Timeframe |
|---|---|---|---|
| 1. Communicate with the existing Transportation Roundtables and Transit Authorities to identify (1) prominent concerns regarding access to necessary transportation for those who are or at-risk of becoming homeless and (2) ideas from the community on how to address those concerns. | a. Designate a CoC member(s) as a liaison to the Transportation Roundtables to bring to the conversations (1) prominent concerns regarding access to necessary transportation for those who are or at-risk of becoming homeless and (2) ideas from the community on how to address those concerns. The liaison will also report back to the Board and Housing Committees on progress/ideas.<br><br>Ideas to bring to the Transportation Roundtables: partnering with Uber to create an affordable rideshare program; extending bus routes to essential locations; engaging Faith-Based Organizations who have buses to provide transportation to those accessing services through providers. | Board<br><br>Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |
| 2. Identify existing transportation resources providers can refer clients to. | a. Work with Transportation Roundtables and Transit Authorities to identify existing transportation resources; include resources in the Resource Guide. | Warren-Washington-Hamilton Housing Committee<br><br>Saratoga Housing Committee | |

## Goal #6: Engage existing and new partners in the SNC Continuum of Care in order to creatively and successfully as a community implement the Strategic Plan.

Measures of Progress:

(1) Has participation in HMIS increased?
(2) Have discharges to homelessness from the criminal justice, foster care, health, and mental health systems decreased?

Context: In order to achieve any of the above goals, it is important that the SNC Continuum of Care continue to grow in membership. In addition, throughout this planning process the CoC grappled with accessing data from numerous providers in order to inform the most pressing needs related to homelessness. As such, it became clear that engaging partner providers in participating in the Homeless Management Information System (HMIS) will allow the community to more easily and accurately identify needs related to homelessness in the future. Finally, the CoC will need to engage other systems of care, including the criminal justice, foster care, health, and mental health systems, all of which have the opportunity to reduce homelessness in the community by decreasing discharges to homelessness. Finally, engaging affordable housing providers will create more housing opportunities for homeless and previously homeless persons the SNC seeks to serve.

| Strategy | Action Item | Responsible Party | Timeframe |
|---|---|---|---|
| 1. Increase participation within HMIS from 0% to 100%. | a. Engage local Departments of Social Services in entering into HMIS. | Board<br>HMIS Lead | |
| 2. Increase participation among existing and new partners in the CoC and CoC Committees. | | Board | |
| 3. Engage the criminal justice, foster care, health, and mental health systems to prevent discharges to homelessness, or when discharges to homelessness are inevitable, create a | a. Identify and establish linkages with existing discharge planning entities. | Outreach Committee | |
| | b. Identify barriers to identifying those who are homeless in the criminal justice, foster care, health, and mental health systems and methods for overcoming identification barriers. | Outreach Committee | |
| | c. Identify the number of people being discharged to homelessness from the criminal justice, foster care, health, and mental health systems. | Outreach Committee | |

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| planned path to emergency housing and services. | d. Collaboratively assess current discharge planning mechanisms and ensure a planned path to emergency housing and services. | Outreach Committee | |
| 4. Work with Public Housing Authorities and affordable housing developers to continue to develop and implement a Move On Strategy. | a. Introduce the concept of the Move On Strategy to PHA's and affordable housing developers. | Glens Falls Housing Authority, who will report to Membership semi-annually. | |
| | b. Create agreements with PHA's and affordable housing developers to establish a preference for moving on tenants from PSH programs. | Glens Falls Housing Authority, who will report to Membership semi-annually. | |

# Appendix I: Definition of Terms

**Affordable Housing:** The definition of affordable housing can vary greatly based depending on your perspective or role in the community. In this plan, the Strategic Planning Committee has decided to define affordable housing as housing that is affordable to those who are at or below 30% of the median income for the area in which they live. Affordable housing is sometimes available within the community naturally due to market levels. Often, however, it is developed by non-profit or for-profit developers who utilize government incentives or subsidies, such as Low-Income Housing Tax Credits to make the development feasible. Another form of affordable housing is Section 8 vouchers, which allow tenants to pay 30% of their income towards rent and utilities, with the rest being subsidized by the Section 8 program.

**At Immediate Risk of Eviction:** Those at immediate risk of eviction, or at-risk, refers to families or individuals who are likely to become homeless within 14 days due to an eviction notice or other circumstances

**Chronic Homelessness:** The definition of chronically homeless that will be used in this plan is also utilized by HUD, and is specified Homeless Emergency Assistance and Rapid Transition to Housing Act 2016 final rule. A person who is chronically homeless per this definition must have a disability and must have been homeless for longer than 12 months or on several occasions. Specifically:

(1) A "homeless individual with a disability," as defined in the Act, who:
    a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
    b. Has been homeless continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months
        i. Occasions separated by a break of at least seven nights
        ii. Stays in institution of fewer than 90 days do not constitute a break

(2) An individual who has been residing in an institutional care facility for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraphs (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

**Continuum of Care:** The Continuum of Care (CoC) program out of HUD is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.

**Emergency Housing:** Short-term housing provided in response to a housing crisis, offered either in emergency shelters (congregate facilities used for this purpose) or motel rooms funded as emergency housing by either a public or not-for-profit agency.

**Equal Access to Housing Final Rule (2012):** Through this final rule, HUD implements policy to ensure that its core programs are open to all eligible individuals and families regardless of sexual orientation, gender identity, or marital status.

**Equal Access in Accordance With an Individuals Gender Identity in Community Planning and Development Programs (2016):** Through this final rule, HUD ensures equal access for individuals in accordance with their gender identity in programs and shelter funded under programs administered by HUD's Office of Community Planning and Development (CPD).

**Homelessness:** In this document, the definition of homelessness provided by HUD and specified in the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2012 has been used, which is as follows:

(1) People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided. People are considered homeless if they are exiting an institution where they resided for up to 90 days, and were in shelter or a place not meant for human habitation immediately prior to entering that institution; or

(2) People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 14 days and lack resources or support networks to remain in housing; or

(3) Families with children or unaccompanied youth who are unstably housed and likely to continue in that state. This applies to families with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment; or

(4) People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.

It should be noted that this definition does not include persons who are precariously housed due to paying too high a percentage of their incomes for rent, nor those doubled up with family or friends because no other housing is available. However, the plan does include homelessness prevention strategies targeted to these at-risk populations.

**Homeless Management Information System (HMIS):** A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. CoC members and community organizations submit data to HMIS in Albany.

**Housing Choice Voucher:** The current name for the Section 8 Housing Program, which tends to be referred to as the Section 8 Program. (Please see "Section 8 Program" below).

**"Housing First" Model:** A model that prioritizes providing people experiencing homelessness with permanent housing as quickly as possible, with no preconditions or service requirements – and then providing voluntary supportive services as needed. In contrast, the more traditional housing model requires homeless persons to successfully complete different "stages" of housing (such as emergency housing and transitional housing) in order to demonstrate housing "readiness," or to complete mandated service treatment, such as reaching sobriety, before being permanently housed. In the

traditional housing model, completion of each housing stage requires physical movement to new housing, causing disruption with each move.

**"Low-Demand" Housing:** Housing that allows program participants who are in need of supportive and treatment services to determine the type and intensity of services that they receive, rather than having to comply with pre-existing service and treatment requirements.

**Permanent Housing:** Housing that can be occupied for an indefinite period, as long as the tenant complies with lease requirements. For the purposes of this Plan, Permanent Housing refers to Permanent Supportive Housing and Rapid Rehousing.

**Permanent Supportive Housing:** Permanent housing accompanied by ongoing supportive and treatment services. Many persons with disabilities require permanent supportive housing in order to remain stably housed. HUD Continuum of Care grants provide funding for permanent supportive housing, which provide housing for formerly homeless individuals and families with disabilities.

**Point-In-Time Count:** The Point-in-Time (PIT) count is a count of sheltered and unsheltered homeless persons on a single night in January. HUD requires that Continuums of Care conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night. Continuums of Care also must conduct a count of unsheltered homeless persons every other year (odd numbered years). Each count is planned, coordinated, and carried out locally. In Albany, both the sheltered and unsheltered count are conducted annually utilizing HMIS and survey outreach.

**Poverty Level:** The set minimum amount of income that a family needs for food, clothing transportation, shelter and other necessities. In the U.S., this level is determined by the Department of Health and Human Services. Federal Poverty Level varies according to family size. The number is adjusted for inflation and reported annually in the form of poverty guidelines.

**President's Interagency Council on Homelessness:** Congress established the Interagency Council on Homelessness in 1987 with the passage of the Stewart B. McKinney Homeless Assistance Act. The Council is responsible for providing Federal leadership for activities to assist homeless families and individuals.

**Rapid Rehousing:** Rapid Rehousing rapidly connects individuals and families 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. A fundamental goal of rapid rehousing, informed by a Housing First approach, is to reduce the amount of time a person is homeless. Although the duration of financial assistance may vary, many programs find that, on average, four to six months of financial assistance is sufficient to stably re-house a household to the point of self-sufficiency. While originally aimed primarily at people experiencing homelessness due to short-term financial crises, programs across the country have begun to assist individuals and families who are traditionally perceived as more difficult to serve.

**Saratoga-North Country (SNC) Continuum of Care (SNC):** The Saratoga-North Country (SNC) Continuum of Care (CoC) is a group of providers and community members dedicated to preventing and reducing homelessness in the Saratoga-North Country region. SNC is the Continuum of Care for Saratoga, Warren, Washington, and Hamilton Counties in New York

State, a Housing and Urban Development (HUD) designated local planning body that coordinates housing and services funding for homeless families and individuals.

**Section 8 Housing Program (now called the Housing Choice Voucher Program):** Housing assistance for rent and utilities secured from a local housing authority or other authorized provider in the form of a voucher which provides monthly direct payments to landlords that qualified low-income people can use to rent apartments and homes in the private market.

**Single Room Occupancy (SRO):** Permanent housing providing an individual a single room in which to live. These units may contain food preparation or sanitary facilities, or these may be shared with others.

**Social Security Disability Insurance:** A federally-funded wage-replacement program, administered by the Social Security Administration, for those who have a disability meeting Social Security rules and who have paid FICA taxes. SSDI is financed with Social Security taxes paid by workers, employers and self-employed persons. SSDI benefits are payable to disabled workers, widows, widowers, and children or adults disabled since childhood who are otherwise eligible.

**Supplemental Security Income:** A Federal income supplement program funded by general tax revenues and designed to help aged, blind and disabled people, who have little or no income. The program provides cash to meet basic needs for food, clothing and shelter.

**Transitional Housing:** Housing coupled with supportive and treatment services that is provided on a time-limited basis (in most cases, not exceeding 24 months). The primary distinction between transitional housing and permanent housing is that in transitional housing, the program, not the participant, determines the length of stay. HUD Continuum of Care grants provide funding for transitional housing, although HUD has prioritized funding Rapid Rehousing over transitional housing except in the cases of housing youth and victims of domestic violence.

**U.S. Department of Housing and Urban Development (HUD):** a cabinet-level agency of the federal government whose mission is to increase homeownership, support community development and increase access to affordable housing free from discrimination. HUD is the primary federal funder of low-income housing for homeless persons through the Continuum of Care grants program and Emergency Solutions grants program.

**United States Interagency Council on Homelessness (USICH):** a group of 19 federal member agencies that fosters partnerships at every level of government and with the private sector to lead the national effort to prevent and end homelessness in America.

# Appendix II: SNC Strategic Planning Committee Members

Robert Landry
Glens Falls Housing Authority
SNC Strategic Planning Committee Co-Chair

Duane Vaughn
Tri-County United Way
SNC Strategic Planning Committee Co-Chair

Alexandra Adams
Community Member

Charles Adams
Community Member

Angela Bronzene
Saratoga County Department of Mental Health and Addiction Services

Krista Conrick
BOCES

John Farrell
Warren Washington Association for Mental Health

Maggie Fronk
Wellspring

Andy Gilpin
CAPTAIN Youth and Family Services

Cheryl Murphy Parant
Shelters of Saratoga

Matthew Ryan
Warren Washington Association for Mental Health

Trisha Smouse
Salvation Army

Kimberly Sopczyk
Family Service Association of Glen Falls

# Appendix III: Community Forum Summaries

The Saratoga-North Country (SNC) Continuum of Care (CoC) hosted a total of three community forums during the strategic planning process:

1) SNC CoC Semi-Annual Membership Meeting, May 9th, 2017
2) Open Community Forum, Crandall Public Library, Glens Falls, January 22nd, 2018
3) Open Community Forum, Saratoga Springs Public Library, January 23rd, 2018

## SNC CoC Semi-Annual Membership Meeting

The SNC CoC began its strategic planning process by hosting a forum during the SNC CoC Semi-Annual Membership Meeting on May 9th, 2017. The SNC Board, with support from CARES, led attendees in a round-robin discussion to identify initial ideas about needs and assets related to homelessness in the community. Attendees rotated through three groups, discussing needs and assets related to street outreach and emergency shelter, permanent supportive housing, and support services. Facilitators took notes at each station. These notes, detailed below, were used by the Strategic Planning Committee as a basis for developing foci in the Strategic Plan.

**Street Outreach**

- More outreach is needed in the following areas:
  - Warren, Washington, Hamilton
  - Warrensburgh
  - Train track/tented areas
  - Campgrounds (in the summer)
  - Trailer park Communities
  - Motels
  - Needle exchange programs
  - Soup kitchens
  - Food banks
  - Local churches
  - Faith-based programs
- More outreach is needed to the following populations:
  - Adults
  - Migrant populations
- More outreach to market services.
- Language barriers present an issue in conducting outreach.
- It is important to build trust with those you are conducting outreach to.
- More staffing is needed to conduct outreach when those who are street homeless are most accessible (i.e. after-hours work).
- There is a need for more willingness to do outreach among agencies.
- There is a lack of funding for outreach.
- In Warren and Washington Counties there is just one small outreach program; there should be an outreach program developed where there are unsheltered youth.
- Involve more law enforcement in conducting outreach (esp. in rural areas). Keep a good relationship with law enforcement.

**Emergency Housing**

- More emergency housing is needed for the following populations:
  - Families
  - Couples (unmarried)
  - Youth
  - Parenting teens

- More emergency housing is needed in the following areas:
    - Washington County (no shelter, so all emergency housing goes through DSS)
    - Rural areas (note: not a lot of available motels in rural areas)
- Types of emergency housing that is needed:
    - Year-round (in addition to Code Blue, motels)
    - Mobile crisis units
    - Accessible via transportation
    - Shelters that allow pets
- Note: Possible shelter opening in Warren County.
- More funding is needed for shelters.
- The limited definition of homelessness (i.e. not including people who are couch surfing) is a barrier to serving those in need.
- There should be increased promotion of support services at emergency housing on weekends.
- Often services/emergency housing referred by law enforcement = arrested before there is a chance to intervene.
- There is a need to better report the number of homeless people in rural areas.
- There is one mental health facility for adults in Warren County and one in Washington County.
- Medicaid funded waivers will house those who are homeless – there is a need to make connections with waiver-funded agencies.
- There is a need to develop peer-outreach programs.

**Permanent Supportive Housing**

- More PSH is needed for the following populations:
    - Mental Health (units limited – TSA & WWAMH)
    - Elderly and/or those with a disability
    - It is also harder to house families
- Barriers to serving potential clients in PSH:
    - It is a challenge to serve those in need and meet the HUD homeless definition (too narrow).
    - Non-Housing First approach might hinder eligibility into program – redesign entry point.
    - Clients may be intimidated by process (ex. Sanctioned too many times).
    - Lack of transportation to PSH
    - Difficulty with eligibility criteria for certain subpops
    - There is not enough awareness of programs available
    - Therapy dogs – limited access to units
    - Many options are full – lack of availability
    - Lack of units for those who can't live dependently
- It's hard to create PSH because of the stigma against certain subpopulations.
- Not enough funding for RRH
- Affordable Housing:
    - Section 8 list closed
    - Rental Administration – hard to find affordable housing
    - Access to apartment search – limited to papers (not tech savvy)
    - Funding used for other community improvement rather than affordable housing
    - NIMBY – specific to Saratoga Springs
    - ADA compliance
    - Landlords – don't want to take or max out vouchers; don't want DSS
- Overall:
    - Not enough PSH units
    - Not enough access to TH beds while waiting for PSH
    - Not enough affordable housing
    - Not enough subsidized housing
    - Geographic barriers – transportation
- Landlords lack of willingness to understand client

- Utilization of unused real estate
- Reluctance to put money in overrun neighborhoods
- Challenge in SNC – economy based on tourism – makes hard to place families for summertime.

**Support Services**

- Current supports siloed – multiple issues and agencies provide/specialize in one service area; want someone to take the lead.
- Washington Support Services – lack of Mental Health services – need counseling. Try to send to Saratoga MH (noted that may need to be residents of Saratoga; this was later clarified that Saratoga residents are prioritized but outside residents are accepted if they have Medicaid).
- Support service staff work to connect people to housing – end up working as housing case managers so clients don't get evicted, and can't focus on support services as a result.
- Clients aren't being asked if they served/are Veterans.
- Client follow-through is an issue (especially when it can't be mandated that a client go through treatment).
- Issue that some programs require treatment to get into PSH (not Housing First).
- Some clients want to integrate into affordable housing in the community, but they are in PSH and thus are placed on the bottom of the list for affordable housing.
- Mental Health – eligibility for services not clear (i.e. may need Medicaid).
- Glens Falls – lack of psychiatrists to diagnose and dispense (i.e. had to take a client to Cooperstown to get necessary medication before ran out).
- Improve Broadband so can have telecommunication services.
- Need directory of services – central number to call – is 211 still working through United Way?
- Lack of participation of all partners who provide services (i.e. DSS). Warren County DSS is starting to participate. Now Saratoga County DSS is on the CoC listserve.
- Lack of follow-up with cases.
- Accessibility to inpatient rehabilitation/detox centers.
- Peer programs.
- Transportation/accessibility – rural outlying, most services centralized around DSS.
- Non-referral based case management for MH, SA, homelessness.
- Lack of access to clinic, DSS = unable to keep appointment times
- Limited detox programs – can't get someone into and need Medicaid.
- Detox centers and hospitals discharge people to the street or Code Blue shelter (especially those hospitals that are out of the area).
- Can't pay qualified Mental Health staff enough (they can make more at Stewarts).
- Other support programs – faith-based, parent support groups, etc. – aren't connected to the CoC and may be underutilized.
- Should publish volunteer/intern/Board opportunities and regulations.

## Open Community Forums

The Strategic Planning Committee planned and hosted two public community forums in January 2018 – one in Saratoga Springs, and one in Glens Falls. The purpose of these forums was to gather feedback on needs and assets related to homelessness as it relates to each of the above four focus areas. Together there were over 100 people in attendance. Attendees included homeless housing and service providers, health care providers, housing authorities, faith-based organizations, community centers, state and local governments, universities, libraries, community members, and persons with lived homelessness experience. Attendees worked through four stations – one on each topic – and discussed the following questions at each:

1. What are gaps/barriers in the community related to the topic area and homelessness?
2. What are assets in the community related to the topic area and homelessness?

3. Keeping in mind the assets listed, what are solutions to the gaps/barriers identified?

Facilitators took notes at each station. The notes, detailed below, were utilized by the Strategic Planning Committee to further detail foci in the Strategic Plan and action items the CoC should pursue to best address homelessness.

**Support Services**

**GAPS**

1. Staffing:
    a. Lack of Advocacy, empathy and compassion
    b. Lack of training of front line staff
    c. Agencies are understaffed
2. Additional services needed in the community:
    a. Emergency access to services (Where to go in off hours, evening access)
    b. Place to receive mail
    c. Place to clean up or keep personal belongings safe
    d. Job placement assistance
    e. Financial literacy
    f. Services for 18-24-year olds
    g. Mental Health services (3 weeks wait for mental health screenings)
    h. Prevention services
    i. Coordination of care
3. Access Issues:
    a. Not enough locations of services outside city area
    b. Transportation
    c. Lack of knowledge and communication about what is available and how to gain access to these services
4. Lack consistent follow up and services once housed
5. Lack of shelter options
6. Affordable housing
7. Lack of funding resources

**SOLUTIONS**

1. Staffing:
    a. Better advocacy
    b. Educate volunteers
    c. Increasing amount of case managers
2. Additional Services:
    a. Resource Navigator
    b. Vocational training programs
    c. Better education in schools for financial and health literacy
    d. Early intervention
    e. Improve access to health care
    f. Better contact and collaboration between agencies
3. Access:
    a. Clear communication & education about resources
    b. Satellite offices
4. Educate and advocate with elected officials

**Chronic Homelessness**

**GAPS**

1. Support Services:
    a. Not being educated on services offered
    b. Preventative Services
    c. Mental Health Services
    d. Substance Abuse Addiction and lack of treatment
    e. Family support
    f. Employment, support increasing income
    g. Transportation
    h. Place to be during the day
    i. Mental illness / chronically in crisis
    j. Medicaid- location, resources, funding
    k. Hygiene services
2. Access:
    a. Shelter availability
    b. No family shelters and motels taking advantage
    c. Requirements to qualify for services, barriers with DSS
    d. Disqualification from HUD assistance; felony/not able-bodied
    e. Sex offender status (public housing, employment)
    f. Transportation
3. Community Support:
    a. Public perception and misconception of homelessness
    b. Outside community support
4. Generational poverty
5. Runaway youth
6. Temporary addresses
7. Lack of Affordable housing
8. Funding

**ASSETS**

1. Agencies: DSS; Catholic Charities; Salvation Army; Soldier On; Shelters of Saratoga; Franklin Center; WAIT House; Captain; Mother Anderson; SPARC; Community Centers; Churches; Library; Hospital; Police; Health Centers
2. Programs: Outreach coordinators; 211; Local health centers/navigators; Coordinated Entry; Code Blue
3. Community: Stakeholders/Community members; Community support and donations; Homelessness Coalition

**SOLTUIONS**

1. Support Services:
    a. Guide for list of services
    b. Database of organizations/services
    c. Street Outreach
    d. Parent and Youth education
    e. Communication between agencies
    f. Satellite DSS Services and other satellite offices
2. Access:
    a. Transportation
3. Housing:
    a. Rapid Rehousing
    b. State waivers for housing
4. Community Support:
    a. Dedication from providers and agencies
    b. Improving partnership with the community

c. Acknowledge generational poverty
d. Educating the general public and lessening the stigma of homelessness
e. Non-traditional hour meetings

**Family and Youth**

**GAPS**

1. Support Services:
    a. Child care options
    b. Affordable transportation
    c. Education
    d. Helping youth with family problems
    e. Prevention services
2. Access:
    a. Lack of education on resources and not using them
    b. Connecting people to the right services that they need
    c. Services in rural areas
3. Housing:
    a. Affordable housing
    b. No family shelter in area, families end up in motels
    c. "Doubled up" is not considered homeless by HUD
4. Community:
    a. Stigma of homelessness on children
    b. Community awareness
5. Lack of resources and housing for special populations
6. The definition of family

**ASSETS**

1. Agencies: WAIT House; CAPTAIN; Catholic Charities; Religious organizations
2. Services: Education services; Homeless liaisons in schools; Mandated Reporters; The resources that are available for rent
3. Communication between DSS (War/Wash)
4. Laws that protect victims of domestic violence
5. Social media

**SOLUTIONS**

1. Services:
    a. Helping homeless children become a part of the community
    b. Partnerships between schools, agencies and law enforcement
    c. Mentoring
    d. Volunteers
2. Access:
    a. Communication and education of available services to community and youth
    b. Raising awareness using tools such as social media

**Transportation**

**GAPS**

1. Lack of accessible transportation:
    a. Buses:
        i. Buses are time consuming; routes do not always go to where services are located
        ii. Areas with CDTA have higher rent
        iii. No buses in rural areas
        iv. No public transit in Washington County
    b. Medicab scheduling process onerous, drivers are inappropriate
    c. Cabs are expensive
    d. To use Uber client must have phone, data plan and credit card. The drivers are not sensitive to client needs
    e. Agencies will not transport due to liability
2. Being eligible for transportation
3. CDTA cards can be stolen, need to be preloaded
4. Lack of knowledge on CDTA Navigator
5. DSS sets unrealistic expectations for how people can get to places

**ASSETS**

1. CDTA
2. CAPTAIN Bike Program
3. Bike-a-toga
4. DSS In House Transporter
5. Veteran groups that help with travel
6. ADK Glens Falls Transportation
7. Some organizations have loaner buses and vans
8. Agencies transport, pay for rides, advocate with transit company
9. Interagency Awareness Day
10. 211

**SOLUTIONS**

1. Hotline for rides
2. Agencies could set up Uber accounts
3. Volunteer driver pool
4. Employers offer transportation vouchers
5. Affordable housing tied to areas with public transit
6. Bike Donation
7. Get Churches involved

# Appendix IV: HMIS Data

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|---|---|---|
| Populations Served in Emergency Shelter as Reported in HMIS | | |
| Negative Destinations and Length of Stay | | |
| Calendar Year 2017 | | |
| Chronically Homeless | | |
| **Total Chronically Homeless Persons served:** | 18 | |
| **Percentage of CH Persons Served in Emergency Shelter compared to All Persons Served:** | 4% | |
| **Average Length of Stay:** | 55 days | |
| **Negative Destinations:** | **Count** | **Percentage** |
| Client doesn't know | 3 | 38% |
| Emergency shelter, including hotel or motel paid for with emergency shelter voucher | 2 | 25% |
| Hospital or other residential non-psychiatric medical facility | 1 | 13% |
| Other | 1 | 13% |
| Transitional housing for homeless persons (including homeless youth) | 1 | 13% |
| **Total Number of Chronically Homeless Persons who Exited to a Negative Destination:** | 8 | 100% |
| **Percentage of Chronically Homeless Persons who Exited to a Negative Destination:** | 44% | |
| Veterans | | |
| **Total Number of Veterans Served:** | 53 | |
| **Percentage of Veterans Served in Emergency Shelter compared to All Persons Served:** | 11% | |
| **Average Length of Stay:** | 44 days | |
| **Negative Destinations:** | **Count** | **Percentage** |
| Client doesn't know | 1 | 3% |
| Client refused | 1 | 3% |
| Emergency shelter, including hotel or motel paid for with emergency shelter voucher | 3 | 10% |
| Hotel or motel paid for without emergency shelter voucher | 1 | 3% |
| No exit interview completed | 11 | 37% |
| Other | 1 | 3% |
| Residential project or halfway house with no homeless criteria | 2 | 7% |
| Staying or living with family, temporary tenure (e.g., room, apartment or house) | 1 | 3% |
| Staying or living with friends, temporary tenure (e.g., room, apartment or house) | 1 | 3% |
| Substance abuse treatment facility or detox center | 1 | 3% |
| Transitional housing for homeless persons (including homeless youth) | 7 | 23% |
| **Total Number of Veterans who Exited to a Negative Destination:** | 30 | 100% |
| **Percentage of Veterans who Exited to a Negative Destination:** | 57% | |
| Youth Destination | | |
| **Total Number of Youth Served:** | 103 | |
| **Percentage of Youth Served in Emergency Shelter compared to All Persons Served:** | 21% | |
| **Average Length of Stay:** | 21 days | |
| **Negative Destinations:** | **Count** | **Percentage** |
| Client doesn't know | 3 | 6% |
| Client refused | 3 | 6% |
| Data not collected | 2 | 4% |
| Emergency shelter, including hotel or motel paid for with emergency shelter voucher | 13 | 25% |
| Hospital or other residential non-psychiatric medical facility | 1 | 2% |
| Hotel or motel paid for without emergency shelter voucher | 2 | 4% |
| No exit interview completed | 10 | 20% |
| Other | 2 | 4% |
| Psychiatric hospital or other psychiatric facility | 2 | 4% |
| Safe Haven | 1 | 2% |
| Staying or living with friends, temporary tenure (e.g., room, apartment or house) | 4 | 8% |
| Substance abuse treatment facility or detox center | 2 | 4% |
| Transitional housing for homeless persons (including homeless youth) | 6 | 12% |
| **Total Number of Youth Exited to Negative Destinations:** | 51 | 100% |
| **Percentage of Youth Exited to Negative Destinations:** | 50% | |

| SUD Drug Destination | | |
|---|---|---|
| **Total Number of Persons with SUD Drug Served in Shelter:** | 122 | |
| **Percentage of Persons with SUD Drug in Shelter compared to All Persons Served:** | 24% | |
| **Average Length of Stay:** | 36 days | |
| **Negative Destinations:** | **Count** | **Percentage** |
| Client doesn't know | 7 | 8% |
| Client refused | 7 | 8% |
| Data not collected | 9 | 11% |
| Emergency shelter, including hotel or motel paid for with emergency shelter voucher | 28 | 33% |
| Foster care home or foster care group home | 1 | 1% |
| Hospital or other residential non-psychiatric medical facility | 1 | 1% |
| Hotel or motel paid for without emergency shelter voucher | 2 | 2% |
| Jail, prison or juvenile detention facility | 3 | 4% |
| No exit interview completed | 11 | 13% |
| Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) | 1 | 1% |
| Psychiatric hospital or other psychiatric facility | 2 | 2% |
| Residential project or halfway house with no homeless criteria | 1 | 1% |
| Safe Haven | 1 | 1% |
| Staying or living with family, temporary tenure (e.g., room, apartment or house) | 2 | 2% |
| Staying or living with friends, temporary tenure (e.g., room, apartment or house) | 3 | 4% |
| Substance abuse treatment facility or detox center | 4 | 5% |
| Transitional housing for homeless persons (including homeless youth) | 1 | 1% |
| **Total Number of Persons with SUD Drug who Exited to Negative Destinations:** | 84 | 100% |
| **Percentage of Persons with SUD Drug who Exited to Negative Destinations:** | 69% | |

| SUD Alcohol Destination | | |
|---|---|---|
| **Total Number of Persons with SUD Alcohol Served in Shelter:** | 49 | |
| **Percentage of Persons with SUD Alcohol in Shelter Compared to All Persons Served:** | 10% | |
| **Average Length of Stay:** | 35 days | |
| **Negative Destinations:** | **Count** | **Percentage** |
| Client doesn't know | 4 | 12% |
| Client refused | 2 | 6% |
| Data not collected | 2 | 6% |
| Emergency shelter, including hotel or motel paid for with emergency shelter voucher | 7 | 21% |
| Foster care home or foster care group home | 1 | 3% |
| Hotel or motel paid for without emergency shelter voucher | 3 | 9% |
| Jail, prison or juvenile detention facility | 1 | 3% |
| No exit interview completed | 8 | 24% |
| Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) | 1 | 3% |
| Residential project or halfway house with no homeless criteria | 2 | 6% |
| Substance abuse treatment facility or detox center | 1 | 3% |
| Transitional housing for homeless persons (including homeless youth) | 1 | 3% |
| **Total Number of Persons with SUD Alcohol who Exited to Negative Destinations:** | 33 | 100% |
| **Percentage of Persons with SUD Alcohol who Exited to Negative Destinations:** | 67% | |

| | | |
|---|---|---|
| **Total Number of Persons with SMI Served in Shelter:** | 236 | |
| **Percentage of Persons with SMI Served in Shelter Compared to All Persons:** | 47% | |
| **Average Length of Stay:** | 42 days | |
| **Negative Destinations:** | **Count** | **Percentage** |
| Client doesn't know | 8 | 7% |
| Client refused | 8 | 7% |
| Data not collected | 8 | 7% |
| Emergency shelter, including hotel or motel paid for with emergency shelter voucher | 39 | 33% |
| Foster care home or foster care group home | 3 | 3% |
| Hospital or other residential non-psychiatric medical facility | 3 | 3% |
| Hotel or motel paid for without emergency shelter voucher | 5 | 4% |
| Jail, prison or juvenile detention facility | 2 | 2% |
| No exit interview completed | 17 | 15% |
| Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) | 1 | 1% |
| Psychiatric hospital or other psychiatric facility | 4 | 3% |
| Residential project or halfway house with no homeless criteria | 5 | 4% |
| Safe Haven | 2 | 2% |
| Staying or living with family, temporary tenure (e.g., room, apartment or house) | 3 | 3% |
| Staying or living with friends, temporary tenure (e.g., room, apartment or house) | 3 | 3% |
| Substance abuse treatment facility or detox center | 2 | 2% |
| Transitional housing for homeless persons (including homeless youth) | 4 | 3% |
| **Total Number of Persons with SMI who Exited to Negative Destinations:** | 117 | 100% |
| **Percentage of Persons with SMI who Exited to Negative Destinations:** | 50% | |
| ***1 Client record indicates SMI, SUD and HIV/AIDS*** | | |
| No exit interview | | |
| Length of Stay = 7 days | | |
| | | |
| **Total number of persons served = 500 from 1/1/2017 - 12/31/2017** | | |