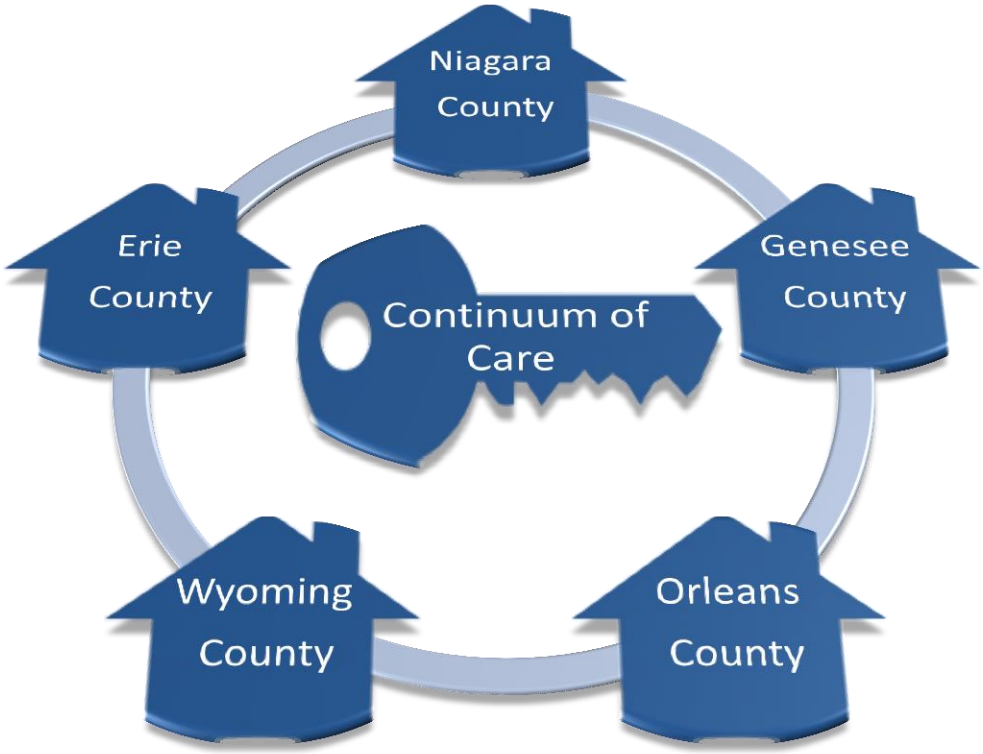
Mid-Term Review for "Opening Doors": A Community Ten Year Plan to End Homelessness update for Erie, Genesee, Niagara, Orleans and Wyoming Counties



An Evaluation Progress Report for fiscal years 2012-2015

A project of the
Homeless Alliance of Western New York

Table of Contents

Introductory Letter

Dear Reader:

Five years ago, we set goals to ending all types of homelessness in "Opening Doors: Buffalo and Erie County Community Plan to End Homelessness". These goals were set in alignment with the federal strategic plan titled "Opening Doors: The Federal Strategic Plan to Prevent and End Homelessness". The goals were the expressed commitment by our community and local leaders towards ending homelessness in our region. The goals include the following:

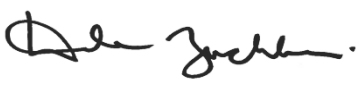
1. Finish the job of ending chronic homelessness in 2017
2. Prevent and end homelessness among veterans in 2017
3. Prevent and end homelessness for families, Youth, and children in 2020
4. Set path to ending all types of homelessness

Furthermore, the plan contains objectives and strategies for addressing the needs of different subpopulations of the homeless individuals and families. During the course of the years, the plan also served as a footprint to community collaboration with service providers, City of Buffalo, local Counties, State and local authorities. For example, the plan paved a pathway to the development of our first Continuum of Care Written Standards for coordinated entry system in 2014 in collaboration with more than 40 local providers, city and county officials to better serve those experiencing homelessness.

Subsequently, the Homeless Alliance of Western New York has expanded our Continuum of Care partners beyond Erie County. This extended collaboration includes the communities of the Niagara County in 2013, as well as Orleans, Genesee, and Wyoming counties in 2015. We were also able to reduce veteran street homelessness to zero with collaborative efforts through the Department of Veteran Affairs and Veteran Outreach Program. Through CoC funding reallocation, we have added about 134 new beds to our homeless service system for chronically homeless population with the hope of ending chronic homelessness by the year end 2016.

Despite all these success, there is still work that remains to be accomplished; redesigning our CoC structure and strategies to fit the collective growth, addressing gaps that are hindering us in our efforts to meet the goals of preventing and ending all types of homelessness.

2016 is therefore a pivotal year for the Homeless Alliance, not only are we racing to meet the goals of ending chronic and veteran's homelessness by 2017, we are simultaneously seeking ways to better coordinate and serve the growth of the continuum and setting paths to **Ending All Homelessness.**



Dale Zuchlewski
Executive Director, Homeless Alliance of Western New York

Amended 2016

Summary of the Plan

PRISM, the original plan, (developed in 2006) was updated in 2011 in support of the federal government's call on all local authorities and citizen organizations to align local resources, collaborative efforts, and policy changes with "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness". The foundation of our plan is therefore based largely on the five themes of "Opening Doors" and thirteen objectives:

Increase Leadership, Collaboration, and Civic Engagement

- Objective 1: Build public will to end homelessness through increasing awareness and knowledge
- Objective 2: Promote Collaborative Efforts
- Objective 3: Maximize effectiveness of local homeless Continuum of Care and full implementation of the HEARTH Act

Increase Access to stable and Affordable Housing

- Objective 4: Increase availability of safe, adequate and affordable permanent housing for all populations in Erie County, Niagara County, Orleans County, Genesee County and Wyoming County
- Objective 5: Provide Permanent Supportive Housing
- Objective 6: Provide housing and services options for rural homeless population

Increase Economic Security

- Objective 7: Improve access to education and increase meaningful and sustainable employment for people experiencing or most at risk of homelessness
- Objective 8: Reduce financial vulnerability

Improve Health and Stability

- Objective 9: Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness
- Objective 10: Prevent family and youth homelessness

Retool the Homeless Crisis Response System

- Objective 11: Strengthen the capacity of BAS-Net to meet the expanded data collection, reporting, and research needs of the community
- Objective 12: Transform current homeless services to focus on preventing homelessness and rapidly returning people who experience homelessness to stable housing
- Objective 13: Improve provider understanding of requirements for access to and receipt of services

The themes and objectives serve as our implementation strategies across our homeless assistance system agencies and programs, both public and private sectors.

Objective of this Report

The primary objective of this report is to highlight the progress of the original plan in relation to activities funded by the Continuum of Care (CoC) Homeless funds, Emergency Solution Grant (ESG) and the Community Development Block Grant (CDBG) covering fiscal years 2012-2015, while also providing future direction for remaining years of The Plan. Additionally, this document acts as an amendment to the original plan to include the four newly merged urban and rural counties to the WNY CoC community (NY-508).

All communities within the CoC community will by supported by the "Increase Leadership, Collaboration, and Civic Engagement" theme of "Opening Doors". Sharing the progress and findings with our communities will both strengthen capacities for our local performance measurement, and support effective system change mechanisms that will help us meet the federal and local goals to prevent and end all homelessness.

Methodology

The report is complemented by information obtained from the Homeless Management Information System (HMIS), local annual homeless reports from 2008 to 2014, our original 10 Year Plan to End Homelessness, rural community needs assessment questionnaires conducted in mid-2015, Coordinated Entry System focus group discussions, Niagara County Plan to End Homelessness and rural homelessness literature reviews. The community needs assessments were conducted by Suckie Smith and Andrew Dearing using focus groups and interview methods with local community leaders and advocates for homeless services for the purpose of identifying needs and gaps in services in the four newly merged counties.

Overview of Progress Made from 2012 to 2015

Progress made to end homelessness in our community since the inception of our first ten year plan in 2006 includes:

Ending Veteran Homelessness

According to HUD 2014 Point-In-Time Count, the number of Veterans who are homeless in the United State is down by 33% since the launch of the federal "Opening Doors" in 2010.[1] According to HUD's Annual Homeless Assessment Report (AHAR), there has been a 43% decline in the homeless Veteran population in our Continuum of Care from 317 in 2013 to 180 in 2015. This decline is even more dramatic since the CoC merger with Genesee, Wyoming and Orleans counties where two Veteran specific programs are now added to this report.

The reduction in Veteran homelessness is attributed to the close collaboration among various CoC and Veteran service providers such as the Veterans Administration Medical Center's (VAMC) Health Care for Homeless Veterans program, Veterans One Stop Center, Pathstone, Veterans Outreach Center, Belmont Housing Resources, Buffalo City Mission, Cornerstone Manor, Cazenovia Recovery, Altamont House, WNY Coalition for the Homeless Outreach Committee, Eagle Star housing and the CoC/HMIS program lead by the Homeless Alliance of WNY. The issuance of Veteran Affairs Supportive Housing (VASH) Vouchers and Supportive Services for Veterans and Families (SSVF) funding is credited with helping to reduce the number of homeless and at-risk Veterans. Our CoC has also prioritized Veterans who are not eligible for VA services for services through Rapid Rehousing and Permanent Supportive Housing programs. The systems are in place to serve each and every Veteran in need of services keeping in mind those services that aren't always financial in nature.

In September of 2015, the VA and U.S. Interagency Council on Homelessness (USICH) held a focus group discussion on sustaining an end to Veteran homelessness known as "functional zero" (discussed in the later part of the report). This group discussion consisted of Buffalo's Community Stakeholders, VA, representatives from the Department of Housing and Urban Development (HUD) and USICH. The discussion mapped out future plans that would both help **End and Sustain Veteran homelessness and focus for improvement in the current homeless system**. This plan includes:

- Enhanced coordination of efforts between the VA and Homeless Service programs
- Implementation of a formal communication strategy for collaboration between the VA and the Homeless Alliance
- Creation of a Homeless Veterans' Task Force subcommittee via the Homeless Alliance CoC program
- Enhance data collection in HMIS to include Veteran Service Organizations, HUD-VASH and SSVF

[1] 2014 HUD Point-In-Time

Furthermore, in assessing whether a community goals on ending chronic veteran homelessness is auditable in 2017, the USICH, HUD and the VA will use the following criteria, which they released in 2015:

Achieving the Goal of Ending Veteran Homelessness: Criteria and Benchmarks

USICH, HUD, VA Criteria on ending chronic Veteran homelessness	Continuum of Care (CoC) activities
1. The community has identified all Veterans experiencing homelessness.	Our CoC community has created a By-Name list to identify Veterans who are experiencing homelessness. A committee of providers reviews this list on a monthly basis. Our CoC has implemented extensive outreach to identify each homeless Veteran and ensure they are offered permanent housing options upon engagement.
2. The community provides shelter immediately to any Veteran experiencing unsheltered homelessness who wants it.	New York State is a "right-to-shelter state", meaning that people who experience homelessness are placed into shelter or motel within one day after they verify their homelessness status. The VA has partnerships with various shelters locally, such as Eagle Star and the Buffalo City Mission, Cornerstone Manor that assist in housing the homeless vets.
3. The community only provides Service-Intensive Transitional Housing in limited instances.	All homeless Veterans are offered permanent housing within 7 days of their first engagement. However, if a Veteran declines the permanent housing offer either through VASH or SSVF programs, the VA will offer them Transitional Housing in their Grant Per Diem programs as an alternative with the option of moving to permanent housing when they choose this option.
4. The community has capacity to assist Veterans to swiftly move into permanent housing.	Permanently housing veterans within 90 days of acceptance of assistance is prioritized using their choice of Veteran specific assistance. VASH and SSVF funding is available for permanently housing veterans who are homeless or at risk of homelessness.
5. The community has resources, plans, and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future.	With extensive outreach, shelters, VASH, SSVF, RRH, PSH and excellent collaboration between the VA, DSS and Veterans One Stop Center, the resources and systems are in place to serve all unstably housed or homeless Veterans.

The benchmarks are an indicator of how well a community's system is working to ensure that veteran homelessness is rare, brief, and non-recurring.[2]

[2] Achieving the Goal of Ending Veteran Homelessness Criteria and Benchmarks, Verson 3, October 1, 2015

Ending Chronic Homelessness

At the end of 2015, HUD released a new definition for identifying Chronic Homelessness, stipulating that the client must experience at least "four episodes of homelessness that cumulatively total 12 months to meet the definition of chronic homelessness or 1 continuous episode of 12 months."

The previous definition for Chronic Homelessness defined by HUD is someone who "has a disabling condition who has either experienced homelessness for longer than a year, during which time the individual may have lived in a shelter, Safe Haven, or a place not meant for human habitation or experienced homelessness four or more times in the last three years". According to this definition, 1,616 people experiencing homelessness in Erie-Niagara metropolitan area were identified as chronically homeless since October 2011 (HMIS Data). Of this group, 566 were housed, and 36 of the chronically homeless were still homeless at the end of 2015.

Chronically homeless clients often have complex living patterns and histories, making it hard to keep track of services utilized within HMIS. Challenges that contribute to understanding chronic patterns include incarcerations, extended periods on the street, exit to another institution like hospitals, staying with family/friends, left the area, and sometimes even death. Our collaborating homeless outreach team addresses these challenges by developing personal relationships with the chronically homeless and maintaining a by-name list of clients to keep track of known locations and potential outreach destinations.

During FY2013-2014, WNY successfully created 134 new chronically homeless beds by reallocating CoC funding and bonus projects. Our Continuum continues to prioritize chronically homeless with permanent supportive housing by adopting a housing first and low barrier approach to sheltering. By collaborating with our Outreach Team performing coordinated entry, about 186 chronically homeless people were placed in permanent supportive housing from 2013 to 2014. As a result of all these efforts, our community is on track to end chronic homelessness by 2017.

Continued Collaboration and Homeless funds

Our communities receives Mckinney-Vento Homeless Assistance Grant through the Continuum of Care program, Emergency Solution Grant (ESG), HOME Investment Partnerships funds, Housing Opportunity for Persons with AIDS (HOPWA) and the Community Development Block Grant (CDBG) for homeless assistance programs on an annual basis. The grants are utilized for homeless shelters, permanent supportive housing, prevention and rapid-rehousing programs, transitional housing, creation of affordable housing for low-income households and other homeless services such as HMIS and client's case management. The City of Buffalo, Erie County, Town of Tonawanda and Niagara Falls manage the ESG, CDBG, HOME and HOPWA funds respectively, whereas the CoC's programming efforts are led by the Homeless Alliance. The continued collaboration between the City, County, Department of Social Services (DSS) and other service providers is imperative to ending homelessness. Over the last 5 years, the Homeless Alliance has provided local officials an opportunity to discuss and collaborate with

community groups on homeless issues through monthly membership meetings, committees, sub-committees and various focus groups to establish common ideas and strategies to end homelessness. For the fiscal period 2012-2015, our community received about $107,656,477 in homeless federal funding.

Homeless Funds Allocations for Erie County and Niagara County 2012-2015:

Buffalo	2012/13	2013/14	2014/15
ESG	$1,259,000	$972,000	$1,090,000
HOPWA	$551,000	$525,000	$550,000
HOME	$2,773,000	$2,628,000	$2,711,000
CDBG	$13,319,000	$13,424,000	$13,003,000
COC	$8,190,480	$8,789,186	$9,759,592
RHY	$195,000	$195,000	$195,000

Niagara Falls	2012/13	2013/14	2014/15
ESG	$198,056	$154,741	$181,121
HOPWA	-	-	-
HOME	$347,028	$357,356	$359,849
CDBG	$2,121,101	$2,202,197	$2,236,738
COC	$103,696	$103,696	$111,640
RHY	$350,000	$350,000	$350,000

Local wide merger of our Continuum of Care

Erie County Continuum of Care merged with Niagara County to apply for HUD funding as a joint CoC in 2013. In 2015, the Continuum decided to again merge with 3 adjacent communities, including Genesee, Orleans, and Wyoming Counties. The merger creates an opportunity for HUD funding to smaller Western New York Counties that receive little to no funding from ESG or CoC sources. The 5 county merger forms as a single CoC entity in the 2016/2017 CoC grant application. Other benefits of merging include future funding opportunities in rural communities, homeless data analysis, and aligned strategies for ending homelessness among human service providers in WNY.

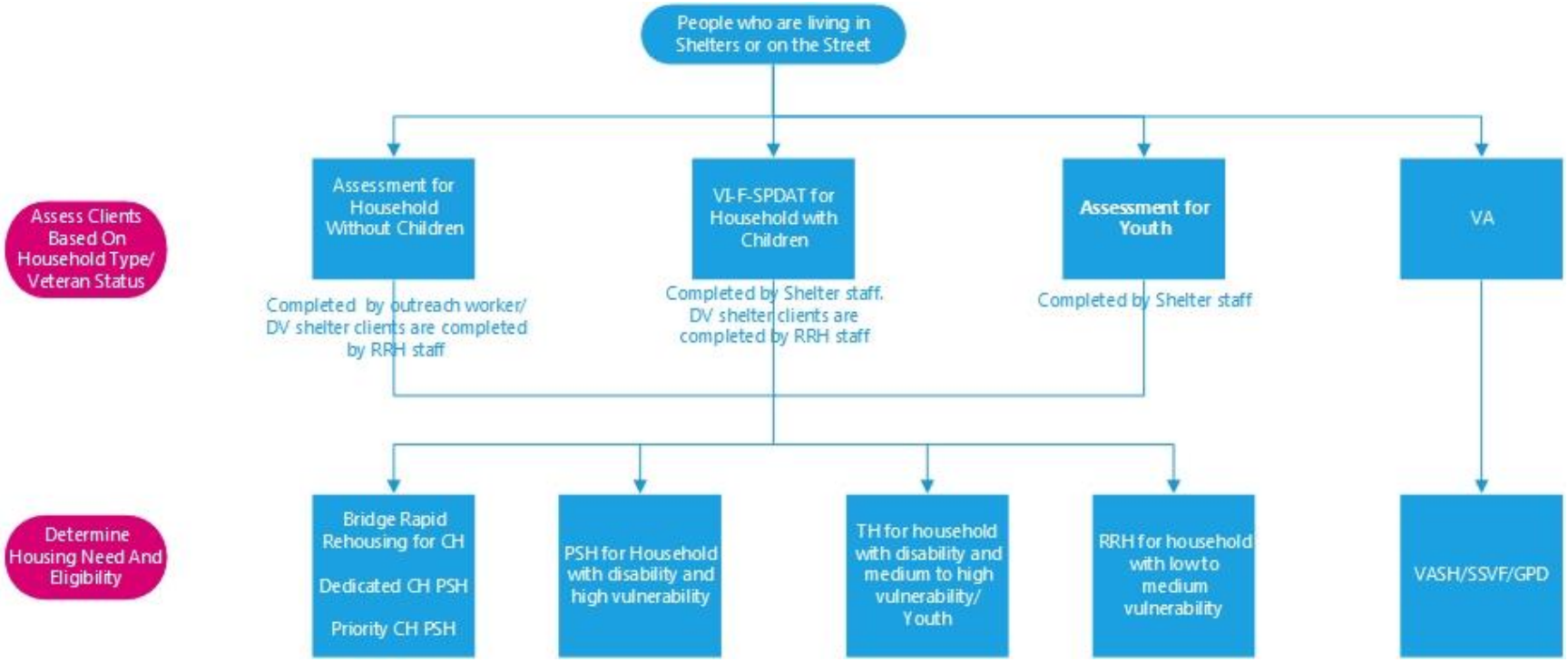
Adoption of Continuum of Care Written Standards and Coordinated Entry System

The Continuum of Care (CoC) is responsible for coordinating and implementing a system to meet the needs of the population and subpopulations experiencing homelessness within the CoC geographic area. An important planning responsibility for the CoC is conducting gaps analysis of homeless needs and services within the geographical area necessary to complete CoC planning. [3] Both the Emergency Solution Grant (ESG) Rules and Regulations and the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Continuum of Care Program Interim Rules state that the CoC, in consultation with recipients of Emergency Solutions Grants program funds within the geographic area, are responsible for (1) establish and consistently follow written standards for providing CoC and ESG assistance, (2) establish performance targets appropriate for population and program type, (3) develop a specific policy to guide the operation of the centralized or coordinated assessment system, and (4) evaluate and monitor recipient and sub-recipient performance.

The CoC written standard was first approved by the full membership on April 2014 then revised and approved on October 2015. All programs that receive ESG or CoC funding are required to abide by these written standards. Other programs within the CoC are encouraged to utilize these written standards, to maintain a uniformed and fair system. Focus groups within the Continuum establish performance targets, develop coordinated assessment system, and maintain an understanding of services available throughout WNY. Committees and subcommittees continually meet to provide feedback on modifying the written standards if necessary.

Besides the ESG regulation and HEARTH act, HUD released the Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status on July 2014 and a Coordinated Entry Policy Brief on February 2015 to emphasize the importance of adopting coordinated entry system. Our CoC responded by revising our written standard to reflect an emphasis on coordinated entry. Below is a flowchart demonstrating how coordinated entry operates within the community.

[3] HUD CoC policy briefs.



Our CoC has experienced a system-wide change by enforcing the coordinated entry system. We have developed a set of standardized assessment tools in order to ensure fair access to programs and prioritized people who are in need; eliminated barriers on admission to CoC funded programs; widely adopted housing first and low barrier approach. These changes are the foundations of our success on ending veteran homelessness and chronic homelessness and setting a path for ending other homelessness within our communities.

City of Buffalo Code Blue Initiative

On January 14, 2009, as nighttime temperatures in Buffalo dipped below 15 degrees, members of the WNY Coalition for the Homeless (WNYCH) took it upon themselves to open up several warming shelters for homeless individuals who could not find shelter from the extremely cold weather. That night, and the next two nights, the WNYCH formed outreach teams to sweep the area, find people still outside, and invite them to the shelters to get warm. WNYCH members quickly realized that their efforts would have been much more effective had a plan been in place before the extreme cold weather hit and decided to develop a plan for the next winter. This plan, titled Code Blue, brought together several local agencies who agreed to donate time and resources to fill a huge emergency services gap for homeless individuals in the City of Buffalo.

The Code Blue initiative has grown; increasing the number of shelters and outreach workers providing emergency housing, coordination and outreach for individuals experiencing homelessness on the street. In 2012, a plan was created to coordinate getting individuals into the designated Code Blue shelters. The Code Blue Committee of the Western New York Coalition for the Homeless began working on how to better engage individuals housed at the added two Code Blue shelters (Buffalo City Mission and St. Luke's Mission of Mercy). The committee also strengthened and established new partnerships that allowed them to provide homeless service in a safer and more effective way.

In 2010, the City of Buffalo awarded funds to Code Blue to purchase a 15-passenger Code Blue Van to transport the growing number of 30 to 40 clients per night from the Niagara Frontier Transportation Authority (NFTA) bus station to the Code Blue warming centers. In recognition of the homeless Outreach Workers efforts, NFTA started a program that will provide free bus rides to Code Blue clients from the bus station to the Code Blue warming centers on each Code Blue night. The NFTA partnership was hugely effective which also resulted in an Outreach Satellite Office being housed in the NFTA bus station.

In 2014 the Code Blue Committee began holding an annual Code Blue Debrief Meeting after the end of the season to discuss successes and challenges of that season and began meeting regularly in the months prior to the Code Blue Season to plan logistics. These meetings yielded in the recruitment of additional 20 Outreach Volunteers from the community, the creation of training protocols and a Code Blue Orientation Outreach Safety Training manual for Outreach Workers.

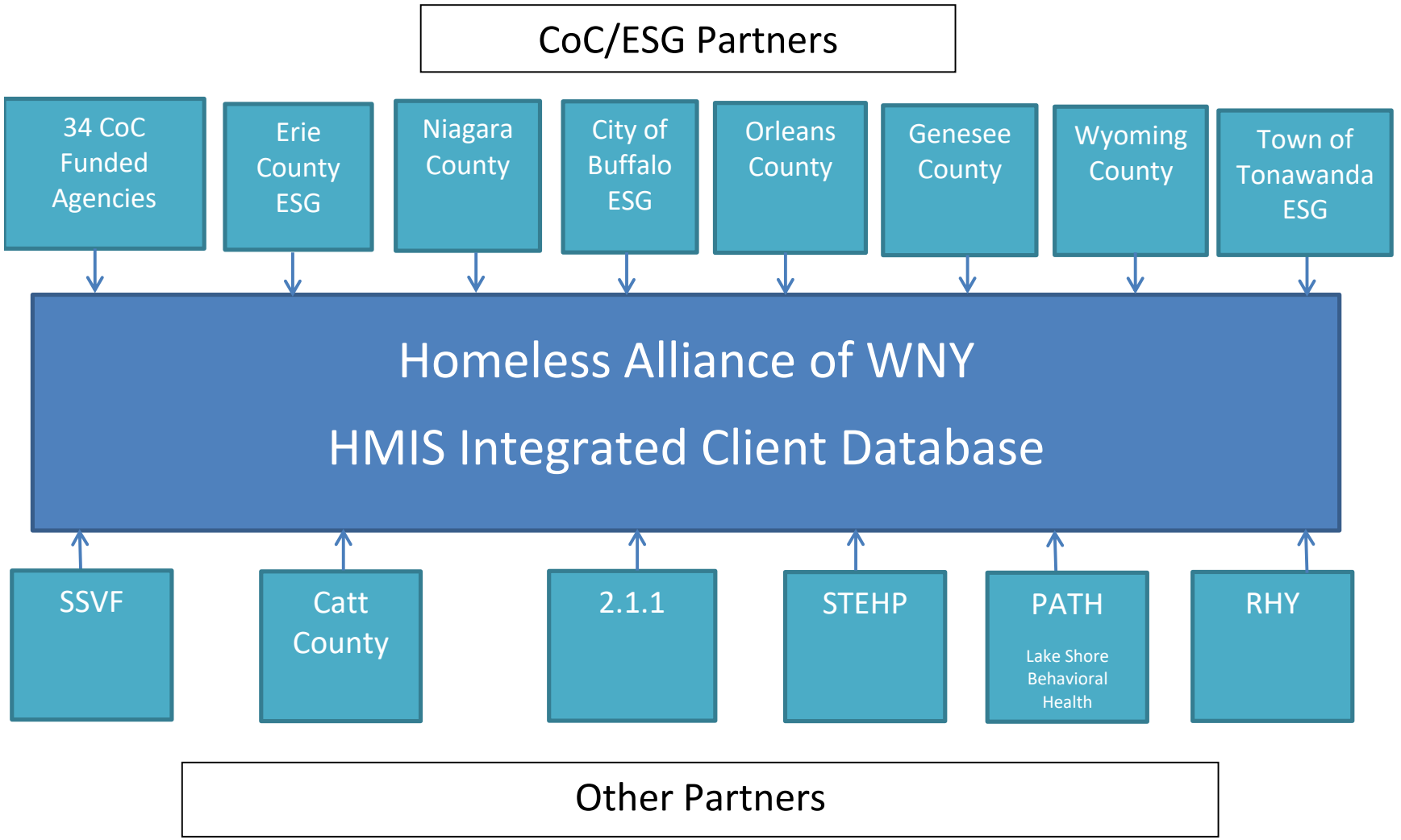
In January 2016, Governor Andrew Cuomo signed an Executive Order mandating local governments in New York State to provide shelter to people that are living on the streets when the temperatures dip below 32 degrees. City of Buffalo Code Blue program amended its procedure in accordance with the new order. Therefore, going forward, Code Blue will take place in Buffalo any time the temperature reaches below 32 degrees, and the Code Blue Van will continue to conduct outreach and transport clients.

Strengthening HMIS

We have increased our HMIS participation rate by 10% since the release of our ten year plan update in 2012. In 2014, there were about 195 HMIS users and 60 homeless programs utilizing HMIS, 205 users in 2015. We managed to reach out to about 4% of non CoC partners to establish future HMIS collaborations. We have integrated 2.1.1 of WNY into HMIS. 2.1.1 of WNY is a centralized human services referral call center for the Western New York region offering different forms of help for the homeless population. We have shared data across agencies to avoid duplication of count and services.

The Homeless Alliance is currently in negotiations with local Department of Social Services (DSS) to have DSS input data into the HMIS system to avoid duplication in tracking and reporting of homeless data and outcomes. The majority of shelter clients in HMIS are DSS referrals and the shelters receive Emergency Assistance fund from DSS. In Genesee, Orleans, and Wyoming Counties, where there are no shelters, DSS often serves as the point of entry to local services and a primary source of emergency/temporary shelter in the form of hotel/motel vouchers. The City of Buffalo, Erie County and Town of Tonawanda have been supporting HMIS services for the last 10 years through the Emergency Solution Grant (ESG) grants as part of their local consolidated plan.

Our HMIS Database Collaborating Partners



Amended 2016

The table below summarizes commitments made and some of the key accomplishments of "Opening Doors: Buffalo and Erie County Community Plan to End Homelessness.

Commitment	What we have done	Areas for improvement/future focus
a) Finish the job of ending chronic homelessness in 2017	a. We have housed about 186 chronic homeless individuals since 2013. We have created 134 new chronically homeless beds and all existing permanent supportive housing (982 PSH beds without children, 173 beds with children) are committed to prioritizing chronically homeless clients using housing first and low barriers approaches. b. Extensive outreach efforts: The Homeless Coalition has an outreach committee and many agencies are involved in the outreach efforts. They meet bi-weekly. They have a by-name list of Chronic Homeless individuals and use Google Maps to map out where they are located. They are the referral source to all the PSH partners especially those who have dedicated beds for the Chronically Homeless population. c. Prioritization tool: Since 2014, the outreach team has been using the coordinated assessment to prioritized homeless clients that are most in need and have the longest homeless history.	a. Disability and health is associated with chronic homelessness, and although our CoC System track health insurance enrollment rate, improvement needs to be made on tracking measurable outcomes to determine whether the enrollment rates are having a positive impact on clients once housed and share those results (annual reporting) with the community at large to inform local and national policy decisions. b. Although we are on target to end chronic homelessness, we are facing difficulty in housing the hard to serve clients. For example, chronically homeless clients who present additional barriers to housing like criminal backgrounds, violent behavior, and/or severe disabilities require comprehensive care. This requires collaboration among systems that identify a common strategy and target high risk/barrier clients that ultimately provides an opportunity to stable housing. c. We need dedicated units for Chronically Homeless population as scattered site rents increase.

Commitment	What we have done	Areas for improvement/future focus
Finish the job of ending chronic homelessness in 2017 continued.	d. Implementing Housing First and low barrier models to all CoC funded housing programs, rather than the traditional housing readiness model. Housing First provides clients living on the street with immediate housing, followed up with one-on-one case management plus services. The low barrier model encourages programs to remove all admission barriers, such as people with criminal backgrounds, no income, or active substance use etc. e. Matt Urban Center in collaboration with the University of Buffalo conducted a study called "Chronically homeless women: Where are they?" The study focused on the needs of the chronically homeless women which opened up discussions on how to better serve this population. f. The Coalition Outreach Committee forged partnership with NFTA to better serve the chronically homeless individuals and families who lack a primary nighttime residence in a safer and effective way.	d. Once we finish the job on ending Chronic Homelessness, we will continue to utilize the current homeless system to continually work with people who have high needs but may not totally meet the CH definition (e.g. people who are homeless for 6 months) to prevent them from becoming chronically homeless. e. The majority of Housing First programs are scattered sites from rental properties, making it critical for participating landlords to collaborate efforts to end chronic homelessness in WNY. f. Corporation for Supportive Housing (CSH) Real Supportive Housing Need in New York State report from October 2015 recommends 1209 new PSH units are needed in Erie and Niagara County.

Commitment	What we have done	Areas for improvement/future focus
b) **Preventing and ending homelessness among veterans in 2017**	g. Reduced the number of sheltered homelessness among veterans. h. Ended unsheltered homelessness among veterans. i. Systems are in place to quickly identify and house veterans. j. Joined the "functional Zero" campaign to better track our progress on ending both chronic and veterans homelessness. k. Analyzed our local systems for collaboration between the VA and Homeless Alliance on veteran issues and sustaining Functional Zero in Buffalo. l. Created consolidated master List of Homeless veterans rather than multiple sub lists. m. Established a strategy on reporting of homeless veteran data from VA programs into HMIS. The VA office and related programs is now inputting data in HMIS.	g. Reduce any duplication to the delivery of veteran services. h. Utilize SOAR program to assist veterans that are not eligible for veteran benefits to access mainstream services. i. Consider and plan for the needs of Veterans who are high need, complex, and disabled but not to the extent that they are eligible for housing programs for people with disabilities. j. Improve upon system wide training of new staff particularly the need for cross training between agencies. k. Create roles and leadership positions that serve as bridges that can span boundaries across sectors in our stakeholder community including local government, the civic sector, etc.

Commitment	What we have done	Areas for improvement/future focus
c) **Preventing and ending homelessness for families, youth, and children in 2020**	n. We have increased Rapid Rehousing programs for families to about 250 beds in 2015. This provides short-term financial assistant to families in shelter; moving them quickly to permanent housing. o. Continually work with DV providers to address the unique challenge faced by the DV population. p. Used coordinated entry to prioritize those most in need for Transitional Housing and Rapid-Rehousing.	l. Continued priority for housing families with children and unaccompanied youth with the most severe service needs. m. Continued collaboration with housing developers to create affordable housing for people exiting the homeless system. n. 92 Emergency Shelter and 68 Permanent Supportive Housing beds are expected to be added to the homeless shelter system by 2019 by the Buffalo City Mission. o. There's a need in our community for Emergency Shelter **Diversion** efforts. **Diversion** according to NAEH is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. p. Attempt to work with school districts to identify and prevent family homelessness.

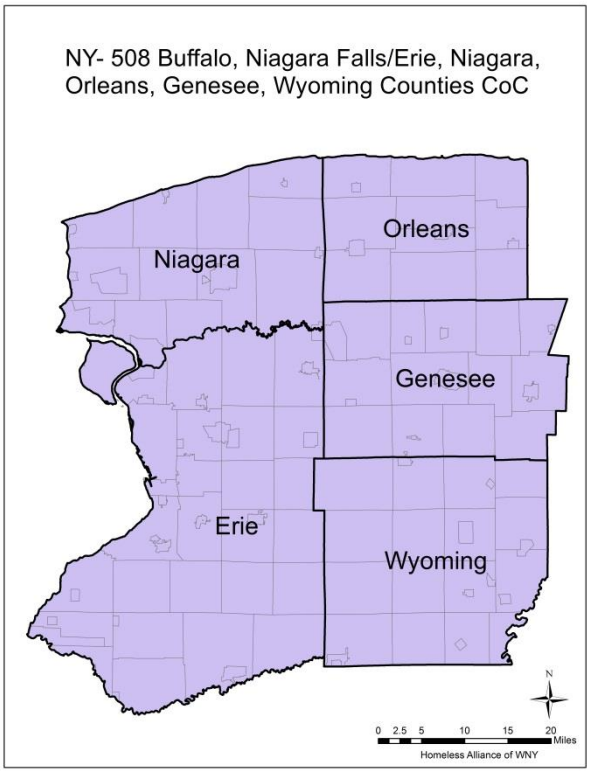
Commitment	What we have done	Areas for improvement/future focus
d) Set path to ending all types of homelessness	q. We have developed a unified intake Coordinated Assessment System to prioritize those most in need. r. We have created about 80 Rapid rehousing beds through ESG and have received 250 more rapid rehousing vouchers through the FY2015 CoC competition. s. The homeless continuum of care is in continued collaboration with the HIV housing continuum of care. This collaboration culminated into a position paper titled "HIV and Homelessness" released in 2014. The paper call for more collaboration to end both homelessness and HIV transmission in our region. This is in alignment with New York State Governor Andrew Cuomo's "2030 Bending the Curve" strategic plan. t. We have merged the Erie County continuum of care with Western New York adjacent rural communities to include them in our plan to end all types of homelessness in our region. u. The Buffalo City Mission established a coordinated transitional process systems in partnership with Erie County Medical Center, Kaleida Health and Catholic Health System to provide more effective care for individuals with unsuitable housing. The process will ensure that the unsheltered individuals are directly discharged from hospital to shelter.	q. We need to expand our coordinated entry system to cover all homeless people including the newly merged Counties. r. Expand the homeless funding stream to include prevention dollars for single individuals with low vulnerability. s. Focused research to better understand homelessness for all subpopulations (family, youth, rural, veterans and chronic homelessness). t. Provide cultural competency training programs in order to work effectively and collaboratively in cross-cultural situations such as rural, chronic homelessness, youth, LGBTQ, DV, refugees, family and HIV homeless services/settings. u. Design motivational and self-worth training programs for people experiencing homelessness through homeless program agencies.

Commitment	What we have done	Areas for improvement/future focus
Set path to ending all types of homelessness continued.	v. In October 2014, the Homeless Alliance started tracking health insurance enrollment rate for people experiencing homelessness. 94% of the CoC participants have health insurance. w. Enhanced HMIS full participation of service providers. There are currently 210 HMIS users. x. Participated in the National 100,000 Homes Campaign in 2012 where our community was ranked within the top 60 CoCs throughout the nation. As part of this campaign, about 186 chronically homeless individuals in Erie County were placed in permanent supportive housing and linked to mainstream services.	v. Housing first is an approach to homeless assistance that prioritizes rapid placement and stabilization in permanent housing and does not have service participation requirements or preconditions such as sobriety or a minimum income threshold. We will continue to encourage ALL PROGRAMS to remove barriers to entry, use coordinated assessment, prioritized households most in need and provide client centered services. w. Encourage all partners to participate in HMIS, especially those who are in the newly merged geographical areas, so that we can better understand the population throughout the CoC. x. Expand partnerships and collaborations with local workforce to increase access to employment and earned income by people who are homeless or at risk. y. Decrease the rate of episodic hospital and shelter visits.

Commitment	What we have done	Areas for improvement/future focus
Set path to ending all types of homelessness continued.	y. Aligned funding for supportive services to ensure that priority populations are housed using a coordinated model approach. z. We have partnered with the University of Buffalo to do a study on "emerging homeless youth". The study is expected to provide the guidance needed in the future on how to address youth homelessness in our community more effectively.	z. Partnerships with landlords and housing service providers. aa. Creating set-asides PSH units for people experiencing homelessness within affordable housing developments that receive investments of public funding or leverage private investments using Low Income Housing Tax Credits. bb. Developing Housing First approach using single-site based housing with support services. With Buffalo at risk of gentrification, this will provide another choice for clients and help ensure that (long-term) rent is stabilized and affordable for the hard to serve homeless population. Although a scattered sites approach provides choices, it can affects rental costs thus making it unaffordable. cc. Local zonings should consider instituting inclusionary zoning policies to help increase affordable housing. dd. Service providers should leverage with public investors to benefit low-income residents and working-class neighborhoods.

Continuum of Care Mergers

The Homeless Alliance of Western New York has consolidated five communities into the NY-508 continuum of care, meant to increase opportunities and collaboration regionally. The merger is now locally known as the Buffalo, Niagara Falls, Erie, Niagara, Orleans, Wyoming and Genesee Continuum of Care and is represented by the map to the right.



The newly merged community creates a diverse region of rural, suburban, and urban communities with housing and homeless challenges unique to each area. It generates an opportunity for the newly established CoC to address challenges and barriers of homeless services found throughout the region, creating a stronger Western New York with one common vision of ending homelessness.

The City of Niagara Falls and Niagara County have the largest comparable population to the City of Buffalo and Erie County. Strategies towards ending chronic homelessness in these urban centers will benefit from shared resources and strategies.

Benefits of merging will also impact smaller communities in Genesee, Orleans, and Wyoming Counties; an area that doesn't qualify for homeless programming funds through HUD's Emergency Solutions Grant (ESG), due to small population. The merger will expand resources to these three counties, establish collaboration among service leaders, and increase opportunities for Federal HUD funding for homeless services.

The purpose of this section is to introduce and incorporate these communities into our local Ten Year Strategic Plan of preventing and ending homelessness in the Western New York region.

Niagara County

Niagara County serves both urban and rural communities. With a population of 213,525 people, Niagara County has an estimated 1,874 homeless people according to the State of Homelessness 2014 report for Western New York.[4] About 14.4% of Niagara County residents live below the poverty level. This includes 32.2% of female-headed households, 20.7% of children under the age of 18 and 9.8% of people age 65 and over, according to the 2012 Niagara County 10 Year Plan to End Homelessness.[5] One out of three people with incomes below poverty in the Niagara area live outside urban areas where support services such as emergency food, housing and employment training are concentrated, making access to homeless services difficult, according to a University of Buffalo study in 2013.[6]

Before merging with the Erie County CoC, Niagara County had a continuum of care entity of housing and supportive services available to its homeless population. The original Niagara CoC was founded in 1994 and served as the lead coordinating entity for the county's CoC homeless funding applications headed by the Community Missions of Niagara County.

Other champion organizations that provide provisions of homeless services to individuals and families in the Niagara area include:

- Lockport Cares – Emergency Homeless Shelter located in Lockport, NY but serving both Niagara and Lockport residents
- Niagara Gospel Rescue Mission – Men's Emergency Homeless Shelter
- Casey House – A shelter for youth experiencing homelessness
- The Crib Family and Children's Service of Niagara – serving homeless youth and their children experiencing homelessness
- YWCA of Niagara Frontier - serving DV victims
- 24 Hour Crisis Services – 716-285-3515
- Isaiah 61 Project – provide Job training and housing rehabilitation
- Niagara Community Action – Neighborhood Center
- Niagara County Department of Mental Health – Provide mental health services to people who access the homeless system, specifically the chronic homeless individuals

Moreover, Niagara County has a Ten Year Plan to End homelessness titled "Niagara County Continuum of Care Plan to End Homelessness 2013-2023" which was released in 2012. The plan details strategic plans and challenges faced by the community in their homeless delivery system. It is used as a reference to identify trends, ensure alignment and avoid duplication of effort and reporting for this plan update.

As a result of strategic planning in Niagara County, the Depaul Taskforce in Niagara County is collaborating with local champions of the homeless system to develop a Daybreak Center for homeless

[4] 2014 State of Homelessness Report for Western New York
[5] Niagara County Plan to End Homelessness, 2013-2023
[6] A community report City of Niagara Falls, University at Buffalo Regional Institute, December 2013

and at-risk clients that will act as a coordinated entry point. This will serve as a non-residential resource that's links clients in need to appreciate supportive services.

In addition to Niagara County's Ten Year Plan, the Homeless Alliance conducted a community needs assessment to identify community strengths and weakness, as well as assess what the Niagara community sees as priority issues in ending homelessness in their community. We accomplished this task by using secondary data, interviews and doing a side by side comparison between the Niagara County Ten Year Plan and community needs assessment to identify trends and gaps in system. Based on the community needs assessment and Niagara County Ten Year Plan, the following were identified as barriers and gaps in services to end homelessness:

Comparison of barriers identified in CoC Needs Assessment and Niagara County's Ten Year Plan

Gaps /Barriers	Niagara County TYP 2013-2023	The CoC's Needs Assessment	New Trend
• Continued cut in funding for supportive services, a catalyst which they see as a mean to ending homelessness in Niagara County	⓿		
• How to address rural homelessness	⓿	⓿	
• Unemployment	⓿	⓿	
• High cost of child care		⓿	
• Transportation (public transportation is sparse)	⓿	⓿	
• Location of service tends to be urban centered		⓿	
• Access to Healthcare		⓿	
• Lack of job opportunities		⓿	
• Coordination of services to help clients navigate a complex homeless system			⓿
• Juvenile re-entry program			⓿
• Lack of safe and affordable housing stock	⓿	⓿	
• Lack of mental health services (People suffering from mental illness are clustered around services)		⓿	
• Largest population-at-risk of homelessness have been in poverty their entire life (55% of people accessing the homeless system receive some form of public assistance)	⓿	⓿	
• Lack of awareness for services available		⓿	
• Individuals leaving the corrections system (seen as the biggest challenge in tackling homelessness in Niagara County)	⓿	⓿	
• Blight: vacant and abandoned properties			⓿

Continued from Page 22

Gaps /Barriers	Niagara County TYP 2013-2023	The CoC's Needs Assessment	New Trend
• Lack of a living wage	⓿	⓿	
• Daily living skills and independence training is needed, especially for those re-entering from institutions or assisted care programs.			⓿
• Lack of permanent supportive housing opportunities (wait list over 100 people).		⓿	

Strengths of the Niagara County Homeless Service System include:

- Strong philanthropic spirit among community groups
- Niagara University's strong involvement in community development
- Collaboration between human service providers
- Optimistic tone focusing on city renewal projects to revitalize the city
- Niagara County's Medicaid Care collaborative care approach known as health homes. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), health homes are designed to facilitate access to and coordination of care to individuals with multiple chronic health conditions, including mental health and substance use disorders. "This approach can yield positive results if well implemented and coordinated" (Michael White, Deputy Director of Niagara County DMH). According to the New York State Department of Health, there are two health home agencies in Niagara County; The Niagara Falls Memorial Medical Center and Health Home Partners of WNY LLC. These agencies partner with medical providers, social service agencies, and local non-profits to provide comprehensive care and housing services to clients with chronic conditions who qualify.[7]
- Case management strategies utilized by The Niagara County Drug Court System linking people to mainstream services, such as treatment, employment and housing

About $111,640 of HUD CoC's McKinney-Vento in annual funds support the homeless system of Niagara County.

[7]https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/contact_information/list_by_county.htm#niagara

GOW (Genesee, Orleans, and Wyoming counties) Subgroup

The GOW subgroup meets once a month to plan and coordinate services for residents experiencing homelessness within the three county region, in addition to collaborating with the entire 5 county CoC region. Major partners in the subgroup consist of government agencies, local nonprofits, and faith based organizations. The GOW's smaller and less dense population results in a tight community of service based agencies sharing common challenges and resources when serving the homeless. These challenges include a lack of emergency shelter services, program funding, and transportation options.[8] This partnership also encourages collaboration among agencies by increasing funding eligibility for the HUD CoC grant for programs that will provide services across the three counties.

To gain a better understanding of homeless and housing challenges in this area, HAWNY conducted an unofficial Point –In-Time Count (PIT) for sheltered and unsheltered clients. Volunteers and local service agencies participated by administering an intake survey, conducting an inventory of clients currently identified as homeless, and an organized street outreach effort during the week of September 14th 2015, reporting on clients' homeless status during the night in question (September 14th). Unsheltered clients were not identified but reported as an occasional occurrence at a select few locations. The sheltered homeless population in the three county areas primarily included veterans' services, transitional housing, and hotel/motel temporary housing vouchers. Those identified include; 86 persons experiencing homelessness, 49 families, 49 people over the age of 24, 16 people under the age of 18, 40 males, and 17 females.[9]

At this time, the GOW area only has one program receiving CoC funding in Orleans County. Rural communities in the GOW area have no designated emergency shelter specific for homeless situations and rely heavily on the County's Department of Social Services to serve as a central access point for emergency placement into hotels and motels, among other services. Local DSS offices provide a variety of useful services that are beneficial to residents experiencing or at-risk of homelessness. Emergency shelter placement to hotel/motels by DSS is often utilized by those exiting the criminal justice system and do not qualify for Section 8, or those who are consistently refused housing by local landlords due to destructive behavior.[10] The table below outlines basic services offered by each DSS office in the GOW. Similar services can also be found by local nonprofits but often work with DSS for referrals and resources.

[8] CoC NY-508 GOW Subgroup Focus Group
[9] PIT-Genesee,Orleans,Wyoming Summer 2015 Count Total
[10] Richard Bennett, Genesee DSS; Holli Nenni, Orelans DSS; David Rumsey, Wyoming DSS

Services Offered by GOW Department of Social Services		
Genesee	**Orleans**	**Wyoming**
• Temporary Cash Assistance • Out-of-County Shelter Placement • HEAP (Home Energy Assistance Program) • Local hotel/motel shelter voucher placement • SNAP/ Food Stamps/ EBT • Child and Family Services • Non-Residential domestic violence services • Child Care Assistance • Employment Program • Wheels for Work • Adult Protective Services • Child Protective Services • Medicaid Applications • Family Health Plus • Child Health plus	• Temporary Cash Assistance • Out-of-County Shelter Placement • HEAP (Home Energy Assistance Program) • Local hotel/motel shelter voucher placement • SNAP/ Food Stamps/ EBT • Child & Family Services including Adult and Child protective services, Adoption, and preventative services • Non-Residential domestic violence services • Child Support Services • Medicaid Applications	• Temporary Cash Assistance • Out-of-County Shelter Placement • HEAP (Home Energy Assistance Program) • Local hotel/motel shelter voucher placement • SNAP/ Food Stamps/ EBT • Child Support Services • Non-Residential domestic violence services • Medicaid Applications • Adult Protective Services • Disabled Client Assistance Program

Due to the variety of services offered to the homeless community by these three county agencies, it will be imperative to further collaborations and discussion with the county government offices, especially in Genesee, Orleans, and Wyoming.

Additionally, HAWNY organized a focus group with GOW partners to identify strengths, weaknesses, opportunities, threats, and general gaps in services. Members from each county were given the opportunity to express concerns specific to their community. A SWOT (Strengths, weakness, opportunities, and threats) analysis was used to assess the needs of the community and formulate strategic areas for the GOW Continuum of Care. The table below is summarizing the discussions from the GOW focus group:

GOW SWOT Analysis

	Helpful to achieving the objectives of the GOW CoC	Harmful to achieving the objectives of the GOW CoC
Internal attributes	**Strength** • Networking among the different service providers throughout the community • Respite housing • Care and Crisis/Mental Health Hotline • Employment services: One-Stop/Ace Employment • Salvation Army Pilot Program for re-entry • Collaborations for Habitat for Humanity	**Weaknesses** • Public awareness of services offered in the community • Lack of commitment or public buy-in • Bringing the right people to the table that will bring funding for needed programming • Public pushback for programming. "Not In My Backyard" (NIMBY) • Transportation to services • Lack of funding and resources
External attributes	**Opportunities** • Public/private partnerships • Shelter alternatives for singles and adults without children • Short-term subsidized housing (rapid re-housing) • Employment and job training • Increased transportation services • In-house substance abuse services • Personal finance and budgeting education • Services for re-entry • Comprehensive planning/training in understanding the causes of homelessness • Utilize hospitals as central service locations • Increase client accountability • Low Barriers Programming (Section 8)	**Threats** • Lack of funding • Political preferences (limitations are set on the construction of SRO/rooming housings). NIMBYs • Seasonal employment • Public transportation services are cut • Awareness of public funding opportunities • Public education about homeless issues and awareness.

Orleans County

Orleans County is a rural community in the Continuum with a population of 41, 984 people. It borders Niagara County, Genesee County, Monroe County and Lake Ontario. About 13.4% of Orleans County residents live below the poverty line.[11] In 2015, Orleans County Community HUD Point-In-Time reported that the continuum of care served about 19 homeless people. This number included 5 people that were served in Emergency Shelter by DSS, 14 in Transitional Housing, and no reports of unsheltered homeless. Orleans County is the only community in the subgroup that has received funding from NY-508 CoC in the past and currently receives about $66, 607 of the CoC's homeless renewal funds for a transitional housing program.

Homeless services in Orleans County are structured through a strong collaboration/communication among these primary agencies:

- Department of Social Services (DSS)
- Ministry of Concern
- Department of Mental Health
- Department of Housing Assistance
- United Way of Orleans County
- Community Action of Orleans and Genesee Counties
- Catholic Charities through the Tri-County Office in Batavia
- Independent Living's Comprehensive services

Most people accessing homeless services in Orleans are working families living below the poverty line. The lack of adequate and affordable housing stock is a great contributor to those at-risk of homelessness. According to the Genesee-Orleans Ministry of Concern, about 50% of people requesting for homeless assistance from their homeless program are families headed by a single parent.[12]

The majority of services in Orleans are comprehensive case management programs. Gaps in services for the homeless were identified by a HAWNY organized focus group and include: single point of entry, transportation to services, lack of emergency shelters, lack of funding for homeless, and lack of housing/shelter options for single adults with no children. A majority of those experiencing homelessness in Orleans County are referred to Pathstone Visions transitional housing or put into a local motel by the DSS.

[11] New York State Poverty Report, 2015
[12] Laverne Bates, Executive Director, Ministry of Concern

Client barriers in Orleans County make it increasingly difficult to shelter or house different people in particular situations. Moving forward, it will be important to address these specific barriers identified by a local focus group:

Barriers specific to Orleans County include:

- Unemployment (income limits)
- Substance abuse
- Mental illness
- "Revolving door" of situational homelessness
- General lack of public transportation (distance from housing to employment centers creates barriers)
- Criminal records is a barrier to subsidized housing and employment
- Lengthy time navigating local services
- Lack of awareness for services available

Genesee County

Genesee County is mostly rural with small urban clusters and a population of 59,162 with a poverty rate of 12.6%.[13] It borders every other county within the Continuum and connects Western New York to the rest of the state via the New York State Thruway. Homelessness in Genesee County is considered rare with more reported cases of at-risk of homelessness. Major factors within Genesee County that contribute to homelessness include**:**

- **Unexpected or sudden tragedies:** job loss, domestic disputes, unexpected financial burden. Many who fall into this category are reported to be low income workers who have more than one minimum paying job
- **People released from prison:** Ex-offenders, depending on their past offense, find it increasingly difficult to locate eligible affordable housing, including Section 8
- **Substance abuse:** Substance abuse is seen as a social and mental issue that acts as a common denominator for those who slip into a state of homelessness
- **Couch surfer:** Considered to be the largest population utilizing homeless services, as well as the most underrepresented

There are currently three (3) HUD programs that provide residential services to Genesee County; 1) Section 8 Rental assistance program, 2) first-time homebuyer program and 3) family unification. The Section 8 program, organized by Pathstone Corporation plays a large role in serving Genesee County residents who are unstably housed by providing affordable housing for the poor/low-income population to prevent homelessness especially among families and the elderly.

The Care + Crisis Hotline, operated by the YWCA, serves as the main point of entry and service referrals for those in crisis situations. Due to the lack of shelters within the county, temporary placement into

[13] U.S. Census Bureau, 2009

hotels, motels, and rooming houses by Genesee Department of Social Services and The Salvation Army serve as a vital resource for families and individuals experiencing a housing crisis, especially those recently released from prison.

Although people released from prison are seen as a homeless issue, there is a lack of reentry programs in the county to help those recently released adjust to life outside prison. However, service providers and faith-based organizations work well with the prison system to ensure that inmates are not released into street homelessness.

For individuals and families experiencing a "situational crisis," such as mental health, drug abuse, and domestic violence, there are agencies that provide "crisis bed" units coupled with supportive services specific to their needs. Those with mental health issues experiencing a housing crisis can seek temporary placement with Living Opportunities of DePaul. Survivors of Domestic Violence may seek refuge and support through an offsite placement with YWCA. The Genesee/Orleans Council on Alcoholism and Substance Abuse (GCASA) provide in-house recovery beds and counselling for those recovering from substance abuse.

This is the first time Genesee County is participating in a CoC funding competition. According to the 2015 Point-In-Time count for Genesee County, 22 people were recorded experiencing homelessness. 1 spent their nights in an emergency shelter and 21 in Veteran's Transitional Housing.

Based on a Community Needs Assessment survey and community focus group, the following were identified as needs and gaps in services for people experiencing homelessness in Genesee County:

- Limited public Transportation (general lack of mobility)
- Stigma regarding who is homeless
- Lack of emergency funds for people experiencing homelessness to prevent eviction. Salvation Army and DSS are the only agency that provides emergency funds for homeless prevention on a limited basis and are extremely limited
- The need to improve mental and drug treatment programs
- Individuals experiencing homelessness find it hard to get assistance from DSS. They end up couch surfing with friends or family. Rapid-Rehousing funds are mostly needed to help this population
- People tend to gravitate for services in Batavia
- Discharge planning between the County parole office and DSS needs improvement. Lack of a proper discharge plan for parolees increases the chances of homelessness and re-entry into the incarceration system
- Lack of individual Client-Centered Comprehensive case management especially for the population suffering from substance abuse (substance abuse is seen by the community as an epidemic)

Based on the same Community Needs Assessment, the following were identified as strengths within Genesee County that contribute to homeless prevention and services:

- Strong Faith-based community with community service based programming.
- Good relationship with landlords. Landlords are willing to negotiate rental fees with service providers to ensure that housing is affordable for low income tenants
- Sharing of information with other agencies
- Section 8 vouchers play a big role in preventing homelessness
- Working with people experiencing personal trauma that would have lead them to homelessness
- Tight-knit community

Wyoming County

Located south of Genesee County and east of Erie County, Wyoming County is a resilient community that prides itself on strong neighborly bonds. Wyoming County has a population of 42,155 and produces large amounts of dairy for the region. According to Community Action for Wyoming County, there are an estimated 1,800 at-risk of homeless people in Wyoming County and 30 people experiencing homelessness annually.[14] In early 2015, the county joined the Erie and Niagara Continuum of Care for their homeless services, led by the Community Action for Wyoming County. The 2015/2016 fiscal year will be the first time the county is participating in the CoC homeless funding competition.

The current homeless service system for Wyoming is structured around the following areas of service delivery: Transitional Housing, Permanent Housing for at-risk seniors, homeless service referrals, strong partnership between service providers, and a community of neighbors that help each other in times of difficulty.

When asked about the county's strategy for serving the homeless, Executive Director of Community Action of Wyoming County indicated that, "It's about reconnecting the homeless with the community to a level they can sustain." He also said that there is a high demand for at-risk-homelessness prevention resources not available to their area.

Wyoming is spread out with limited transportation options, creating additional challenges for those who are homeless or cannot afford their own vehicle. The majority of reported homeless cases are seen as hidden or situational. HUD defines situational homelessness as being forced to live without housing due to a specific emergency, such as a natural disaster, job loss, divorce, or death of a primary income earner.

People returning from prison or a person facing hospital discharge with no place to go, is reported as a growing concern for unsheltered homelessness. The willingness of local landlords to rent housing to

[14] Community Action for Wyoming County, 2015

persons experiencing homelessness or returning society from prison will play a large role in stably housing and preventing homelessness in Wyoming County.[15]

There is a permanent housing component in Wyoming county homeless service system that only serves homeless adults with children managed by Wyoming County Community Action. The program has 9 units with 30 beds. The County once had a shelter for domestic violence victims/survivors but has been shut down due to lack of funding. Currently, there are no emergency shelters for homeless individuals or individuals fleeing domestic violence. Individuals in urgent need of a homeless shelter are referred to Erie, Niagara, or Monroe Counties.

Based on the community needs assessment questionnaire for Wyoming County conducted in 2015, the following were identified as challenges in the delivery of homeless service system:

- Transportation (general lack of mobility, including public transportation)
- Lack of emergency shelter such as Domestic Violence Shelter
- General lack of knowledge among the community about available services
- Distance between employment, home and services
- Lack of funds for supportive services, services such as transportation, rapid-re-housing and homeless prevention
- The community utilize section 8 vouchers for their homeless veterans in lieu of VASH absence
- Lack of permanent supportive housing for the hard to serve homeless population
- Demand from resources are from those experiencing situational homelessness
- Individuals that are experiencing homelessness choose to go into hiding to avoid moving to Buffalo (Erie County) when referred to go for housing services there

Key stakeholders and cross-sector collaboration agencies in Wyoming County that play a big role in ending rural homelessness are:

- Community Action for Wyoming County
- Department of Social Service, led by Commissioner David Rumsey
- Probation Office
- Office for the Aging
- Community of neighborhoods, their act of kindness and willingness to help each other
- The various agencies in the community

Currently, no programs operating in Wyoming County receive CoC funding but by identifying the major partners and opportunities, Wyoming County takes its first steps in defining the challenges and resources needed to solve homelessness in its community.

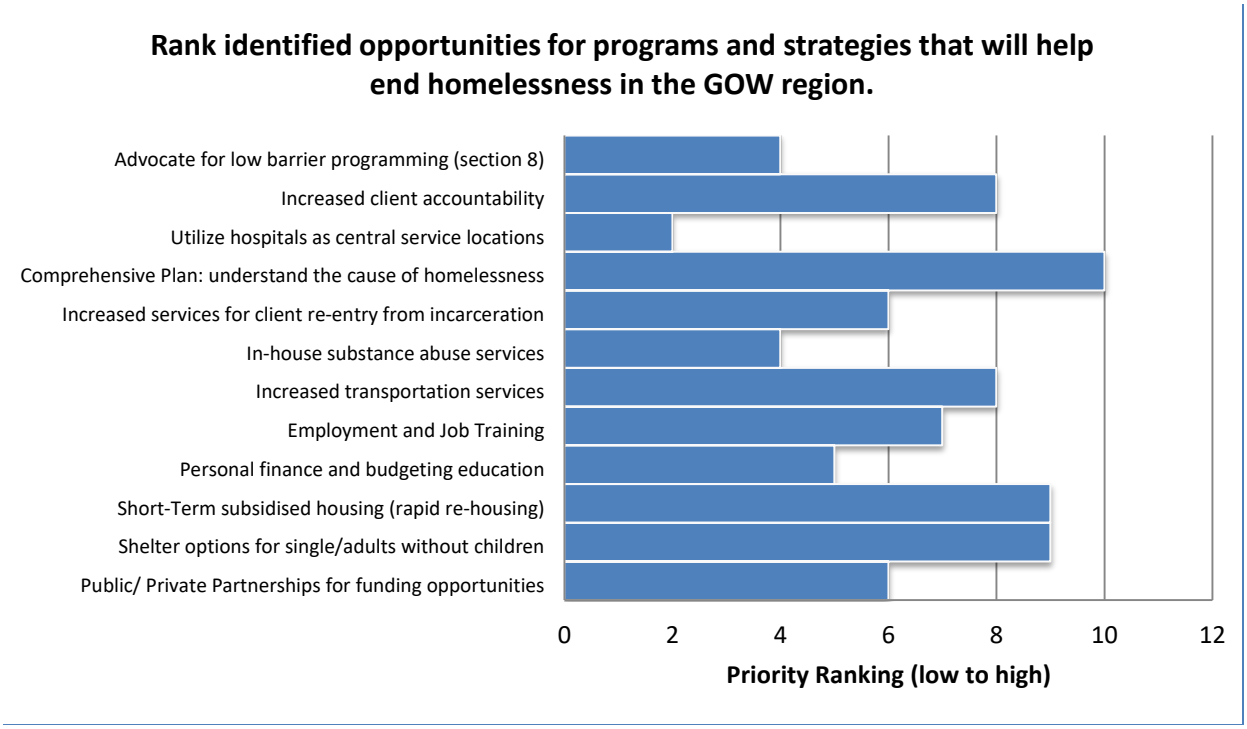
[15] Executive Director, Community Action for Wyoming County.

CoC funds allocation by counties

	2012/13	2013/14	2014/15
Genesee County	-	-	-
Erie County	$8,190,480	$8,859,170	$9,759,592
Niagara County	**$103,696**	**$103,696**	**$111,640**
Orleans County	$66,697	$66,697	65,344
Wyoming County	-	-	-

Merging the NY-508 CoC into its present 5 county region offers the opportunity for facilitated collaboration among participating agencies and expansion of resources to a broader audience. The hidden nature of homelessness in rural communities negatively impacts the amount of resources in an area, forcing many to leave the county. By working with community leaders and government officials in these areas, we can create a strong advocacy network that will support and advocate for the gaps in services for the homeless population in these areas through recommended action steps.

The opportunities identified through the GOW focus group were collected and redistributed to committee members for a ranking according to need 1 to 12. Results of this study can be seen in the graph below.



The GOW opportunity ranking shows us that there is a need for planning and coordination among agencies for a better understanding of homelessness in their community. Other common gaps include: lack of funding, shelter services, and specialty services that will lead clients to more stable housing. The merger will give counties like Genesee and Wyoming the opportunity to use pursue CoC funding that will support programs that will fills the gaps in services identified for their homeless population. Other barriers may be overcome through continued collaboration and advocacy among government agencies and human service organizations throughout the area.

Way Forward

Ending Family and Youth Homelessness

Although we have drastically reduced chronic and veteran homelessness, ending family and youth homelessness still require our utmost attention. One of *Opening Doors: Federal Strategic Plan to End Homelessness* goal is to prevent and end child, youth and family homelessness by 2020. **5 years from now, it will be 2020! Can we reach that goal?** Over the past 5 years, the Homeless Alliance as the coordinating agency for the collection of homeless data has been working towards: 1; improving on how we report data to better inform policy, 2; reallocating CoC funds to stabilize child and family homelessness, 3; expanding our collaboration to non-CoC partners that serve families experiencing homelessness to establish common goals of ending child and family homelessness, and 4; establishing systematic response programs such as rapid-rehousing in both urban and rural areas with collaborating partners (Cities, Counties, and Towns) to reduce family homelessness in our region. Most recently, we have started conversations with the school systems and state funders to bring them on board as collaborating partners in the fight to reduce child and family homelessness by 2020.

According to HAWNY reports, there has been an improvement in overall data quality that has been collected on the homeless population in the Western New York area and for family and youth homelessness in particular. However, as data quality continues to improve it would be helpful to conduct local community case studies to better understand the data behind the nature and extent of family and youth homelessness in urban, suburban and rural areas. Markedly, people experiencing homelessness and how they access services differ considerably from one community to another; services are frequently difficult to access in rural areas in particular, people travel greater distances to access them. The characteristics and needs of family experiencing homelessness are also different, but poverty, affordable housing, domestic violence and livable wages are the principal causes of family homelessness, according to the National Center on Family homelessness. In fact, a recent 30 months longitudinal SHIFT (Service and Housing Interventions for Families in Transitions) study of single mothers experiencing homelessness in four cities including Buffalo found that:

- More than half of families entering shelters and housing programs still didn't have stable residences after 30 months. The study attributes this to factors impacting the mother's ability to earn an income, including unemployment, level of education, poor health and low self-esteem.
- 93% of homeless mothers who enter a homeless shelter experienced a trauma.
- Another finding was that the incidence of trauma among the mothers affects their housing stability.[16]

Given the correlation between trauma and housing instability for families, the study recommends that housing and homeless programs serving families be trained in trauma-informed care. Locally, this is

[16] Service and Housing Interventions for families in Transitional (SHIFT) Study Final Report

happening. A shelter that serves families, unaccompanied youth fleeing domestic violence or the hard to serve population for example generally provides residential counselling to people suffering from trauma, and offer counselling services linkages for people with disability or substance abuse. The University at Buffalo School of Social Work offer workshops in trauma-informed care to social workers and human service providers. It is however, not known how many providers often send their staff to these trainings. Generally, nonprofits operate on a tight budget, and most staff training is funded out of general operating support which is hard to come by. Therefore, it would be helpful if local, state and federal funds come with funding to support training.

Family Homelessness

Over the past few years the number of homeless persons in families with children has been decreasing. [17] While this is a positive finding, it is not clear why this has been occurring due to lack of substantial evidence to support the findings. But, there are local social services homeless prevention programs in all of the CoC counties which are the vital safety net for families with children and/or low income population when homelessness occurs. The Department of Social Services (DSS) play a big role in ending family homelessness, and it is for this reason that **we do not have families experiencing homelessness on the street**. It is suggested that poverty is the number one cause of homelessness, particularly for families. [18] Research has also shown that rapid-rehousing may be the best way to house families who have become newly homeless. [19]

Increased funds through the Emergency Solutions Grant (ESG) funds and Continuum of Care have become available to help house homeless families. These funds can continue to be used to help create Rapid Rehousing programs for families and individuals and to narrowly target families for shelter diversion.

Over the years it has been found that the majority of households experiencing repeated homelessness are households with only adults. Consistently around 75% of the chronically homeless are adult singles, particularly males. Households with adults and children have the lowest recidivism rate of about 10%.

[17] Homeless Alliance of Western New York, Annual Report on the State of Homelessness, 2008-2014.
[18] Homeless Alliance of Western New York, Annual Report on the State of Homelessness in Erie-Niagara Metropolitan Area, 2014.
[19] Homeless Alliance of Western New York, Annual Report on the State of Homelessness in Erie-Niagara Metropolitan Area, 2014.

The SHIFT study, mentioned above, mirrors the Family Options study that was conducted by HUD from 2010-2013 with the goal of learning more about the effects of different housing and services interventions for homeless families'. [20]. This study advocates for the following, at policy level, in ending family homelessness:

Family Option recommendation	CoC recommendation
• **Fund more permanent housing vouchers to decrease wait-list.** • **Removing unnecessary barriers to housing.** • **Invest in rapid re-housing and continue to study its outcomes.**	• Supportive Housing solves homelessness especially for individuals, families and young adults who are homeless and vulnerable, including those living with serious and persistent mental illness, chronic health conditions including HIV/AIDS, and long term addition.[21] • Use Rapid Rehousing to assist families with low to modest barriers overcome housing and other barriers. • Policies to end homelessness must include jobs that pay livable wages. In order to work, families with children need access to quality childcare that they can afford, and adequate transportation. Education and training are also essential elements in preparing parents for better paying jobs to support their families.[22] • But jobs, childcare, and transportation are not enough. Without affordable, decent housing, people cannot keep their jobs and they cannot remain healthy. • Affordable housing is a key component to resolving family homelessness. Preventing poverty and homelessness also requires access to affordable health care, so that illness and accidents no longer threaten to throw individuals and families into the streets.[23] • Section 8 targeting homeless clients or clients graduating from homeless programs.

[20] HUD Family Options Study
[21] Campaign 4NY/NY Housing
[22] National Center on Family Homelessness
[23] National Center on Family Homelessness

Unaccompanied Homeless Youth

Youth ages 18-24 make up about 10-15% of the overall homeless population.[24] Research shows that youth experiencing homelessness, increase the risk of becoming homeless as adults. Homelessness disrupts daily routine and structure especially for children, affecting their health, education, as well as their parent's abilities to seek employment. Western New York has a concentration of homelessness among those who are less educated. Housing stability and education would be beneficial to decrease this trend. It is suggested by the National Alliance to End Homelessness that the best solution to tackling youth experiencing homelessness is:

1. "Family reunification" (when it is safe to do so) more so for youth under the age of 18
2. Rapid re-housing programs (18-24 age group) that are tailored with support services linking them to education, income and employment programs. Our CoC provides counselling services to young people and their family. However, our CoC lack shelters that tailors to young adults in the 18-24 age group.

The tables below show annual HMIS data for homeless youth in Erie and Niagara Counties from 2010 to 2014.

Erie County	2010 HMIS Count	2011 HMIS Count	2012 HMIS Count	2013 HMIS Count	2014 HMIS Count
Youth under 18	168	149	250	199	250
Young adults 18-24	439	115	295	311	338

Niagara County	2010 HMIS Count	2011 HMIS Count	2012 HMIS Count	2013 HMIS Count	2014 HMIS Count
Youth under 18	-	-	-	-	96
Young adults 18-24	-	-	-	-	49

Source: BAS-NET – HMIS, 2015

Currently, there is a gender disparity with more young women going to shelters than men. Providers such as Compass House that serve youth suggest the cause could include that young men feeling more able to survive on the street. Attention to this trend will become important when addressing comprehensive services across the CoC for unaccompanied youth.

There is a gap in services for unaccompanied youth as well. This population is thus at a greater risk for becoming newly homeless. More programs to help youth under 18 develop independent living skills and employment seeking skills would better prepare the youth population later in life. Still, not a lot is known locally about this particular population (both in urban and rural areas) or what can be done to

[24] National Alliance to End Homelessness Policy Snapshot, 2015

better serve them. Future research will help guide strategies towards addressing homeless youth barriers.

The University of Buffalo's School of Social Work is working on a research project with help from HAWNY to determine how to better serve youth homelessness in Buffalo. The project will identify factors contributing to homelessness for young adults, what risks are associated with being homeless, and what resources do homeless young adults value, as well as barriers they recognize. The International Institute of Buffalo also partners with Community Connection of New York (CCNY) and has hosted various focus groups with various youth groups to discuss service barriers and needs. Final reports from these two studies will soon be available to the public.

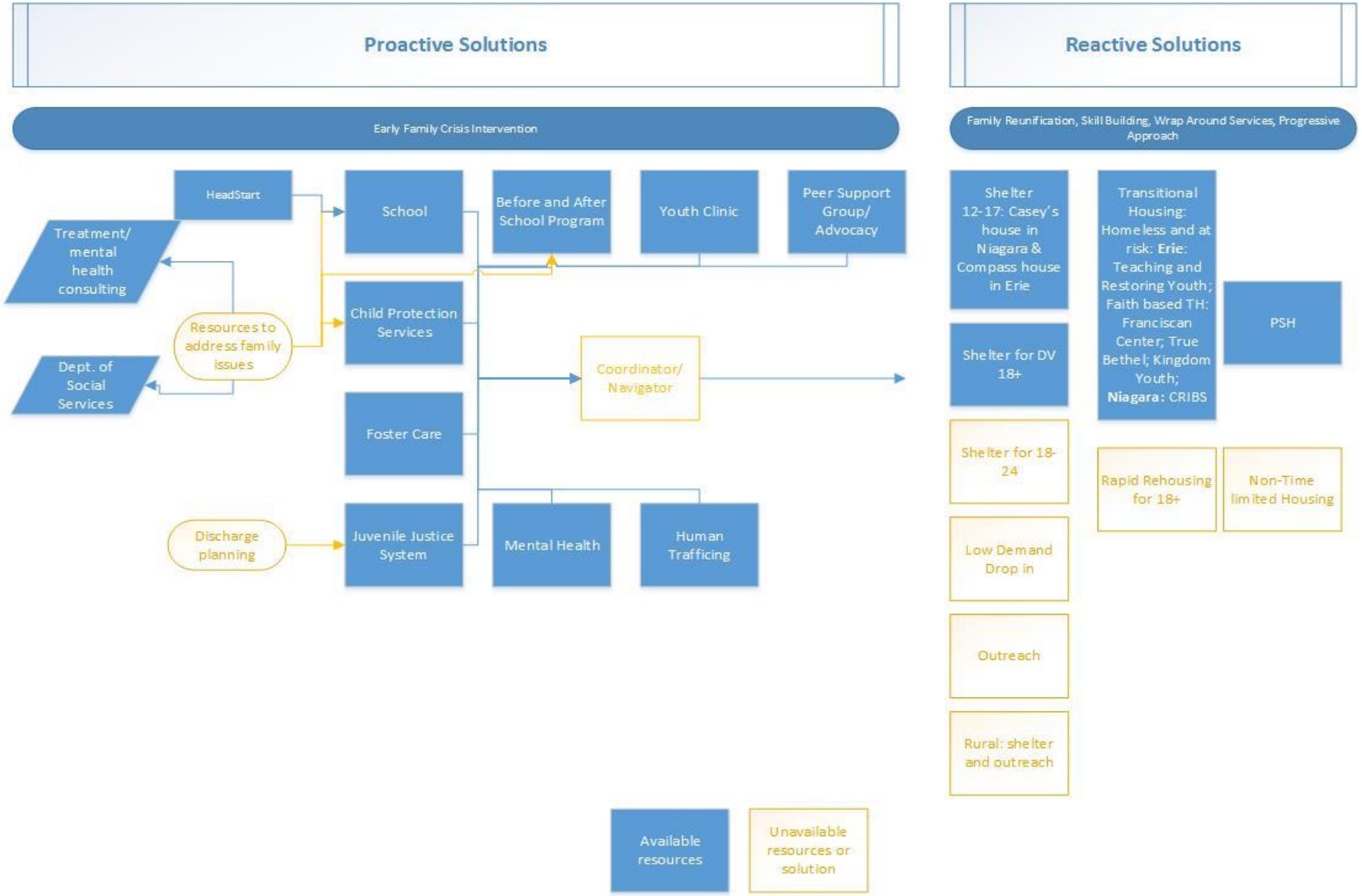
Additionally, our CoC system established A Youth Committee in 2016 consisting of more than 15 different agencies serving youth and young adults in Erie, Niagara and Genesee Counties to discuss solutions around ending youth homelessness. Based on the committee discussions, the following were identified as gaps in service when youth are experiencing homelessness:

- Lack of resources in addressing the issue of homeless youth
- Lack of Housing Navigators or coordinated system for homeless youth
- Lack of a clear set of solutions to addressing homeless youth
- Poor Discharge plan for youth returning from juvenile justice system

The committee further suggested some key solutions when addressing an end to youth homelessness:

- Have a point of contact to help youth navigate the homeless system. Also informing the youth of available resources and giving them options
- In need of a young adult shelter serving clients age 18-24
- In need of a low demand drop in center that runs overnight and provides youth a safe place to stay, while engaging youth in a more relax setting
- An effective youth outreach program that also provide basic needs of food, clothing, hygiene products, medical care, transportation and other basic need supply, especially in the rural areas. Currently there are no shelters or outreach services for youth in rural areas
- For the 18-24 age group, Rapid Rehousing could be a housing solution, which will provide rental voucher as well as services. More intensive services might also be needed
- No-time-limited housing model could be used to replace or fill-in the gaps of transitional housing and permanent supportive housing. Giving youth flexibility on program length will help youth better transition into adulthood and gain independence
- Services should use the progressive engagement and focus on skill building

The chart below, developed by the HAWNY Youth Committee, summarizes the service gaps along with recommended strategies to ending youth homelessness in our region.



Ending all Types of Homelessness

Both rural and urban homelessness have negative effects on our communities without exception. Marginalized populations, such as the homeless, become increasingly powerless to decisions made about their community. Many don't vote or even bother voicing concerns about their lives. It is an isolated life with very little representation to resources and possible severed family ties. Advocates for the homeless need to speak out and ensure the needs and concerns of the marginalized are heard. Rather than prolonging homeless status through shelter stays, community priorities should focus on immediate housing solutions. Although progress has been made in addressing homelessness, there is still work to be done when confronting poverty and the root cause of homelessness. This includes economic inequality, chronic/mental illness, domestic violence, the continuing widening gap between housing costs and income, the lack of affordable housing, lack of a living wage and criminal records that are preventing people from getting housed or employed.

Domestic Violence Victims

For the general population, the Center for Disease Control (CDC) estimates that 35.6% of women and 28.5% of men will experience intimate partner violence in their lifetime.[25] Research shows domestic violence plays a role in family homelessness. Most of the domestic violence shelters in our community serve women. While domestic violence shelters cannot turn men away, there is a lack of services available for men. There are no domestic violence shelters in the area designed specifically for men.

It is important to note that the percentage of domestic violence victims who are single and female has decreased while males have become a greater percentage[26]. When looking at families though, females are consistently 97% of the victims.[27] The overall numbers of homeless domestic violence victims seems to be decreasing.[28] However, it could be that these clients are receiving shelter from domestic violence programs. Agencies such as the Family Justice Center and Child and Family Services have increased their outreach to domestic violence victims and try to house them before they become homeless. Agencies have not experienced a decrease in clients they serve. [29]

Due to a lack of resources and funding, Wyoming County is currently the only community within the continuum without a facility to specifically and safely shelter domestic violence victims. Currently, the county contracts RESTORE Sexual Assault Services to manage situations and victims of domestic violence, which will result in transporting the client out of county, if shelter services are needed.

[25] Prevalence and Characteristics of Sexual Violence, Stalking, and Intimate Partner Violence Victimization—National Intimate Partner and Sexual Violence Survey, United States, 2011
http://www.cdc.gov/violenceprevention/pdf/nisvs_executive_summary-a.pdf
[26] Homeless Alliance of Western New York, Annual Report on the State of Homelessness, 2008-2014
[27] Homeless Alliance of Western New York, Annual Report on the State of Homelessness, 2008-2014
[28] Homeless Alliance of Western New York, Annual Report on the State of Homelessness, 2008-2014
[29] Family and Justice Center of Buffalo, NY

Snapshot of Domestic Violence Shelters by Counties

County	Program Type
Erie County	
Haven House	Shelter for female victims of domestic violence
Community Services for the Developmentally Disabled Safe House	Safe House for the developmentally disabled victims of domestic violence
Genesee County	
YWCA of Genesee County	DV shelter for female victims of domestic violence
Orleans County	
PathStone Corporation	Safe Housing for female victims of domestic violence
Niagara County	
YWCA of Niagara, Inc	Safe house/shelter for female victims of domestic violence
Family & Children's Service of Niagara	DV shelter for victims of domestic violence and their children
Wyoming County	N/A: non-residential domestic violence service and counseling

Human Trafficking

Many survivors of human trafficking in United States Citizens occur domestically. Those experiencing homelessness, runaway youth, as well as those engaged in sex work are vulnerable to being subjected to commercial sexual exploitation and human trafficking. These populations need special attention to properly identify survivors and provide supportive, tailored services, according to the International Institute of Buffalo (IIB), the primary service provider for any and all survivors of human trafficking in Western New York, offering intensive case management and criminal justice-based advocacy.

Victims of human trafficking are often unidentified or criminalized for the illegal activity coerced upon them. New York State has enacted several initiatives aimed towards the identification and support for survivors labeled as criminals, including Safe Harbor legislation, vacate laws and Human Trafficking Courts. Expertise in these services is vital for survivor support, as lack of appropriate shelter, medical care, legal services, substance abuse support, and mental health counseling can lead to re-assault, re-arrest and re-trafficking.

While IIB has expertise in this population and tailored intensive case management services, it also works collaboratively with providers who espouse and prioritize trauma-informed, harm reductionist service models. Referrals are consistently made to Haven House, Teaching and Restoring Youth, Jericho Road, Matt Urban Hope Center, Volunteer Lawyer's Project, PATH, and Lakeshore Behavioral Health.

According to Cornell University, it is estimated that over 100,000 migrant workers are employed on farms throughout New York State, with a substantially growing number of dairy farms.[30] These workers most of whom possess temporary visas or are undocumented, are especially vulnerable to human trafficking and other exploitation. This poses an increased risk for rural communities within the Continuum that rely on migrant workers and are disadvantage due to less transportation options.

FY2015 is the first year HUD put emphasis on human trafficking issue and allowing CoC to use CoC dollars to approach the issue of human trafficking and human trafficker are now qualified as category 4 in HUD definition of homelessness as victims who are fleeing domestic violence.

LGBTQ Homeless Population

20% of homeless youth nationally are LGBTQ - Lesbian, Gay, Bisexual, Transgender and Questioning.[31] LGBTQ individuals often have great difficulty finding shelters that accept and respect them. Findings from community focus groups that were conducted in 2012 point to the difficulties case managers face when serving the LGBTQ homeless population as some shelters are traditionally designed to serve one gender.

Some possible reasons for homelessness in the LGBTQ community stem from family conflicts and lack of shelters that are not tailored to their needs. Currently, there are no programs in the CoC system that are specifically designed to serve this population, however, there are Runaway and Homeless Youth (RHYA) OTDA funded housing programs such as Compass House, Casey's House, Independent Living of Genesee and DSS Emergency Housing Services that are inclusive of the LGBTQ population.

Parolees and Convicted Felons

Studies have shown that people leaving prisons are more likely to experience long-term homelessness if they are not properly linked to mainstream services before their release. Although there are halfway house/reentry programs in our community for people leaving prison, many still find themselves confronted with challenges that push them to end up on the street, such as unemployment, mental health issues, and chronic poverty.

Existing criminal records often make finding a job challenging. Many businesses even have policies to exclude anyone with a criminal record from the hiring process. The City of Buffalo actively opposes this practice by passing a law in 2013, banning the prejudice against those with a criminal background from any business within the city.[32] Similar pressure should be put on business throughout the region by services organizations to overcome prejudice against those with criminal backgrounds.

In Wyoming County, close to the border of Genesee County, is Attica Prison, the largest maximum security corrections facility in WNY, making homelessness among people leaving prison a large concern

[30] Cornel Farmworker program, 2015.
[31] LGBT Homeless Youth fact sheet, National Coalition for the Homeless, 2012
[32] McCarthy, Robert J., The Buffalo News, Council 'bans the box' to help ex-cons land jobs, 2013

for the GOW subgroup. DSS representatives from Genesee, Orleans, and Wyoming County have expressed unique challenges when housing past convicted criminals, especially sex offenders. In some cases having a criminal background will interfere with acquiring Section 8, HUD related funding, and limit housing options altogether. Housing paroles in the GOW area also receives public pushback from the community making it even more difficult.[33]

To address the issue of reentry in their community, the GOW created Bright Futures Genesee, a collaborative program between the Mental Health Association of Genesee and other social service agencies to better coordinate services between prison parole offices and supportive services in the area that will connect past convicts to permanent housing, stable jobs, and reintegrate them into society more effectively.[34]This Improved coordination among social service agencies and correctional facilities on the county and state level like this is needed for better discharge planning to avoid exits to homelessness.

Healthcare and Housing

HUD has defined chronic homelessness as an individual or family with a disabling condition who has been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years. At least half of people living with a disability or chronic condition experience homelessness or housing instability following diagnosis. Many lose their employment due to frequent hospitalizations and need for care. Along with this, the costs of healthcare can became unmanageable and take away from resources intended for housing. Studies have shown that linking housing and healthcare may be an effective strategy for people who are chronically homeless.

It seems that health care and homelessness are related to each other in a circular fashion. For example, people living with HIV/AIDS can face challenges such as lack of affordable housing, lack of support, lack of a stable income, and potential struggles with mental health issues and substance abuse. This can put them at a higher risk for becoming homeless. [35] Affordable health care could help achieve housing stability. Further evidence shows that housing has a major effect on health and that stable housing can significantly improve health outcomes for chronically homeless individuals.

Programs around the country, such as those in Boston and New York City, use a Vulnerability Index to assess and prioritize the housing and healthcare needs of homeless individuals. The Chicago Housing for Health Partnership has tested an approach that combines housing with intensive case management services. This approach has yielded greater housing stability and fewer hospital visits for chronically homeless patients. [36]

To better integrate both housing and healthcare systems, the Homeless Alliance is planning on fully implementing HUD's soon to be released H^2 (Healthcare and Housing) plan developed for New York

[33] David Rumsey, Wyoming County DSS; Tom Kuryla, Orleans County DSS
[34] Sue Gagne, Mental Health Association of Genesee
[35] AIDS Network of Western New York, Children and Young People's Committee, Homelessness and HIV Position Paper
[36] Linking Housing and Health Care Works for Chronically Homeless Persons, HUD Policy Brief , 2012

State by housing and healthcare providers during a 2-day planning seminar that was held in May 2016. The goal will be to improve data quality, strategic integration, and analysis to better understand the comprehensive needs of clients to reduce client burden and improve housing stability and health outcomes.

Rural Homelessness/ "Hidden Homeless"

Since merging to a 5 county region, the NY-508 Continuum of Care includes a more diverse collection of less dense communities with less access to housing and supportive services. The Homeless Alliance of WNY is working to ensure that those experiencing homelessness in these rural communities receive the same opportunities to those living in suburban and urban communities throughout the CoC.

Compared to the Continuum's urban centers (City of Buffalo and City of Niagara Falls), the newly adopted counties of Genesee, Orleans, and Wyoming consist of a small clustered cities, remote rural towns, and isolated villages.

In urban areas, homelessness is an issue more visible to the community, whereas in smaller rural communities, homelessness is hidden from the public eye (other rural homelessness is more like urban homelessness, e.g. someone sleeping on a friend's sofa or floor). "Hidden Homeless" issues persist in less densely populated communities where supportive shelter services and access to public transportation are not readily available.

Many residents experiencing homelessness in rural communities resort to doubling up on a friends' couch, living in tents or cars far away from public view, or forced to leave the area due to lack of emergency shelter services. Other trends affecting rural homelessness include high levels of poverty, the distance between low-cost housing and employment opportunities, transportation, lack of affordable housing, and fewer homeless shelters than their urban counterparts. [37]

According to the National Alliance to End Homelessness *Geography of Homelessness* report, there are approximately 14 homeless people on average for every 10,000 people in rural areas, compared with 29 homeless people out of every 10,000 in urban areas. Between 2013 and 2014, homelessness in statewide Continuums of Care (CoCs), which are typically composed of multiple rural counties, declined by 5 percent.[38]

Moving forward, the Homeless Alliance of Western New York is working to ensure that appropriate housing and shelter resources are made available in the Continuum's rural communities. This will allow current residents to maintain social resources and remain in their preferred community without being forced to relocate to urban areas where concentrations of social service agencies are located. Identifying the current situation of homelessness in these communities will also require consistent collaboration with public and private sector leaders, increased participation to the CoC's HMIS system, and establishment of a coordinated entry system for those experiencing homelessness in these communities.

[37] National Coalition to End Homelessness
[38] HUD 2014 Homeless Assessment Report

Gentrification and housing affordability

Housing is considered affordable when tenants pay no more than 30% of their income toward their rent and basic utility. Although Buffalo's owner occupied units are considered to be very affordable compared to the national market, the majority (56.4%) of renters in Erie County, Niagara Falls and GOW are paying more than 30% of their income on rent.[39] Recent development projects within Buffalo increase the risk of city neighborhoods and housing becoming gentrified, and thus decreasing affordable housing stock. This is an economic and geographic trend that could greatly impact homeless clients being served in the area. Gentrification is predicted to increase property/rental prices (most notably in urban areas), thus displacing the low-income population. Low-income earners who lack rent-stabilized housing are then forced to relocate to a different area or are forced to live on the streets. Other populations affected by gentrification include minimum wage workers, the elderly, and the disabled population whose income is heavily dependent on SSI/SSDI income. Those on welfare struggle to find moderately priced rental housing affordable with public assistance vouchers. Collaborative efforts are needed among private developers, city officials, and service providers to maintain affordable housing; not only for urban renewal projects but also to protect the low-income population and neighborhoods that will be threatened by gentrification.

Refugee's resettlement

A refugee is a person who fled their home in order to escape war or political persecution. An estimated 12,000 refugees have resettled in Erie County since 2010. 2,000 more are expected by the end of 2015, according to Journey's End Refugee Services, a resettlement agency in Buffalo. While Erie County sees the increase in the number of resettled refugees as a positive trend in the repopulation of Buffalo, some refugee families however end up staving off homelessness in the U.S.A due to lack of income and poverty[40]. It is reported that about 56% of immigrants and refugees who reside in the Buffalo-Niagara Falls Metropolitan area are living in poverty-ridden neighborhoods.[41] While government assistance is provided to them temporarily, many find themselves struggling to pay rent and utility after the government assistance runs out. For those unable to find work they resort to doubled-up. Double-up in this brief is described as an individual or family living in a housing unit with extended family, friends, and other non-relatives due to economic hardship. While not all people who are doubled-up become homeless, for many this event serves as a precursor.[42]

Moreover, as tough to navigate as the homeless-support system can be for the growing numbers of those experiencing homelessness in our region, it can prove profoundly challenging for the refugee population who are assimilating into a culture that is foreign to them, coupled with the language barrier. Some suffer from substantial Post Traumatic Stress Disorder (PTSD) as a result of their exposure to traumatic events and the hardships associated with life as a refugee, according to Jericho Community

[39] Erie County Homeless Annual Report, 2014
[40] Refugees Face Homelessness All over Again in U.S, the Seattle Times, 2010
[41] Gretchen Sullivan, Immigrants, Refugees, and Poverty in Buffalo, 2012
[42] Economy Bytes: Doubled Up in the United States Report, National Alliance to End Homelessness, 2010

Health Center, a family practice that provides health services to low-income people and trauma-informed care of traumatized refugees. PTSD (a disease that today affects 11% of veterans) and Homelessness are connected. PTSD raises the risk of homelessness because it makes it difficult to hold down a job. The implications for people suffering from it create challenges for both homelessness and mental health providers.[43]

As this new population becomes part of our community, attention needs to be given to future plans on how to address refugee's unique needs to make sure they don't join the growing number of the general homeless population. Currently, the Homeless Alliance does not collect data on refugees; therefore it is not known how many are experiencing homelessness or at-risk of becoming homeless. Similar local studies as the one mentioned earlier in the report need to be done to better understand the experiences of resettled refugees. Data collected via PIT count could also be updated to include the Homeless Refugee category. Furthermore, advocates for refugees, researchers and county officials need to collaborate to see how refugee families in general get help to guide future plans.

Sustaining "Functional Zero" for Veteran Homeless

Functional Zero is a new phrase coined by Community Solutions to define the meaning of "ending homelessness" particularly among chronic Veterans who are experiencing homelessness. Community Solutions defines "functional zero" as:

> *"At any point in time, the number of people experiencing sheltered or unsheltered homelessness will be no greater than the current monthly housing placement rate for people experiencing homelessness."* (In simple terms, it means: homelessness has ended when the number of people entering homelessness in a community is equal or less than the number of people exiting homelessness).

On the other hand, US Interagency Council on Homelessness (USICH) defines ending homelessness as:

> "*An end to homelessness means that every community will have a systematic response in place that ensures homelessness is prevented whenever possible or is otherwise a rare, brief, and non-recurring experience."*

[43] Addressing Post-traumatic Stress Disorder caused by homelessness, National Alliance to End Homelessness

Vision	**Every Veteran has a right to housing. No Veteran will become homeless, but if they do have a housing crisis, it will be brief and adequate supports are in place to ensure retention of stable housing.**
Goal	A goal of housing Veterans from the time they choose a permanent housing solution to move-in is 45 days.
Process	1. A Housing First philosophy has been adopted to serve homeless Veterans. 2. A By-Name list of Veterans is used to identify Veterans and refer them to the appropriate agency for service. This list is managed by the Homeless Alliance of Western New York, the CoC/HMIS lead for NY-508. It is reviewed on a monthly basis. a. HMIS will be the main data source utilized to maintain the By-Name list augmented by the VA HOMES and SQUARES data bases. 3. If a Veteran is identified in conditions not meant for human habitation through the extensive, continuing street outreach effort, they will be immediately referred to the VAMC for determination of eligibility for VA programs and offered immediate shelter in one of the area emergency shelters. a. If a Veteran is eligible for VA services they are immediately offered a permanent housing solution through VASH or SSVF funding. They will be also advised of their right to transitional housing through the Grant Per Diem programs. b. If a Veteran is not eligible for VA services they will be immediately referred to the Continuum of Care Coordinated Entry system to determine the proper housing stabilization plan. The CoC Written Standards prioritize Veterans who are not eligible for VA services in the placement of Permanent Supportive Housing or Rapid Re-housing - whichever is more appropriate for the client. They are also advised of the availability of transitional housing if they choose. c. Regardless of the entry point, the Veteran will work with a case manager to receive a permanent housing plan within 7 days. 4. If a Veteran uses an Emergency Shelter or seeks assistance of the Department of Social Services in any of the counties in the CoC, they will be referred to the VAMC for a determination of eligibility and referral to VA services or a CoC service agency. 5. If a Veteran chooses to enter transitional housing, they will work with a case manager to develop a permanent housing and services plan with 72 hours of placement. The plan includes permanent housing options, identifying barriers to achieving permanent housing and implementing a plan to remove the barriers. Educational, vocational, health, mental health and substance abuse issues are discussed in detail and assistance options offered to the client. This includes VA GPD and non-VA transitional housing. a. The housing options will be discussed with a case manager, at minimum, on a bi-weekly basis in addition to the services plan goals. b. In addition, the VA GPD Coordinator will meet with clients at least once per month to offer permanent housing options. The Coordinator is also available at least 1 day per week in each of the GPD programs if clients choose or need his assistance. 6. Veterans placed in permanent housing will receive adequate supports to ensure they remain housed. a. Permanent Supportive Housing clients receive case management either

	through the VA or housing first provider of the CoC. 7. Those Veterans accessing SSVF or Rapid Re-housing assistance receive case management referrals to the level identified in their housing and services plan.
Prevention	SSVF funds have the program flexibility to be the main resource to prevent Veterans from becoming homeless in the future. Additional resources are available through the county Departments of Social Services and the Erie County and Town of Tonawanda Emergency Solutions Grant funds which already prioritize Veterans for service.

The entire CoC must make the community more aware of the services that are available to Veterans in order for a successful prevention strategy to work.

Furthermore, for "functional Zero" to work, community leaders/legislators/policy makers need to focus on the following areas:

- creating employment opportunities geared toward this population
- creating enough affordable housing
- expand health and mental health care programs
- address the link between housing and health care as basic human rights. Housing is healthcare! (100,000 homes campaign)
- expand community development to inner city neighborhoods that have heavily dilapidated housing conditions. Improve housing stock, engage housing developers, Landlords, local public housing authorities (PHA), Buffalo Management Housing Authority (BMHA), Rental Assistance Corporation of Buffalo (RAC)
- our community is lagging behind when it comes to employment rate for those exiting homelessness. Continue to advocate for living wage jobs opportunities and income that will end and prevent homelessness among those experiencing homelessness
- economic development done with public money needs to be transparent and distributed equitable

HIV/AIDS and Homelessness

As mentioned earlier, housing is healthcare! While chronic and disabling health conditions increase the vulnerability of those experiencing homelessness by reducing people's ability to work, those living with HIV or AIDS (PLWHA) face additional challenges of housing insecurity. Many living with HIV/AIDS lose employment due to periodic hospitalizations or inability to perform job functions. Costs of healthcare become unmanageable, resulting in available income normally reserved for housing to be used for exigent medical costs.[44] Many have to drop their careers in order to get Medicaid because it is the only way to afford their medical costs.[45]

In the Western New York region:

[44] Opening Doors: Buffalo and Erie County Community Plan to End Homelessness
[45] AIDS Network of WNY Community Assessment Report, 2015.

- There are approximately 56,300 new infections in the US per year and a cumulative AIDS diagnosed case total of 982,498 (2006). Western New York has a cumulative total of 2,792 cases reported, representing .28% of the epidemic in the United States, or approximately 157 new cases per year. [46]
- The Centers for Disease Control and Prevention (CDC) estimate approximately .003-.004% of the U.S. population is living with HIV/AIDS. The U.S. Census Bureau projected the WNY region's 2007 population to be 1,534,277. Based on this data the number of individual living with HIV/AIDS in the region would be 4,603-6,137. [47]
- The CDC further reports that approximately 21% of individuals living with HIV infection are undiagnosed or unaware of their HIV status. (i)[48]
- According to the AIDS Network of WNY 2015 community survey, there are about 20.6% of PLWHA experiencing homelessness in Western New York. Since testing HIV positive, an estimated 7.8% of PLWHA spent their night in an emergency shelter or a place not meant for human habitation.

HUD is currently redesigning future planning efforts and strategies to more accurately reflect the unmet housing needs of people living with HIV or AIDS. New York State has taken the step further by addressing the healthcare and housing issues of the homeless population through Governor Andrew Cuomo's 2020 Strategic Plan titled "Bending the Curve". This plan, released in 2015, serves as the foundation for budget and policy priorities to realize the goal of Ending the Epidemic (ETE) and invest in critical steps towards ending AIDS, primarily by making a major commitment to ending homelessness among PLWHA across New York State. [49]

Call for Collaboration to End Homelessness

In the winter of 2015, New York State legislature enacted Chapter 482 of the Laws Bill S4343 which requires the New York State Commissioner of Temporary and Disability Assistance (OTDA) to report annually to the Governor and the Legislature detailing local social services district efforts to prevent, identify, and address homelessness in their communities.

The purpose of the Bill is to: "identify gaps in service delivery, underutilized funding streams, shifts in available funding streams, adequacy of funding, and best practices innovated by or in partnership with the local district." This is in alignment with "Opening Doors" new theme of Partnership with the specific mission of identifying best practices for "helping people with histories of homelessness and barriers to entering the workforce, identifying emerging practices that communities can undertake to improve communities' coordination and integration" in relation to employment and homeless assistance programs to help end homelessness (Partnerships for Opening Doors, July 2015).

[46] 2012 Data Collection Report, AIDS Network of Western New York
[47] 2010-2013 Community Health Assessment, Erie County Department of Health, Erie County NY
[48] Reportable communicable Diseases in Erie County 2012, Erie County Health Department, Erie County NY
[49] Housing Works www.housingworks.org/advocate

Over the years, our CoC consortium has built a close relationship with local social service providers including the Department of Social Services (DSS) as they are the first point of entry for most people experiencing homelessness. Moreover, since our coordinated assessments are implemented across the homeless service systems in all the five CoC's counties: Erie, Genesee, Niagara, Orleans and Wyoming, we have leveraged our partnership with them by engaging them in all our efforts to end homelessness in order to maximize all available dollars including ESG, CDBG and STEHP funding streams to end homelessness. Most recently, our CoC system has taken a new community engagement approach to end homelessness by putting more efforts on building and strengthening partnerships with the education system, healthcare system, workforce development programs and local public housing authorities.

In light of the new law, it is becoming more imperative that OTDA and the COC's program work hand-in-hand to arrive at a common goal in tackling homelessness across the state. To further promote collaboration, Governor Cuomo's office created the New York State Interagency Council on Homelessness (NYSICH) to better align strategies used to end homelessness in New York State.

	Community Policy Recommendations				
	Increase Leadership, collaboration, civic engagement	Increase access to stable & Affordable Housing	Increase Economic Security	Improve Health & Stability	Retool the Homeless Response System
1. Convene annual regional consortium to find common ways in addressing both urban and rural homelessness in the five CoC counties; Erie, Niagara, Orleans, Genesee and Wyoming.	X				
2. Expand the availability of affordable permanent supportive housing throughout the five counties.		X			
3. Strengthen community support for those experiencing homelessness through coordinated entry systems.	X	X	X	X	X
4. In order to capture all homeless youth, CoC needs to collaborate with schools and local colleges liaison officers.	X	X			X
5. Conduct local research studies to understand the numbers behind family, youth homelessness and others to inform policy changes.	X	X	X	X	X

	Increase Leadership, collaboration, civic engagement	Increase access to stable & Affordable Housing	Increase Economic Security	Improve Health & Stability	Retool the Homeless Response System
6. Utilize SOAR to assist sheltered chronic, veteran's homeless individuals/families and prisoner who are preparing for discharge to secure an income to maintain housing.	X		X	X	X
7. To be relevant in a highly competitive job market and to gain public support, human service programs (reentry) should target jobs in new and expanding business such as those funded through the Buffalo Billion Investment Development Plan where there is not yet a trained work force competing for those jobs.	X		X		X
8. Employment programs should work hand-in-hand with programs that advance community and economic development.	X		X		X
9. To address the shortage of public funding for reentry programming, work related programs should engage private sectors in the design, delivery, funding, and follow-up to their reentry programming.	X				X
10. The continuum of care should collaborate with state government and higher ranking county officials. Many of the federal resources designed for rural areas flow through the state and counties.	X	X	X	X	X

	Increase Leadership, collaboration, civic engagement	Increase access to stable & Affordable Housing	Increase Economic Security	Improve Health & Stability	Retool the Homeless Response System
11. Collect data in a way that is conducive to informing housing and health care policy. Integrate HIV homeless data collection into HMIS to better serve this population.				X	
12. Now that the Continuum of Care includes Erie, Niagara, Genesee, Orleans and Wyoming Counties we need to develop partnerships to effectively assist those experiencing homelessness and address the unique needs of those living in rural communities.	X	X	X	X	X
13. There's a shortage of affordable housing in Buffalo and Niagara Falls. Legislators need to put a cap on rental market rates in order for rent and wage to balance. High rents combined with low wages pushes people into homelessness.	X	X			
14. Extend rapid rehousing programs to unaccompanied youth who are residing on the streets or in emergency shelters or who are fleeing domestic violence and are unable to access social services due to their age.	X	X	X	X	X

Conclusion and Future Directions

United Nation Article 25 of The Universal Declaration of Human Rights state: "everyone has the right to a standard of living adequate for their health and well-being including food, clothing, housing, medical care, and necessary social services." This Article was written in 1948 and the United State is a signatory to this proclamation, yet 68 years later**,** about **578,424** of our homeless population do not have a proper home to live, according to the 2014 Annual Homeless Report to Congress. In the Western New York region, it is about **8,000** homeless people (2014 Homeless Annual Report for Erie-Niagara metropolitan areas). Indisputably, these counts (both national and local) did not include rural-urban sections, often overshadowing the needs of the rural homeless population (even HUD name in itself excludes the word rural).

As the community needs assessments indicates, homelessness exists in both rural and urban areas, largely due to the socio-economic disregard of human rights to marginalized people. Socio-economically, homelessness is caused by negative attitudes that stigmatize and further isolate the homeless (NIMBYs), poor, disabled, and the unemployed. The general lack of affordable housing effectively pushes people from their homes and communities onto the street or unstably housed situations. Corporate interests are making it difficult for the low income communities to access affordable housing. Private markets do not cater to the needs of low-income people, when studies have shown multiple positive impact of affordable housing, such as economic diversity and social equality. However, this is unattainable if the market supply does not prioritize affordable housing or views it as a bad investment.

"Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, and housing and medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

The Universal Declaration of Human Rights, 1948

To assume that insufficient affordable housing and/or poverty is solely responsible for homelessness is not the answer. Further studies are needed in order to understand the specific needs of each sub-population. Economic and political policies are needed that will empower the poor and minimum wage earners to attain better lives. In order for this to happen, the community needs to collectively and actively work together to advocate for those changes on behalf of the people we serve.

The following are action steps that we must take collectively to prevent and end homelessness and streamline our existing resources to serve all homeless population be it in urban, suburban or rural areas.

Buffalo, Niagara Falls, Erie, Niagara, Orleans, Genesee and Wyoming Counties CoC/HMIS NY 508 10 Year Plan Future Objectives and Action Steps

Theme 1: Collaboration								
Objective 1: Build public will to end homelessness through increasing awareness and knowledge.	**CoC County**					**Timeframe**		**Lead Agency**
	Erie	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	
a) Collect and provide local homeless statistic.		**X**	**X**	**X**	**X**	**X**		HAWNY/Coc/ DSS
b) Educate the public about urban and rural homelessness.	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY/CoC
c) Seek support & involvement from diverse & non-traditional partners.	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY/Coc
d) Educate the public about poverty & homelessness	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY/CoC
Objective 2: Promote Collaborative Efforts.	**Erie**	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	**Lead Agency**
a) Establish a regional intergovernmental council on Homelessness.	**X**	**X**	**X**	**X**	**X**	**X**		CoC/HAWNY/ NYS/DSS/City /County/Tow n
b) Establish Coordinated Entry System.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/CoC
c) Consolidated Plans should be amended to fund priority needs and gaps .	**X**	**X**	**X**	**X**	**X**		**X**	City/County/ Towns
d) Enhance collaboration between urban and rural areas.	**X**	**X**	**X**	**X**	**X**			CoC/City/Cou nty/Town
e) Host employment and housing fairs for all CoC members to acquaint members with new employment services and programs.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/CoC

Theme continued: Collaboration								
Objective3: Maximize effectiveness of local homeless Continuum of Care and full implementation of the HEARTH Act.	**CoC County**					**Timeframe**		**Lead Agency**
	Erie	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	
a) Collaborate with service providers and the public to identify and address priority issues related to homelessness.	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY
b) Ensure that CoC funding priorities address identified gaps/needs.	**X**	**X**	**X**	**X**	**X**		**X**	City/County/ DSS/Town
c) Retool, Reallocate, and Repurpose CoC/ESG/HOPWA funds to meet the needs of the homeless population.	**X**	**X**	**X**	**X**	**X**		**X**	CoC/City

Theme 2: Affordable Housing								
Objective 4: Increase availability of safe, adequate and affordable housing for all populations.	**CoC County**					**Timeframe**		**Lead Agency**
	Erie	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	
a) Develop affordable rental housing units for families through state, federal, and local resources (Worchester Housing Model).	**X**	**X**	**X**	**X**	**X**	**X**		NYS/City/County/Municipalities
b) Implement neighborhood revitalization strategies for neighborhoods with houses that are heavily dilapidated.	**X**	**X**	**X**	**X**	**X**		**X**	City/County/Local Developers
c) Provide annual monitoring of TH & PSH outcomes and report information to the CoC's	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY
d) Improve housing stock.	**X**	**X**	**X**	**X**	**X**	**X**		City
e) Engage BMHA, RAC and housing developers.	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY
Objective 5: Provide Permanent Supportive Housing (PSH).	**Erie**	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	**Lead Agency**
a) Promote and expand Housing First Model.	**X**	**X**	**X**	**X**	**X**		**X**	CoC
b) Research specific barriers to transition from TH to PH and develop programming to address barriers.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/CoC

Theme continued: Affordable Housing								
Objective 6: Provide housing options for rural homeless population.	CoC County					Timeframe		Lead Agency
	Erie	Genesee	Niagara	Orleans	Wyoming	2016-2022	Continuous	
a) Establish "alternative" shelter options for rural areas.		X	X	X	X		X	County
b) Increase transportation options		X	X	X	X	X		NFTA/County
c) Provide rapid-re-housing finding options for rural areas		X	X	X	X	X		CoC/City/County
d) Increase collaboration planning efforts.	X	X	X	X	X			HAWNY/CoC
c) Develop local data collection methods for rural homeless.		X	X	X	X	X		HAWNY
e) Create a pocket-guide for homeless services that are available in all five counties.	X	X	X	X	X	X		HAWNY

Theme 3: Economic Security								
Objective 7: Improve access to education and increase meaningful and sustainable employment for people at risk or experiencing homelessness.	**CoC County**					**Timeframe**		**Lead Agency**
	Erie	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	
a) Enhance life skill programming.		X	X	X	X	X		CoC/Service Providers/ DSS
b) Improve the identification of children experiencing homelessness and support them in enrolling in school.	X	X	X	X	X		X	City/County/ NYS
c) Coordinate/integrate employment programs.	X	X	X	X	X	X		CoC
d) Establish a CoC employment committee to focus on employment issues.	X	X	X	X	X	X	X	CoC
Objective 8: Reduce financial vulnerability.	Erie	Genesee	Niagara	Orleans	Wyoming	2016-2022	Continuous	Lead Agency
a) Increase Shelter Allowance for households on TNF to par up with increase in rental cost.	X	X	X	X	X	X		NYS/DSS
b) Provide affordable day care opportunities which will allow parents who are currently unemployed to enter the workforce.	X	X	X	X	X	X		County/NYS

Theme 4: Health and Stability								
Objective 9: Integrate primary and behavioral health care services with homeless assistance programs and housing to reduce people's vulnerability to and the impacts of homelessness.	**CoC County**					**Timeframe**		**Lead Agency**
	Erie	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	
a) Co-locate housing and health care.	**X**	**X**	**X**	**X**	**X**		**X**	Health Home providers/developers/NYS
b) Provide training to case managers working with people experiencing homelessness to help them access health care services.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/CoC
c) Make housing assistance a top health care prevention priority.	**X**	**X**	**X**	**X**	**X**		**X**	CoC/Health Home Providers
Objective 10: Prevent family and youth homelessness.								
a) Families with children under age of 5 should be targeted for prevention and homeless services.	**X**	**X**	**X**	**X**	**X**	**X**		DSS/Service Providers
b) Improve discharge plan for Youth Aging Out of Systems for a longer period of time.	**X**	**X**	**X**	**X**	**X**		**X**	Youth Service Providers
c) Insure homeless programs that serve households with children are using family-centered approaches.	**X**	**X**	**X**	**X**	**X**	**X**		Board of Education
d) Study the disparity in adolescents seeking homeless services.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY /Researchers

Theme 5: Crisis Response								
Objective 11: Strengthen the capacity of HMIS to meet the expanded data collection, reporting and research needs of the community.	**CoC County**					**Timeframe**		**Lead Agency**
	Erie	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	
a) Increase participation in HMIS to include all homeless providers who are not mandated by a funding source to participate.	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY
b) Develop new employment tracking system using HMIS. Continue emphasizing employment services at CoC's general meeting in an effort to have all providers focus on employment goals for all clients.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/CoC
c) Improve the collection of data regarding HIV, DV, Youth, and Veterans homelessness.	**X**	**X**	**X**	**X**	**X**		**X**	CoC/VA/Service providers
d) Expand data collection to include Veteran Services, HUD-VASH, and SSVF.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/CoC/VA
e) Find new ways to use HMIS data as a local decision tool for planning work on Veteran homelessness.	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY/VA
f) Make a systematic review of any trends in recidivism by Veterans back in HMIS and how to use that information for program planning.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/VA
g) Plan and host an Annual HMIS/VA Data Evaluative Meeting.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/VA

Theme 5 continued: Crisis Response								
Objective 12: Transform current homeless services to focus on preventing homelessness and rapidly returning people who experience homelessness to	CoC County					Timeframe		Lead Agency
	Erie	Genesee	Niagara	Orleans	Wyoming	2016-2022	Continuous	
a) Develop a single point of entry system/common assessment form	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY/CoC
b) Develop rapid re-housing programs		**X**	**X**	**X**	**X**	**X**		HAWNY/CoC
c) Use data-driven and outcome-bases approaches to target and place highly vulnerable individuals in PSH with supportive services.	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY/CoC
d) Create a Homeless Veterans' Task Force subcommittee of HAWNY Continuum of Care	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/VA
Objective 13: Improve provider understanding of requirements for access to and receipt of services.	**Erie**	**Genesee**	**Niagara**	**Orleans**	**Wyoming**	**2016-2022**	**Continuous**	**Lead Agency**
a) Increase the communities understanding of "Equal Access to Housing in HUD programs" rules to ensure all populations are being served equally.	**X**	**X**	**X**	**X**	**X**	**X**		HAWNY/CoC
b) Train homeless service providers to become culturally competent (refugee, LGBT, non-English speaking persons, sex offenders, and those with criminal histories.)	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY/CoC
c) Strengthen links between homeless service providers, schools, local colleges and hospitals	**X**	**X**	**X**	**X**	**X**		**X**	HAWNY/CoC

Acknowledgment

The CoC needs assessments partnership consisted of the following organizations and their representatives who contributed their time and effort to the update of this plan:

Mary Ellen Wilber, Genesee County Work Force

Nadia Pizarro, Code Blue Initiative

Joyelle Tedeschi, Code Blue Initiative

Keith Lukas, City of Buffalo

Susan Lumadue, City of Buffalo

Babette Sullivan, AIDS Network of WNY Women, Children and Young People Committee

Brooke Goergen, AIDS Network of WNY Women, Children and Young People Committee

Alex Pierce, Community Action of Wyoming County

Rae Frank, Independent Living of Genesee County

Major Patricia Kurtz, Salvation Army Batavia

Mary Rice, PathStone

Robyn Krueger, Community Missions of Niagara Falls

Holli Nenni, Orleans County Department of Social Services (DSS)

Thomas Kuryla, Orleans County Department of Social Services (DSS)

Judith Gardner, Wyoming County Department of Social Services (DSS)

David Rumsey, Wyoming County Department of Social Services (DSS)

Laverne Bates, Ministry of Concern (Orleans County)

Richard Bennett, Genesee County DSS

Cheryl Thompson, Orleans County PathStone

Lydia Mosg, Fidelis Care

Kelly Dryja, Wyoming County Department of Mental Health

Debra McKnight, Independent Living of Genesee Region

Sue Gagne, MHA in Genesee/Orleans County

Joan Kibler, Wyoming City Probation

Joan Mrzywka, Conifer Realty

Connie Sanderson, Pathstone

Robin Arnold Scott, Independent Living of Genesee Region

Karen Anderson, Veteran Affairs

Michael A. White, Niagara County Department of Mental Health, Alcohol & Drug Abuse

Roger L. Woodworth, Veterans One-Stop Center of Western New York

Glossary of Acronyms

BASNET – Buffalo Area Service Network

BMHA – Buffalo Management Housing Authority

CH – Chronic Homeless

CDBG – Community Development Block Grant

CDC – Center for Disease Control

CoC – Continuum of Care

DMH – Department of Mental Health

DSS – Department of Social Services

DV – Domestic Violence

ESG – Emergency Solution Grant

ETE – Ending the Epidemic

GOW – Genesee, Orleans, Wyoming

HAWNY – Homeless Alliance of Western New York

HEARTH – Homeless Emergency Assistance and Rapid Transition to Housing

HIV – Human Immunodeficiency Virus

HMIS – Homeless Management Information System

HOME – Home Investment Partnership

HOPWA – Housing Opportunities for Persons with HIV/AIDS

HUD – Housing, Urban and Development

LGBTQ – Lesbian, Gay, Bisexual, Transgender, and Queer (and/or Questioning)

NFTA – Niagara Frontier Transportation Authority

NIMBY – Not In MY Back Yard

PATH – Persons Against Trafficking Humans

PHA – Public Housing Authority

PIT – Point-In-Time

PLWHA – People Living With HIV/AIDS

PSH – Permanent Supportive Housing

RAC – Rental Assistance Corporation of Buffalo

RHY – Runaway Homeless Youth

RRH – Rapid Re-Housing

SAMHSA – Substance Abuse and Mental Health Services Administration

SNAP- Supplemental Nutrition Assistance Program

SOAR – SSI/SSDI Outreach, Access, and Recovery Technical Assistance

SSVF – Supportive Services for Veterans Affairs

STEHP – Solutions to End Homelessness Program

SQUARES - Status, Query and Response Exchange System

SWOT – Strength, Weakness, Opportunity and Threat

USICH – United State Interagency Council on Homelessness

VA – Veteran Affairs

VA HOMES – Homeless Operations Management and Evaluation System

VAMC – Veteran Affairs Medical center

VASH – VA Supportive Housing

CCNY – Community Connections of NY

PRISM – Prevention, Resources, Independence through Housing, Services, and Maintenance

CSH – Cooperation for Supportive Housing

Homeless Alliance™
of Western New York

Facilitating Dialogue and Strategic Action to End Homelessness

960 Main Street, Buffalo, NY 14202, U.S.A
(716) 853-1101 www.wnyhomeless.org

Amended 2016