

Winter Homeless Services: *Bringing Our Neighbors in from the Cold*

January, 2010



A Report From

National Coalition for the Homeless

www.nationalhomeless.org

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The National Coalition for the Homeless

The National Coalition for the Homeless (NCH) is a national network of current and formerly homeless people, activists and advocates, community-based and faith-based service providers, and others committed to ending homelessness. NCH is committed to creating changes necessary to prevent and end homelessness. At the same time, we work to meet the immediate needs of people who are currently or at risk of experiencing homelessness. NCH is committed to the principle that current and formerly homeless people must represent and be actively involved throughout the organization. Toward this end, the National Coalition for the Homeless (NCH) engages in public education, policy advocacy, and grassroots organizing. NCH focuses its advocacy on housing justice, economic justice, health care justice, and civil rights.



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Summary

Seven hundred people experiencing or at risk of homelessness are killed from hypothermia annually in the United States. Forty-four percent of the nation's homeless are unsheltered. From the urban streets of our populated cities to the remote back-country of rural America, hypothermia - or subnormal temperature in the body - remains a leading, critical and preventable cause of injury and death among those experiencing homelessness.

The National Coalition for the Homeless (NCH) has published **Winter Homeless Services: *Bringing Our Neighbors in from the Cold*** to raise awareness of the dangers and consequences of hypothermia on people experiencing homelessness. NCH maintains that knowledge, networking and temporary seasonal shelter and outreach are three of the most important elements to an effective regional or local approach to the reduction and prevention of exposure and hypothermia.

This report is a snapshot of winter homeless services nationwide. NCH staff has gathered information for this report from ninety-four respondents representing forty states and the District of Columbia, from urban, suburban and rural communities. NCH interviewed state and local coalitions, healthcare providers, and shelter operators in order to gain the best and broadest possible understanding of cold weather services available through these direct service providers and first responders.

There is general consensus among public health officials, medical professionals and service providers that to reduce the incidence of hypothermia nationwide, local communities should implement effective and timely strategies to address the needs of vulnerable populations, including creating temporary homeless shelters and extending the hours of operation for existing shelters.

Three critically important elements to an effective regional or local approach to the prevention of injury and hypothermia:

- **Knowledge** – Accurate and timely information can be life saving for people experiencing homelessness, while a lack of information can be damaging or deadly. In many communities, elected officials and decision-makers hold and keep critical information across a broad range of public and private resources and services. Effective prevention strategies include a pre-approved plan for the gathering and dissemination of lifesaving information to all critical stakeholders, including those at risk on the streets.
- **Networking** – In cold weather, local elected officials and decision-makers are a critical first step to preventing hypothermia. Those in need must receive clear, consistent and repeated messages about the signs, symptoms and consequences of hypothermia, as well as emergency services that are being made available for them. Furthermore, the general public wants and needs to know how to help those in danger of hypothermia and what responses are most appropriate. The public also needs to know who the decision-makers are and what decisions are being made.
- **Temporary Seasonal Shelter and Outreach** – Appropriate approaches to the level, design and schedule of prevention resources, shelter and outreach, are critical to an effective response. The level of response must be timely and measured against the imminent and emerging concern of injury and hypothermia. The design must place the human cost of injury and death front and center. And, the schedule of emergency shelters and outreach services must be developed and available based solely on sound established prevention practices.

Introduction

People experiencing homelessness have a much higher risk than the general population of developing exposure-related conditions such as hypothermia and frostbite. These conditions can be immediately life threatening and may also increase the risk of dying from unrelated conditions in the future. Increased homeless services, especially additional shelter availability, are necessary to accommodate the amplified need in the winter. The National Coalition for the Homeless (NCH) interviewed homeless coalitions and shelters nationwide to gain an understanding of the cold-weather services offered in each area. Of the reporting parties that responded, thirty-eight have temperature-specific cut-offs for their winter services, twenty-seven are open every night between specific dates, and twelve have no cut-offs but base their decisions on judgment, need, and capacity. Thirty-four (54.0%) of the reporting parties are open only at night, even in the winter. Additionally, thirty-eight (76.0%) of the reporting parties admit people who are inebriated into their shelters, and twelve (24.0%) do not. Governments need to provide funding to ensure adequate winter services in their communities. In addition, every state and city should have a cold-weather response plan in place before the winter in case of extreme cold.

Each year, as winter approaches and the temperature begins to drop, many homeless people move from the streets to their city's shelter system to escape the cold. Without a carefully constructed winter plan, homeless service facilities may find themselves unable to accommodate the influx of residents, and some of those people who seek shelter are turned out into the cold. With nowhere to stay except the streets, homeless people are at risk for a variety of conditions caused by exposure to the cold, including frostbite and hypothermia, both of which can be permanently damaging to one's health and can sometimes be life-threatening. Many of the chronic problems faced by the homeless people, including inadequate clothing, malnutrition, and underlying infection, further increase the risk of developing and dying from hypothermia. In addition, many homeless people struggle with alcohol and drug addictions. The use of these substances substantially increases their susceptibility to hypothermia.

Communities have a responsibility to protect their residents from overly adverse conditions. However, few communities have city-wide cold-weather response plans, and many of the nationwide plans currently in place leave gaping holes in accessibility. In rural areas, shelters often have no outside resources to help them cope with the increased demand caused by cold weather conditions. The majority of shelters and organizations surveyed offer expanded winter services only during certain months or only when the temperature falls below a pre-determined and arbitrary cut-off temperature. Above those cut-offs, even in conditions under which the most dangerous cases of hypothermia occur, many cities do not offer resources to help the homeless people escape from the cold.

Precautions to Reduce the Risks of Hypothermia*

- Wear hats, mittens, gloves and clothing that create a static layer of warm air, provides a barrier against the wind, and keeps the body dry.
- Avoid alcohol and other mood- and cognition-altering drugs.
- Recognize the signs and symptoms of hypothermia (e.g., shivering, slurred speech, and drowsiness) that indicate the need to seek shelter and call for help.
- Keep and carry emergency supplies containing blankets, non-caffeinated fluids, high-energy food, and an extra supply of medications for chronic conditions readily available.

**These precautions are important for both homeless people and those who help them.*

Exposure-related Conditions: Hypothermia and Frostbite

Hypothermia

Hypothermia occurs when a person's core body temperature falls below 95°F. The level of severity of the condition is defined according to body temperature. A core body temperature between 90°F and 95°F is classified as mild hypothermia; between 82°F and 90°F is classified as moderate hypothermia; and a core body temperature below 82°F is considered severe hypothermia (Centers for Disease Control and Prevention [CDC] 2006; O'Connell 2004). Signs and symptoms of hypothermia include exhaustion, numbness, cold sensation, shivering, pale or flushed skin, decreased hand coordination, slurred speech, and confusion (CDC 2006). Hypothermia can cause the heart, brain, and kidneys to malfunction and may be life-threatening. People suffering from hypothermia often have impaired judgment and cannot perceive their own need for shelter or medical care. Between 1999 and 2002, hypothermia-related deaths, totaling 4,607 in number, occurred in all 50 states in the United States (CDC 2006).

Frostbite

Frostbite is defined as local tissue freezing and injury, while cold-related tingling and numbness without tissue damage is referred to as "frostnip" (O'Connell 2004). Frostbite is generally classified from first degree (least severe) to fourth degree (most severe) based on the extent of tissue damage, although some clinicians prefer to classify frostbite as "superficial" (first and second degree) or "deep" (third and fourth degree) for reasons of practicality. Superficial frostbite only affects the skin and nearby tissues, whereas deep frostbite may affect the nearby bones, joints, and tendons (Biem et al. 2003). Frostbite can occur with any degree of hypothermia. Around ninety percent of frostbite cases affect the hands and feet, although it also may involve the ears, nose, cheeks, and penis (O'Connell 2004). Frostbitten areas often develop sensory loss and increased sensitivity to cold that may last for years. After deep frostbite, areas may also develop arthritis and chronic pain. In cases of severe frostbite, the affected areas may have to be medically amputated if they do not autoamputate (O'Connell 2004).

Relationship to Homelessness

Hypothermia does not occur only when the ambient temperature becomes very cold. Other aspects of the weather, such as wind and precipitation, lower the perceived temperature and cause the body to lose heat more quickly. Wet clothing causes a 20-fold increase in heat loss, and submersion in cold water causes heat to be lost 32 times faster (O'Connell 2004). Adequate clothing, including hats and mittens, helps prevent hypothermia by creating a static layer of warm air, keeping the skin dry, and creating a barrier against the wind (CDC 2006). Hats are especially crucial: up to 50% of a person's body heat can be lost through an uncovered head (O'Connell 2004). Inadequate or wet clothing is also a risk factor for frostbite. Additional risk factors for hypothermia include malnutrition, decreased body fat, underlying infection, lack of fitness, fatigue, inadequate shelter and heat, and other pre-existing medical conditions (Biem et al. 2003; O'Connell 2004). Infants and elderly people are particularly vulnerable. Other risk factors for frostbite include diabetes, smoking, and the presence of an infected wound (O'Connell 2004).

Many of these risk factors are common among the homeless population. Due to the circumstances of life on the streets, many homeless people do not have hats, gloves, or other clothing necessary for cold weather, and do not have extra outfits to change into when their clothing becomes wet. Many homeless people are not able to eat full or healthy meals and, as a result, suffer from malnutrition. People experiencing homelessness are three to six times more likely to become ill than housed people (National Health Care for the Homeless Council 2008).

The risk of developing hypothermia is raised substantially by the use of alcohol, nicotine, drugs, and some medications (CDC 2006; O'Connell 2004). Alcohol and other drugs that alter mood and cognition are associated with increased mortality from hypothermia (CDC 2006). This is partially due to the fact that these substances impair judgment, and may decrease the likelihood of the user to seek medical care. In addition, alcohol causes blood vessels at the surface of the skin to dilate, accelerating the loss of body heat (D.C. Department of Human Services 2008). Substance abuse is extremely common among the homeless population. Although recent, accurate estimates are difficult to obtain, the

Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that in 2003, 38% of homeless people were dependent on alcohol and 26% abused other drugs. In addition, nearly 80% of homeless people smoke tobacco (Lee et al. 2005).

Homelessness itself is associated with higher levels of hypothermia-related death. Relatively few people die directly from hypothermia. However, a significant number of people die from hypothermia- and/or exposure-related complications. Perhaps the most important factor, however, is that people who are homeless often have nowhere to go when the temperature drops. Even those who seek shelter – and are allowed to enter – are frequently turned back onto the streets during the day. Cities must provide adequate services to protect every homeless person from hypothermia and frostbite during all hours of the day, regardless of their intoxication status or past behavior.

Overview of Current Programs

Methods

Interviews were conducted with staff from nearly one-hundred homeless coalitions and shelters across the country. Organizations were selected from NCH’s membership and contacts. Interviewers attempted to gain the best possible understanding of the cold-weather services offered to the homeless population in each community. Although we asked each organization the same set of questions, we did not follow a specific format during phone conversations. Responses were recorded as accurately as possible during and after interviews.

The report data reflects 94 reporting parties from 60 cities and counties in 40 states and the District of Columbia. A list of organizations interviewed is found in the “References” section (page 17 - 20). We gathered data from individual shelters as well as data for entire cities. For this reason, when we refer to the “number of services”, this reflects the number of reporting parties rather than the number of shelters that offer those services. When analyzing our results, we only included organizations that have a specific winter policy or change the availability of services depending on the weather.

This study is a snapshot using data from 70 communities from various areas across the country, the results may not reflect the cold-weather responses in every part of the country. Our aim was to learn which services are common and what programs have been successful, less successful or unsuccessful. We believe that the major concepts of this study are applicable to the nation as a whole. We have, to the best of our ability, identified the main shortcomings and strengths of existing programs and used this information to draft recommendations for the benefit of people experiencing homelessness nationwide.

Results

Of the ninety-four reporting parties, sixty-two (66.0%) simply adapt or add to their year-round services when the weather becomes cold, and twenty-three (24.5%) offer their services only during the winter. Two reporting parties offer both year-round and winter-only services, and seven parties declined to answer. This decision is generally based on the needs of the specific community and the capacity of the year-round shelters. Boston, Massachusetts and Washington, D.C. were the only cities interviewed with city-wide winter response plans.

Many shelters expand their hours during the winter, allowing homeless people to escape from the cold for longer. Of the sixty-three reporting parties that responded to this question, twelve (19.0%) offer their services 24 hours each day year-round, and an additional seventeen (27.0%) remain open all day during the winters only. However, thirty-four (54.0%) of the reporting parties are open only at night, even in the winter. Some of these require residents to leave as early as 6 am. Of the overnight services, at least six (17.6%) do not have a day center nearby.

Another common theme is adding beds, laying down mats or cots, or providing sleeping bags and space on the floor during the winter. Of the parties surveyed, forty-eight (51.1%) are able to open up extra space within the facility, and twenty-two (23.4%) have access to an additional building to accommodate the overflow. Furthermore, eleven

(11.7%) reporting areas have limited funding to provide hotel or motel vouchers to people who are turned away from shelters.

In many cases, although services are available consistently during the winter, they are restricted to people who meet specific criteria. Commonly, homeless people can only enter shelters if they are sober. Some shelters test for intoxication at the door, whereas others ask people to leave if they are obviously inebriated. Until this year, for example, the Ruth Meiers Hospitality House in Bismarck, North Dakota only allowed people who had been using drugs or alcohol to stay when the ambient temperature was below 0°F. This winter, they have repealed the set cut-off and will allow people who are intoxicated to stay when the executive director or assistant director determines that remaining outdoors would be dangerous. Other criteria are also used to restrict who can benefit from winter services.

Many shelters respond to cold weather by relaxing their restrictions on who can enter the shelter. For example, some shelters that usually breathalyze everyone who enters allow people who have been using alcohol or drugs to stay when the weather becomes extremely cold. During the winter, 38 (76.0%) of the reporting parties admit people who are inebriated, and 12 (24.0%) do not; the rest did not respond to this question. In addition, many shelters do not admit people who have been previously banned for behavior problems, who have already stayed in the shelter for a specific number of days, or who are convicted sex offenders. Twenty-two (23.4%) of the reporting parties waive these restrictions in the winter and only turn out people who are violent or causing a disturbance.

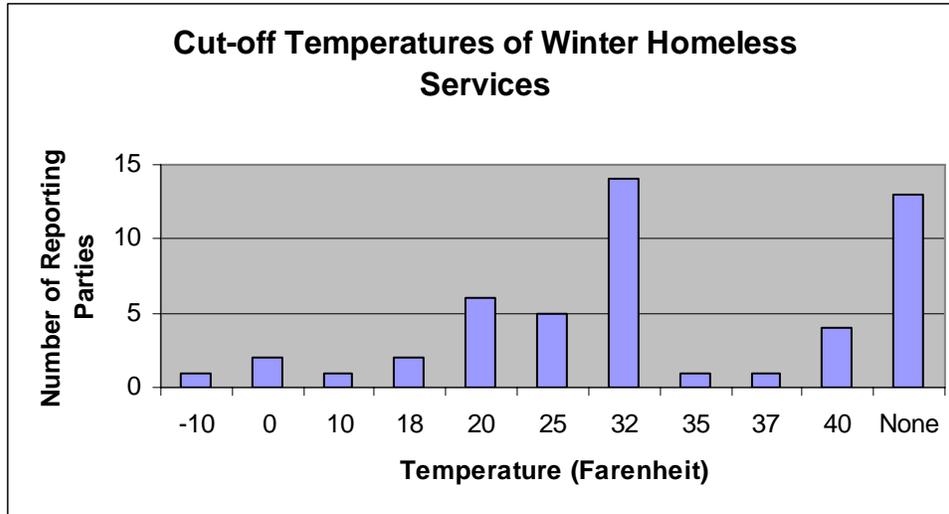
Although these programs are, for the most part, admirable and constructed in a way that benefits the homeless population, their effectiveness is often mitigated by the fact that they are not open every day and every night. Many shelters and services are offered only when the temperature falls below a certain cut-off point. At times, these cut-offs are motivated by finances. For example, the Nome Emergency Shelter Team (NEST) of Nome, Alaska opens its doors only when the temperature falls below -10°F or -20°F with wind chill. In Nome, however, the winters are so cold that the shelter is open

approximately 75 nights each winter even with this cut-off. Although NEST would like to open more often, they do not have the resources and volunteer energy to sustain more frequent openings. In this and other such cases, especially in cases where no other shelter is available, the government needs to contribute funding to expand the availability of winter services. In other situations, however, temperature cut-offs are arbitrary and fail to protect the cities' homeless populations from hypothermia. Still other services are offered only during specific months, although the weather may be cold during other times.

Of the reporting parties that responded to this question, 37 have temperature-specific cut-offs for their winter services, 27 are open every night between specific dates, and 13 have no cut-offs but base their decisions on judgment, need, and capacity. The temperature cut-offs are summarized in Figure 1 (below). Some of these cut-offs take wind chill into account, while some do not. Most of the cut-offs are relaxed in the presence of precipitation. Fourteen reporting parties (36.8%) use the freezing point, 32° F, as the cut-off temperature.

Figure 1 illustrates the number of reporting areas, of the 50 that responded, that use each temperature as their cut-off for providing services.

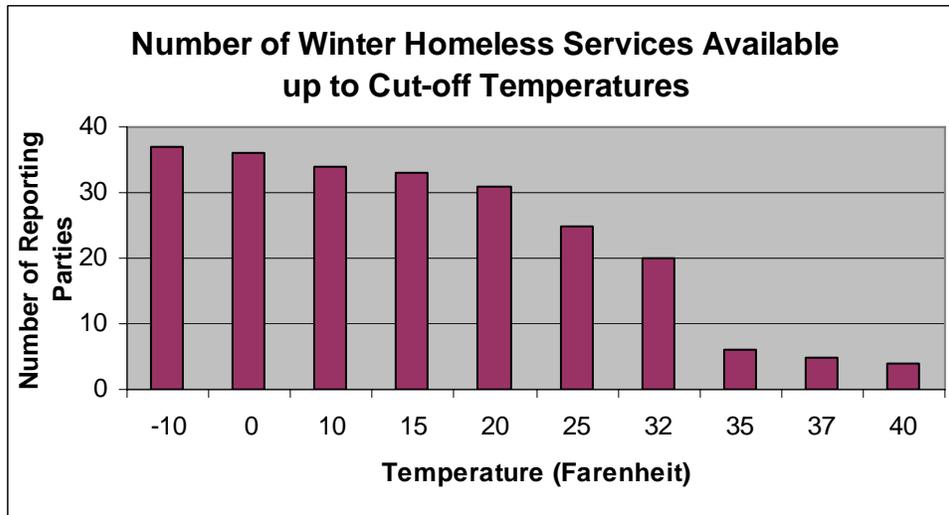
Figure 1



Temperature cut-offs of winter services: -10°F (one), 0°F (two), 10°F (one), 18°F (two), 20°F (six), 25°F (five), 32°F (fourteen), 35°F (one), 37°F (one), 40°F (four), no cut-off (thirteen)

Figure 2 demonstrates the number of reporting areas, of the 37 with cold-specific cut-offs, that are open at each temperature.

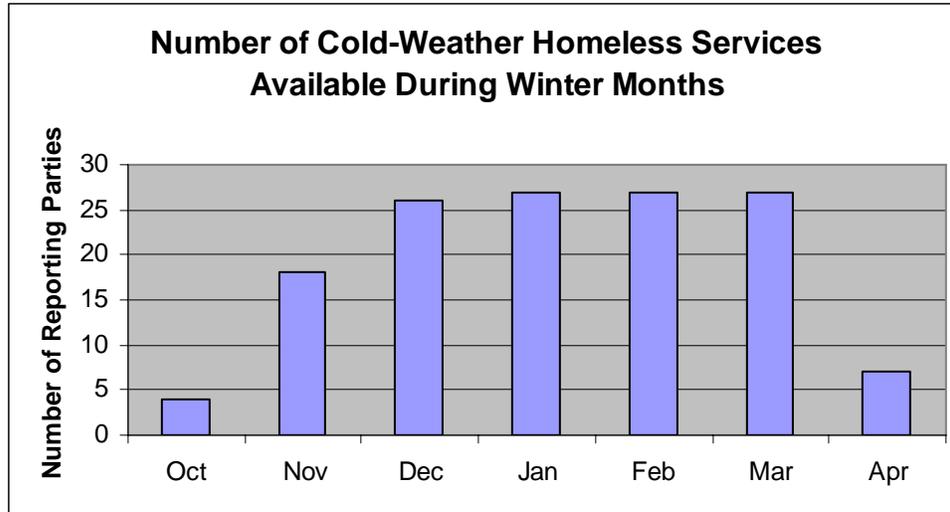
Figure 2



Number of available services up to the cut-off temperature (out of 38): -10°F (37), 0°F (36), 10°F (34), 18°F (33), 20°F (31), 25°F (25), 32°F (20), 35°F (6), 37°F (5), 40°F (4)

Figure 3 presents the approximate number of reporting areas that are open each month between October and April, of the 27 that open between specific dates.

Figure 3



Number of available services each month (out of 27): October (4), November (18), December (26), January (27), February (27), March (27), April (7)

Recommendations

There are many different factors that determine an individual's vulnerability to hypothermia. The result is that health experts cannot predict how long a person can safely remain outdoors at various temperatures. According to Dr. James J. O'Connell from the Boston Health Care for the Homeless Program (BHCHP), the most dangerous cases of hypothermia do not occur when the ambient [surrounding] temperature is far below freezing. Instead, Dr. O'Connell says, the worst cases they see arise when the days are warm (between 40° F and 50° F) and the nighttime temperature drops to the mid-30s.

Life-threatening cases of hypothermia often occur when the ambient temperature is between 32° F and 40° F. For example, the most drastic case ever seen at the BHCHP, in which a homeless man was brought in with a body temperature of 57° F, occurred when the temperature was greater than 50° F during the day and fell to 36° F at night.

In order to protect their homeless citizens from extreme cold, cities must organize and fund a winter response plan that provides enough extra beds to accommodate the increased need of the season. Dr. O'Connell asserts that "all cities should have a plan well in place" before the cold weather arrives. Temperature cut-offs should be avoided, since the effectiveness of a shelter is decreased when the population it serves does not know, from night to night, whether the shelter will be open. If a temperature cut-off is necessary, due to financial or other reasons, the cut-off should be at least 40° F in order to prevent the most dangerous cases of hypothermia, according to Dr. O'Connell. If it is possible to keep services open every night during the winter, regardless of temperature, the winter season should be defined as October through April. This allows homeless people to find shelter during the transitions from fall to winter and from winter to spring, which Dr. O'Connell acknowledges is a very dangerous period for homeless people.

A comprehensive approach is necessary in order to make city-funded winter response plans as effective as possible. When a homeless population has nowhere to take refuge indoors, it is threatened by low daytime temperatures as well as nighttime cold. Winter services must be available throughout the day, and cities must have adequate space in day centers to accommodate people who would otherwise remain outside until nightfall. If

there is no day center in an area, shelters in that area must open during the day, at least when the temperature falls below 40° F.

Additionally, winter services must be available to all homeless persons, without restrictions. Naturally, people who are violent, threatening, or exceedingly disruptive may be excluded from shelters for the safety of others. However, past bans and other restrictions should be waived on nights when the temperature is lower than 40° F. Most importantly, every city must make winter shelter space available for people who have been consuming alcohol or other drugs. The risk of developing hypothermia is greatly increased for those who have been using substances, especially alcohol. People who are inebriated must be allowed to spend the night indoors during cold weather. If needed, they may be separated from those who are sober, as long as they can remain safe and warm.

Local governments should play a large role in the improvement of winter homeless services. Every state and every major city should have a winter plan in place detailing options for shelters, day centers, and emergency transportation, as well as increased outreach and distribution of blankets and warm clothing. This plan should be revised yearly, before the start of the winter season. Additionally, the government should allocate funds to winter services if there is not enough shelter space to meet the nightly demand.

It must be understood that we do not write this report to criticize existing winter services that are imperfect due to funding or other circumstances out of their control. Limited services that cannot be open reliably or cannot accommodate everyone whose needs are certainly better than no services at all. However, all homeless service providers must be constantly trying to improve.

Conclusions

The homeless population is at greatly increased risk for hypothermia and other cold-related conditions. This risk is even higher from those who suffer from substance addictions, mental illness, or other physical illnesses. Even if they do not die from these conditions, their risk of death from future unrelated conditions is greatly increased.

Homeless service providers and governments have the responsibility to protect their homeless citizens through state- and city-wide winter plans and increased shelter availability. An exemplary winter shelter would be open 24 hours each day between October 1 and April 30, regardless of temperature, as well as any other days during the year when the temperature falls below 40° F. It would also admit all homeless people, regardless of sobriety status or past bans, unless they are violent or causing an extreme disturbance.

Though many of the providers we interviewed had impressive winter services, many others were inadequate in some way. In some cases, this is a challenge that must be met by providers themselves; in others, it is the result of a lack of funding. In such situations, both the state and federal government must provide sufficient and lasting resources and services to its homeless constituents.

References

- Biem, Jay, Niels Koehncke, Dale Classen, and James Dosman. 2003. Out of the cold: management of hypothermia and frostbite. *Canadian Medical Association Journal*, 168(3): 305-11 (February 4), <http://www.cmaj.ca/cgi/reprint/168/3/305>.
- Centers for Disease Control and Prevention. 2006. Hypothermia-Related Deaths – United States, 1999-2002 and 2005. *Morbidity and Mortality Weekly Report* 55(10): 282-4 (March 17), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5510a5.htm>.
- District of Columbia: Department of Human Services. The winter plan: Protecting the lives of those who are homeless in the winter of 2008-2009 in the District of Columbia. [http://dhs.dc.gov/dhs/frames.asp?doc=/dhs/lib/dhs/pdfs/hypothermia/hypothermia05202009-5b_\(2\).pdf](http://dhs.dc.gov/dhs/frames.asp?doc=/dhs/lib/dhs/pdfs/hypothermia/hypothermia05202009-5b_(2).pdf).
- Lee TC, Hanlon JG, Ben-David J, Booth GL, Cantor WJ, Connelly PW, and Hwang SW. 2005. Risk factors for cardiovascular disease in homeless adults. *Circulation* 111(20):2629-35.
- National Health Care for the Homeless Council. 2008. Health Care for the Homeless: Comprehensive services to meet complex needs. <http://www.nhchc.org/Publications/HCHbrochure2008.pdf>.
- O’Connell, James J. 2004. “Accidental Hypothermia & Frostbite”: Cold-related conditions. In *The Health Care of Homeless Persons: A Manual of Communicable Diseases & Common Problems in Shelters & on the Streets*, ed. James J. O’Connell, 189-97. Boston Health Care for the Homeless Program.
- Substance Abuse and Mental Health Services Administration. 2003. Homelessness – Provision of mental health and substance abuse services. <http://mentalhealth.samhsa.gov/publications/allpubs/homelessness/>.

Respondent Organizations and Shelters for this Report

Alabama

Housing First Inc. (Mobile and Baldwin Counties)
McKemie Place (Mobile)
Salvation Army (Mobile)
Waterfront Rescue Mission (Mobile)

Alaska

Alaska Coalition on Housing and Homelessness (Anchorage)
Alaska Housing Finance Corporation (Anchorage)
Anchorage Coalition on Homelessness (Anchorage)
Nome Emergency Shelter Team (Nome)

California

Coalition on Homelessness (San Francisco)

Colorado

Colorado Coalition for the Homeless (Denver)

Connecticut

Connecticut Coalition to End Homelessness (Hartford)

Delaware

Homeless Planning Council of Delaware (Wilmington)

District of Columbia

Catholic Charities
District of Columbia Department of Human Services

Florida

Tallahassee/Leon Shelter (Tallahassee)
Waterfront Rescue Mission (Pensacola)

Illinois

Chicago Coalition for the Homeless (Chicago)
Good Samaritan House (Granite City)
The Light House Shelter (Marion)

Pacific Garden Mission (Chicago)
South Illinois Homeless Coalition (Marion)

Indiana

Good News Mission (Indianapolis)
Wheeler Shelter for Women and Children (Indianapolis)

Iowa

Central Iowa Shelter and Services (Des Moines)
Sioux City Gospel Mission (Sioux City)

Kansas

Kansas Statewide Homeless Coalition (Topeka)
Lawrence Community Shelter (Lawrence)

Kentucky

Coalition for the Homeless, Inc. (Louisville)

Maine

Maine State Housing Authority (Augusta)
Preble Street Resource Center (Portland)
York County Shelters (York County)

Maryland

Baltimore Homeless Services - Office of the Mayor (Baltimore)
Montgomery County Coalition for the Homeless (Montgomery County)

Massachusetts

Boston Health Care for the Homeless Program (Boston)
City of Boston – Office of the Mayor (Boston)
Massachusetts Coalition for the Homeless (Lynn)
Pine Street Inn (Boston)

Michigan

Community Housing Network (Oakland County)

Battle Creek Homeless Coalition (Battle Creek)

Missouri

Missouri Housing Development Commission (St. Louis; Kansas City)
Restart Inc. (Kansas City)
St. Patrick Center (St. Louis)

Montana

Montana Council on Homelessness (Helena)

Nebraska

Continuum of Care (North Central region)
Continuum of Care (Omaha)
Crossroads Center (Hastings)
People's City Mission (Lincoln)
Salvation Army (Omaha)

Nevada

Reno Men's Drop-in Center (Reno)
Reno-Sparks Gospel Mission (Reno)

New Hampshire

New Hampshire Coalition to End Homelessness (Manchester)
New Hampshire Homeless (Northfield)

New Jersey

New Jersey Alliance for the Homeless (Newark)

New Mexico

New Mexico Coalition to End Homelessness (Santa Fe)

New York

Coalition for the Homeless (New York City)
Nassau-Suffolk Coalition for the Homeless, Inc. (Nassau and Suffolk Counties)

North Carolina

North Carolina Coalition to End Homelessness (Raleigh)

North Dakota

Missouri Valley Coalition for Homeless People, Inc. (Bismarck)
North Dakota Coalition for Homeless People, Inc. (Bismarck)
Ruth Meiers Hospitality House (Bismarck)

Ohio

Faith Mission of Ohio (Columbus)
Friends of the Homeless (Columbus)
Greater Cincinnati Coalition for the Homeless (Cincinnati)

Oklahoma

Homeless Alliance (Oklahoma City)

Oregon

City of Portland
Multnomah County
Northwest Coalition for Homeless Families (Portland)
Southwest Oregon Community Action (Coos Bay)

Pennsylvania

Community Human Services (Pittsburgh)
Pennsylvania Coalition to End Homelessness (Harrisburg)

Rhode Island

Rhode Island Coalition for the Homeless (Providence)

South Carolina

Upstate Homeless Coalition of South Carolina

South Dakota

Minnehaha County Human Services (Sioux Falls)
South Dakota Homeless Consortium (Pierre)

Tennessee

Knox Area Rescue Ministries (Knoxville)

Wyoming Coalition for the Homeless
(Cheyenne)

Texas

House the Homeless, Inc. (Austin)

Utah

The Road Home (Salt Lake City)

Vermont

Bennington Coalition for the Homeless
(Bennington)

Committee On Temporary Shelter
(Burlington)

Vermont Agency of Human Services
(Waterbury)

Vermont Coalition to End Homelessness
(Burlington)

Virginia

Arlington Street People's Assistance Network
(Arlington)

New Hope Housing (Fairfax County)

Washington

Associated Ministries (Tacoma)

Tacoma-Pierce County Coalition for the
Homeless (Pierce County)

Washington State Coalition for the Homeless
(Tacoma)

West Virginia

Greater Wheeling Coalition for the Homeless
(Wheeling)

House to Home (Parkersburg)

Wisconsin

Brown County Homeless and Housing
Coalition (Green Bay)

Salvation Army (Madison)

Wisconsin Department of Commerce
(Madison)

Wyoming

Comea House (Cheyenne)

Good Samaritan Mission (Jackson)

Sheridan Community Shelter (Sheridan)