Surveying Local Homeless Service Providers (Part 3): Responses from November 2020

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Introduction

The nation is now ten months into a national emergency caused by the COVID-19 pandemic. For homeless services systems, it has impacted temporary housing offerings, staffing, resources, and countless other areas. To understand these changes, the Alliance initiated the Voices from the Field project, which has included three national surveys, a series of interviews, and data collection from a small sampling of Continuums of Care (CoCs). The current report highlights the most recent survey (conducted in November) and some insights from the data collection efforts.

The findings point to systems that quickly set up motel/hotel programs, most of which are still up and running as of November. Although survey respondents report expanding the availability of permanent housing, they also estimate that most clients leaving these quarantine/isolation rooms return to shelters and unsheltered locations. Frustration with this norm is causing CoC representatives to identify permanent housing as their number one priority for any new resources that become available. Other significant needs include staffing and growing existing motel/hotel efforts. If CoCs are unable to fund such items, they predict tragic consequences such as growth in unsheltered homelessness.

Methodology

The Alliance sent the COVID-19 CoC Response Survey to Grantee Contacts for every Continuum of Care via email on October 27, 2020. Alliance staff retrieved the list of CoCs on the morning of April 23, 2020 from the U.S. Department of Housing and Urban Development's Grantee Contact Page, which included multiple contacts for each CoC. While there are 397 CoCs, the survey went out to 861 unique email addresses. Forty-eight emails bounced back as undeliverable (9.8%).

The Survey Monkey platform was used to distribute the survey (*See Appendix A*) and collect responses. The initial request provided a deadline of November 17, 2020 for completion of the survey. The Alliance sent reminder emails on November 5, 2020; November 12, 2020; and November 16, 2020 for communities to provide responses.

There were 79 unique responses from 76 CoCs, representing 19% of the CoCs in the United States. The completion rate for the survey was 69%. Fifty responders from the first survey and 40 responders from the second survey returned to complete this third round of questions. Twenty-nine CoCs responded to all three of the surveys. Responses came from all four geographic categories designated by the U.S. Department of Housing and Urban Development: Major Cities, Largely Urban, Suburbs, and Rural areas.

| Geography	Total Number of Responses	Percent of All CoCs in Category
Major Cities	14	29%
Largely Urban	11	18%
Suburban	27	16%
Rural	24	21%
Uncategorized	3	N/A
Total	79 responses, 76 CoCs	19%

To develop a deeper understanding of the issues, the Alliance asked responders to the first and second surveys if they would be willing to share detailed system data with the research team. Volunteers were asked to complete a data collection worksheet (*See Appendix B*) by October 23. The worksheet went out to 70 communities. Sixteen completed it, forming a sample. Their responses were used in this report as examples of system crisis responses and challenges.

Testing and Health

The Alliance's November survey revealed that sheltered people are more likely to be tested for COVID-19 than those who are unsheltered (*See Figure 1*). For example, 46 percent of CoCs say that sheltered people with known exposure are being tested, while only 15 percent say the same for unsheltered people. Further, communities tend to focus on symptomatic people, sometimes neglecting those with known exposure who are non-symptomatic.

Previous surveys posed questions about testing. In general, increasing percentages of CoCs are reporting that symptomatic and exposed people are being tested.

Figure 1

Who is being tested for COVID-19? (Check all that apply) *n*=61
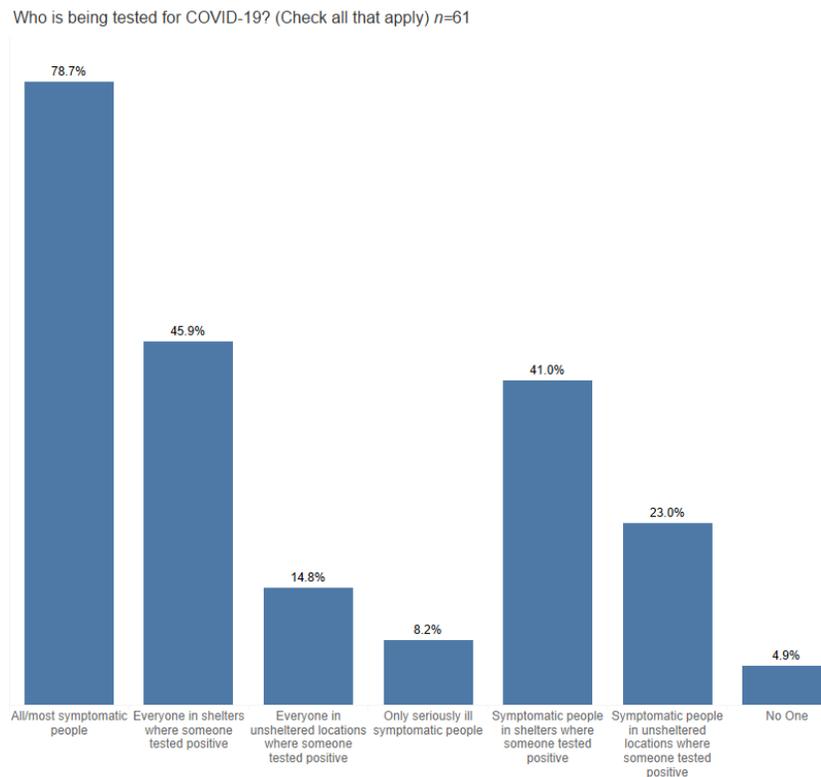
The sampling of 16 CoCs was asked about COVID-19 cases. The findings can be summarized as follows:

- **Case Counts Are Highly Variable.** The number of positive COVID-19 cases in this CoC sampling varied greatly. While most reported less than 100 total cases among people experiencing homelessness, the number of cases in the communities who responded ranged from 0 to 313 positive cases.

- **Revealing Hospitalization Numbers.** Twelve percent of positive cases across communities who responded resulted in hospitalizations. For one CoC, all the people identified had also been hospitalized. One possible explanation is that communities have focused on testing those who are symptomatic and possibly seriously ill.

- **Individual Adults Are a Concern.** The positive COVID-19 cases in the sampling have primarily occurred among single adults. For some, this subgroup accounts for 100 percent of their cases. Nevertheless, people in families have been impacted, including ten children representing 2 percent of the cases across the sampled CoCs. However, since not every CoC could offer subpopulation information, these numbers present an incomplete picture.

- **Racial and Ethnic Disparities Are Evident.** For some CoCs, the racial and ethnic disparities in their positive cases roughly match those that already existed in their homeless populations. Some communities have higher than expected positive case numbers among white people, given that group's share of the 2020 PiT Count population. Communities with unexpected disparities should explore the reasons why.

  For example, in communities with white people who tested positive at higher rates than expected, members of that group may be more likely to fall into other categories that make them vulnerable to becoming seriously ill and flagged for testing: older age, preexisting medical conditions, or staying in locations featuring less social distancing. Alternatively, it is also possible that white people are simply more likely to be tested, receive medical attention, and/or be tracked by homeless services providers. In such a scenario, homeless people of color may be disadvantaged when it comes to getting their health needs met and accurately tracked.

Notably, the Alliance's sample of CoCs reflects a small window into the impacts of COVID-19 on people experiencing homelessness. The National Healthcare for the Homeless Council regularly updates two useful dashboards tracking COVID-19 cases among people experiencing homelessness:

1) **Testing Event Results.** Communities across the country have been holding time-limited events to test everyone at a shelter or encampment-based service sites. As of early December, 7.81 percent of clients tested positive at 295 events across the country.
2) **Health Center Data.** The organization tracks the number of people who have ever tested positive for COVID-19 at health centers receiving Health Care for the Homeless funding (some clients are not literally homeless). As of late September, 10.34 percent of clients have tested positive.

Pandemic-Related Housing Shifts

Providing temporary housing is a central function of homeless service systems. Before the COVID-19 pandemic, congregate shelter had been a standard solution. The associated close quarters of congregate shelter programs now make it difficult to prevent the spread of an infectious illness like COVID-19.

Federal funds directed towards the crisis – like funds granted through FEMA and the CARES Act - have allowed for growth in temporary and permanent housing beds that enable people to quarantine, isolate, or maintain social distancing. Most communities have used these resources to create hotel/motel programs. These new resources tend to be targeted towards those who are:

- Symptomatic or tested positive for COVID-19
- Exposed to someone who tested positive
- Vulnerable to becoming seriously ill (older adults and people with preexisting medical conditions)

However, some CoCs have expanded housing for people outside those categories to help reduce shelter crowding and virus spread amongst everyone experiencing homelessness.

Early Crisis: New Beds Become Available

By April 2020 (just one month after COVID-19 was declared a national emergency), CoCs were already shifting their temporary housing offerings.

Hotels/motels were the most popular type of intervention. This non-congregate option ensures that people can more effectively quarantine, isolate, and maintain social distance from others. Of those CoCs responding to the Alliance's April survey, 83 percent had procured new hotel/motel rooms for those already sheltered ,and 74 percent had done so for unsheltered people.

Continuums of Care added a significant number of beds in this category (*See Table 1*). For example, CoCs in major cities added an average of 197 motel/hotel beds. However, the people able to use those beds only represented 3 percent of the average homeless population of a major city CoC. These findings indicate a widespread adoption of this strategy, which only impacted a small minority of people experiencing homelessness.

Figure 1: Average Number of Beds Added by Community Type

	Average Homeless Population Size*	# of Hotel/Motel Beds	# of Permanent Housing Beds	# of Congregate Shelter Beds
Major City	6102	197	135	170
Other Largely Urban	785	126	16	47
Largely Suburban	872	70	3	9
Largely Rural	630	39	4	1

* Average homeless population size is calculated based on the results of the 2019 Point-in-Time Count.

Thus, during the early response to the pandemic, most people experiencing homelessness likely remained in congregate shelters and unsheltered locations. Available resources and policy decisions by FEMA and other government actors that focused motel/hotel rooms on people falling within narrowly defined categories contributed to the limited reach of these efforts. Within shelters, many CoCs reported adding new beds to this category and nearly all CoCs

worked to implement social distancing guidance issued by the CDC (e.g., keeping beds at least six feet apart).

Notably, even during the early stages of the pandemic, some systems also continued to add new permanent housing beds. But, as with motels/hotels, movement in this direction was modest. The people able to take advantage of these opportunities amounted to about 2 percent of the homeless population in major cities and other largely urban areas, and less than 1 percent of those in rural and suburban areas.

Changes Over Time

The Alliance followed up on these early findings by asking a sampling of CoCs to provide more significant information about how their housing offerings evolved over time.

What follows are the data stories of two communities. They illustrate growth in available beds but also the severity of remaining challenges. Each CoC was told that identifying information would be withheld—thus, the Alliance substituted generic identifiers for specific CoC names.

CoC A

CoC A is a major city with a significant homeless population. By September (the peak of its response), the system had added 494 new beds to allow for quarantining, isolation, and social distancing. The new beds were able to reach 9 percent of the people experiencing homelessness at the beginning of the crisis (sheltered and unsheltered). Despite the new beds, some people have remained unsheltered (about 31 percent).

While the CoC has been providing motel/hotel rooms, exiting people into improved housing situations has been challenging. Only 13 percent end up in permanent housing. Most leave and return to shelters and other temporary housing situations (64 percent), while some are added to unsheltered counts (22 percent).

CoC B

CoC B is a suburban area with a relatively small homeless population (under 500 people). At the peak of its response, it had 48 more beds than it did at the beginning of the year. The new beds reached roughly 23 percent of the CoC's homeless population as it existed at the beginning of the crisis (both sheltered and unsheltered).

Challenges with unsheltered homelessness have persisted. By September, it had increased by 119 percent. Exits from hotels/motels contribute to the problem: twenty-nine percent of people who left motels/hotels ended up in unsheltered locations. Only 21 percent have ended up in permanent housing.

Current Status

In recent weeks, news reports from places like Baltimore, the Seattle suburbs, and various California counties indicate that municipalities are considering shutting down motel/hotel programs created in response to the pandemic. To help determine the extent to which this may be occurring in other communities, the Alliance's November survey asked CoC representatives about the persistence of motel/hotel programs.

Figure 2

Since the beginning of the COVID-19 Crisis, has your CoC been involved in securing isolation/quarantine housing for people experiencing homelessness?
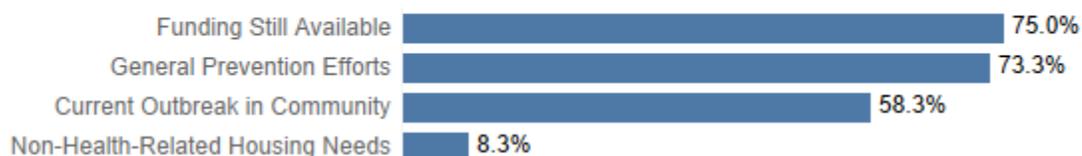
Yes	89.7% (*n*=70)
No	10.3% (*n*=8)

Are your isolation/quarantine units still operating?

Yes	91.4% (*n*=64)
No	8.6% (*n*=6)

Of the CoCs that started motel/hotel programs in response to COVID-19, nearly all (91 percent) reported that they were still up and running (*See Figure 2*). They attributed the persistence of these options to the continued availability of funds and a desire to prevent the spread of the virus (*See Figure 3*). Only 3 CoCs had shut down these rooms, citing funding challenges, a limited number of COVID-19 cases among the homeless and/or general populations, and logistical constraints. Available news reports suggest a need to investigate the extent to which NIMBY-ism[1] also threatens motel/hotel programs.
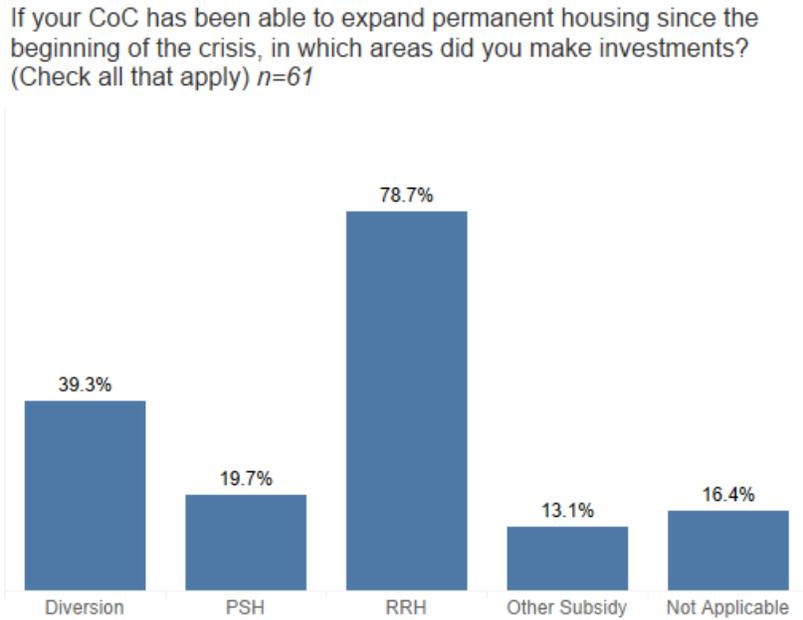
Figure 3

Your isolation/quarantine units are **still operating**. Why? (Check all that apply) *n*=60

Funding Still Available	75.0%
General Prevention Efforts	73.3%
Current Outbreak in Community	58.3%
Non-Health-Related Housing Needs	8.3%

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[1] "NIMBY" is an acronym for "Not in My Backyard". The term is used to describe local opposition to locating homeless services and housing in their neighborhoods due to beliefs that it is unsightly, dangerous, or likely to decrease property values.
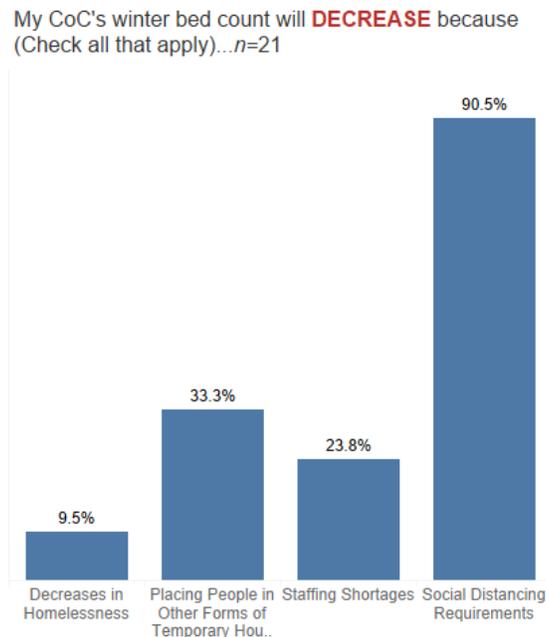
Many CoCs have also continued to expand the availability of permanent housing during the crisis. Within the Alliance's November survey, Rapid Re-Housing (RRH) was the most popular target for investments (*See Figure 4*).

Figure 4

If your CoC has been able to expand permanent housing since the beginning of the crisis, in which areas did you make investments? (Check all that apply) *n=61*

Diversion	PSH	RRH	Other Subsidy	Not Applicable
39.3%	19.7%	78.7%	13.1%	16.4%

Finally, as the weather gets colder, some CoCs are anticipating decreases in their number of available winter beds. Social distancing requirements are a concern: CoCs will need to reduce the number of beds they will be able to fit into existing spaces.

Figure 5

My CoC's winter bed count will **DECREASE** because (Check all that apply)...*n=21*

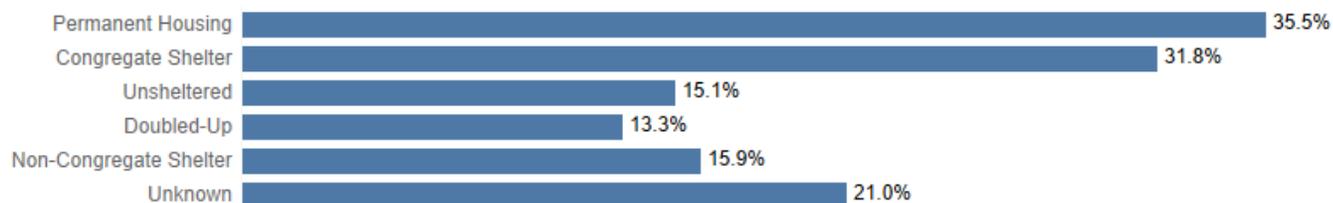| Decreases in Homelessness	Placing People in Other Forms of Temporary Hou..	Staffing Shortages	Social Distancing Requirements
9.5%	33.3%	23.8%	90.5%

Exits from Motels/Hotels

Lengths of stay in motels/hotels can vary. Some people experiencing homelessness are only given access to these spaces for as long as they are ill or need to quarantine. Highly vulnerable individuals may stay much longer. Whenever they exit, according to November survey respondents, most return to unstable or unknown living situations. Despite reporting new investments in permanent housing, respondents estimate that only roughly a third of those exiting hotels/motels move to permanent housing (*See Figure 6*).

Figure 6

When COVID-19 temporary placements end, where do people go? Please estimate the percentage who have exited to the below:

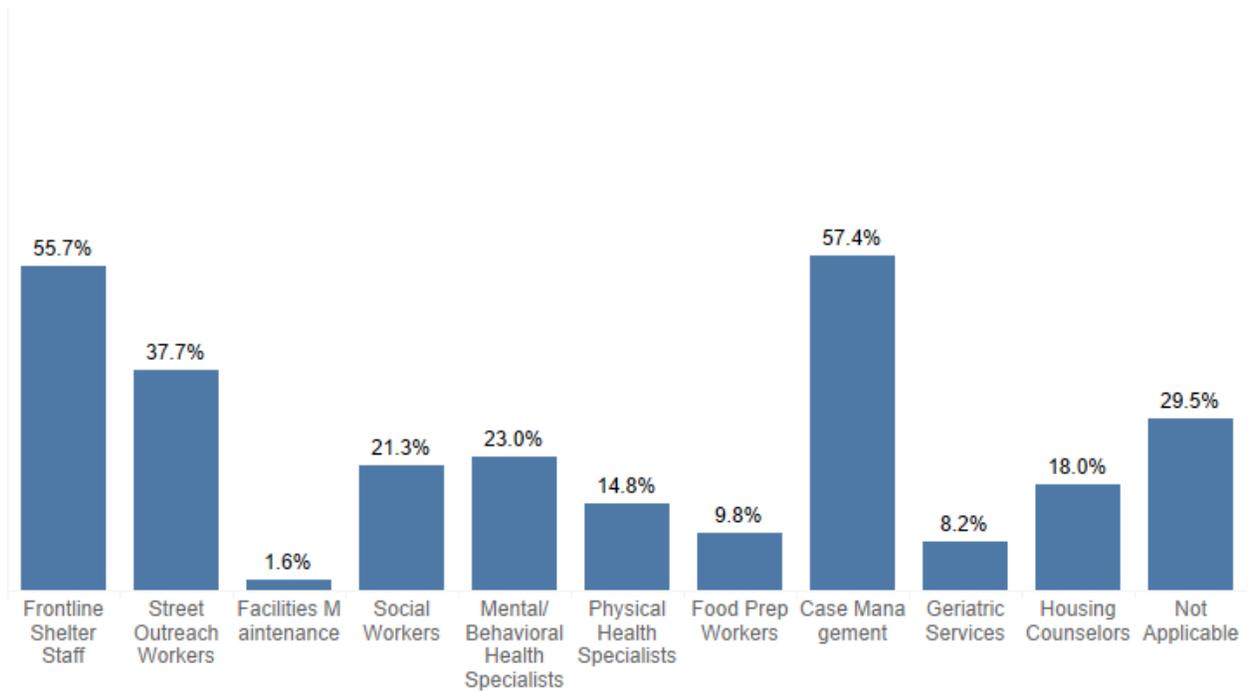|	
Permanent Housing	35.5%
Congregate Shelter	31.8%
Unsheltered	15.1%
Doubled-Up	13.3%
Non-Congregate Shelter	15.9%
Unknown	21.0%

Staffing Shortages

The Alliance has conducted three surveys throughout the crisis. Within the November version, 70 percent of CoCs reported staffing shortages - the highest ever share recorded during the survey series. (*See Figure 7*). The most significant challenges in staff retention are among a few key positions: case managers, frontline shelter workers, and street outreach teams.

Resource constraints are a part of the story. Seventy-three percent of respondents labeled "staffing" as a funding priority, should new resources become available (*See* Figure 8). And 72 percent predict their CoC will experience staffing shortages if the crisis extends for at least another year and new resources do not become available (*See* Figure 9).

Additionally, efforts to attract and retain workers are associated with challenges. Many positions are low paid, and the Alliance's previous surveys reported workers facing shortages of personal protective equipment (PPE), increased stress, increased responsibilities amidst worker shortages, decreased morale, and fear of contracting the virus. In interviews conducted during an earlier stage of this project, some CoCs indicated implementing or considering hazard pay, bonuses for good attendance, and other incentives to help shore up their workforces.

Figure 7

If your CoC is experiencing COVID-19 related personnel shortages, in what areas are the occuring? (Check all that apply) *n=61*

|	
Frontline Shelter Staff	55.7%
Street Outreach Workers	37.7%
Facilities Maintenance	1.6%
Social Workers	21.3%
Mental/ Behavioral Health Specialists	23.0%
Physical Health Specialists	14.8%
Food Prep Workers	9.8%
Case Management	57.4%
Geriatric Services	8.2%
Housing Counselors	18.0%
Not Applicable	29.5%

Resource Needs

Throughout the crisis, CoCs have consistently listed permanent housing as the number one priority, should new resources become available (including the November survey) (*See Figure 8*). In terms of funding priority, staffing and motel/hotel rooms are also ranked highly among CoC needs. Notably, the list of items CoCs would spend new funds on is long and includes items ranging from food to transportation assistance to landlord engagement.
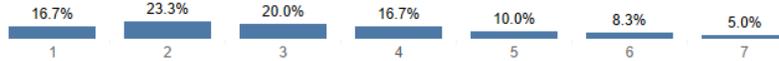
Figure 8

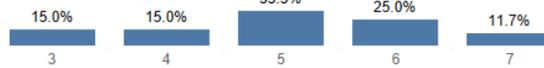## Funding Priorities if Receiving New Funds
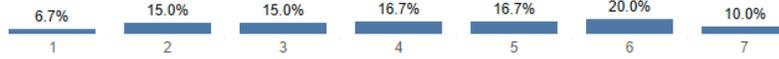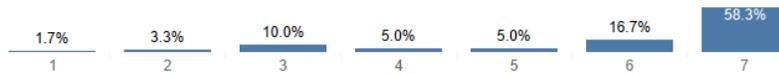
Other Priorities Listed
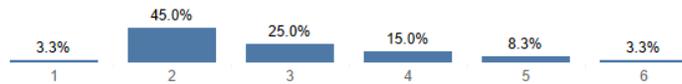
Administrative Funds	1
Affordable Housing Units and Navigation	2
Capacity Building	1
Diversion	5
Food	5
Homelessness Prevention	6
Landlord Efforts	3
Mental and Physical Health Services	2
Outreach	3
Shelter Needs	2
Staff Training and Pay	3
Transportation	2

New Shelter Space

6.7%	15.0%	15.0%	16.7%	16.7%	20.0%	10.0%
1	2	3	4	5	6	7

Hotel/Motel Rooms

16.7%	23.3%	20.0%	16.7%	10.0%	8.3%	5.0%
1	2	3	4	5	6	7

PPE

15.0%	15.0%	33.3%	25.0%	11.7%
3	4	5	6	7

Staffing

3.3%	45.0%	25.0%	15.0%	8.3%	3.3%
1	2	3	4	5	6

Resources for Encampments

3.3%	8.3%	25.0%	25.0%	23.3%	15.0%
2	3	4	5	6	7

Permanent Housing

71.7%	10.0%	6.7%	6.7%	1.7%	3.3%
1	2	3	4	5	6

Other Priority

1.7%	3.3%	10.0%	5.0%	5.0%	16.7%	58.3%
1	2	3	4	5	6	7

CoCs paint a stark picture of what will happen in their systems, should the crisis last another year and they do not receive new resources (*See Figure 9*). Most worry about increases in unsheltered homelessness amidst increased shortages of both permanent housing and temporary housing.

Figure 9

If additional funds do not become available and the current crisis extends for at least another year, our system will likely experience...(Check all that apply) *n=57*
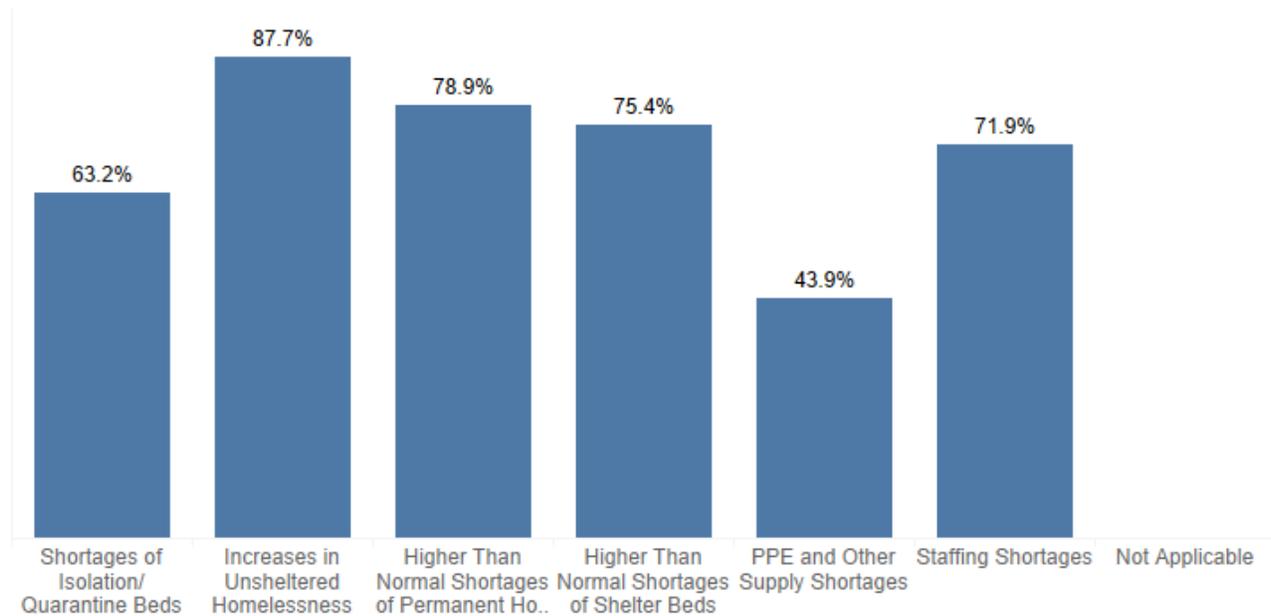
Discussion

In response to the COVID-19 crisis, homeless services systems across the country have secured motel/hotel rooms that allow clients to quarantine, isolate, or socially distance themselves from others. These beds significantly added to housing inventories and were scaled up quickly, many within a month of the national disaster being declared.

Systems have targeted many of these hotel/motel resources towards narrowly defined categories of people. Thus, within communities, only a small fraction of people experiencing homelessness are in hotel/motel rooms at a given time. Most people remain in congregate shelters or unsheltered locations.

Those who do access hotels/motels often return to congregate shelters or unsheltered locations upon exiting those rooms. Making matters worse, in recent weeks, some communities have considered reducing or ending access to motels/hotels. Importantly, the vast majority of those completing the Alliance's survey have yet to do so. Ending these programs would send even more people back to congregate shelters and unsheltered locations.

What are the health consequences of having so many people in congregate shelters and other locations where social distancing may be difficult? Early research suggests that infections can spread widely if introduced in congregate shelters. An April study published by the CDC found

66 percent of shelter residents in San Francisco, 36 percent of those in Boston, and 17 percent of those in Seattle tested positive for COVID-19. More recently, researchers tracking multiple waves of the virus in Seattle area shelters concluded that there were fewer cases among those able to socially isolate in motels/hotels.

The CDC has issued protocols for shelters and encampments. Little information is available about how successfully they are being implemented and the degree to which these protocols help control the spread of the virus among people experiencing homelessness. The Alliance's sample of CoCs reveals that many are serving people who have tested positive and become ill enough to be hospitalized.

Data from the National Healthcare for the Homeless Council provides a much more extensive account of the cumulative number of people who have tested positive at testing events and health centers. However, there is a lack of clarity on 1) how many people have experienced homelessness during this time period and 2) the share of homeless people who fail to be captured by these data collection methods. This makes it is difficult to put available data into a context that reveals just how severely the COVID-19 crisis is impacting the population as a whole.

In general, data are a challenge. Not all CoCs are collecting data related to COVID-19 cases, and there is significant variation in the amount of information immediately available to CoC administrators. For example, some CoCs can track unsheltered people, COVID-19-positive clients, and detailed trends among racial/ethnic groups; others have not been able to. These inconsistencies make it difficult to garner a national picture of homelessness during the current crisis.

Staffing shortages have persisted throughout the pandemic. Systems need more case managers, frontline shelter workers, and street outreach team members. Such workers are a part of a long list of other resource needs flagged by CoCs. Most significantly, an overwhelming majority of systems want to move more vulnerable people who are currently in motels/hotels into permanent housing upon exit.

Communities are working daily through all these challenges and unprecedented conditions. They are often moving mountains for those who are most vulnerable and in need. They require continued support to do the best possible work.

Limitations

There are some notable limitations to the analysis and generalizability of this survey. Fewer than a quarter of all CoCs responded to the survey, and only 69% of those respondents completed the survey in full. Survey and item nonresponse is unlikely to be random, with factors such as staff time, ability to gather requested data items, and political considerations

likely influencing completion rates. Therefore, the Alliance cannot generalize findings from this survey to other communities. In addition, all data are self-reported. Beyond removing obvious data entry errors, the Alliance was unable to validate the responses. Thus, in a few instances, the answers to different questions may appear inconsistent.

Despite these limitations, these data provide a unique picture of the COVID-19 pandemic response in communities in the United States, with respect to issues facing persons experiencing homelessness. The findings here show a clear commitment by communities to the health and safety of persons experiencing homelessness, as well as demonstrate nearly universal challenges with respect to finding adequate resources to meet all the needs posed by the pandemic.

APPENDIX A-Survey Instrument

1. Since the beginning of the COVID-19 crisis, has your CoC been involved in securing isolation/quarantine housing for people experiencing homelessness?

   ¨ Yes   ¨ No

2. Are your isolation/quarantine units still operating?

   ¨ Yes   ¨ No

3. Your isolation/quarantine units are still operating. Why (Check all that apply)?

¨ Funding Still Available	¨ General Prevention Efforts	¨ Other ____
¨ Current Outbreak in Community	¨ Non-Health-Related Housing Needs	

   or

   Your isolation/quarantine units are no longer operating. Why (Check all that apply)?

¨ Funding Limitations	¨ Limited COVID-19 Cases in Community Generally	¨ Logistical Limitation
¨ Limited COVID-19 Cases Among Homeless People	¨ Limited Prevention Efforts in Community Generally	¨ Other ____

4. Who is being Tested for COVID-19?

¨ All/Most Symptomatic People	¨ Only Seriously Ill Symptomatic People	¨ Other ____
¨ Everyone in Shelters where someone tested positive	¨ Everyone in Unsheltered Locations where someone tested positive	o No One

o Symptomatic People in Shelters Where Someone Tested Positive   o Symptomatic People in Unsheltered Locations Where Someone Tested Positive

5. When COVID-19 temporary placement (e.g., hotels/motels) end, where do people go? Please estimate the percentage who have exited to the below:

___ Permanent Housing   ___ Congregate Shelter   ___ Unsheltered
___ Doubled-Up   ___ Non-Congregate   ___ Unknown
                              Shelter

6. Compared to last year, my CoC's winter bed count will . . .

¨ Increase   ¨ Decrease   ¨ Stay about the same

7. My CoC's winter bed count increased because (check all that apply) . . .
¨ Increases in Homelessness   ¨ Efforts to Prevent Virus Spread   ¨ Other _____
¨ COVID-19-Related Funding   ¨ Newly Available Space
     Increases

or

My CoC's winter bed count decreased because (check all that apply) . . .

¨ Decreases in Homelessness   ¨ Staffing Shortages   ¨ Other _____
¨ Placing People in Other Forms   ¨ Social Distancing
     of Temporary Housing (e.g.,   Requirements
     motels/hotels)

8. If your CoC is experiencing COVID-19-related personnel shortages (staff, contractors, professionals from external agencies), in what areas are they occurring (check all that apply).

¨ Frontline Shelter Staff   ¨ Mental/Behavioral Health   ¨ Geriatric Services
                                      Specialists

¨ Street Outreach Workers   ¨ Physical Health Specialists   ¨ Housing Counselors

¨ Facilities Maintenance   ¨ Food Prep Workers   ¨ Other ____

¨ Social Workers   ¨ Case Management

9. If your CoC has been able to expand permanent housing since the beginning of the crisis, in which areas did you make investments (check all that apply)?

¨ Diversion   ¨ RRH   ¨ Other ___

¨ PSH   ¨ Other Subsidy

10. If additional funds become available, how will you use them? Rank the below according to your priorities, labeling your most significant priority as a "1" and leaving non-priority items blank.

¨ New shelter space   ¨ Staffing   ¨ Permanent housing

¨ Hotel/motel rooms   ¨ Resources for encampments   ¨ Other ___

¨ PPE

11. If additional funds do not become available and the current crisis extends for at least another year, our system will likely experience . . . (Check all that apply)

¨ Shortages of isolation/quarantine beds   ¨ Higher than normal shortages of shelter beds   ¨ Staffing shortages

¨ Increases in unsheltered homelessness   ¨ PPE and other supply shortages   ¨ Other _____

¨ Higher than normal shortages of permanent housing

APPENDIX B-Data Collection Instrument

National Alliance to End Homelessness COVID-19 Data Collection Form

Thank you for agreeing to share your CoC's data with The National Alliance to End Homelessness. This information will be used for analysis purposes and may inform future

What is your CoC Number?

	Estimate

TEMPORARY HOUSING Bed and People Counts

Count #1: 2020 POINT-IN-TIME

How many TEMPORARY HOUSING beds did you report in your Housing Inventory Count?		
How many people were in some form of TEMPORARY HOUSING at your Point-in-Time Count?		
How many were:		
Black?		
White?		
Native American/Alaska Native?		
All Other Races?		
How many were:		
Under 18?		
18-24?		
Older Adults 55+		
How many were Hispanic?		
Household Types:		
How many were Adult Individuals?		
How many were People in Families?		
How many were Unaccompanied Youth Under 18?		

Count #2: PEAK PANDEMIC RESPONSE

When during the crisis did you have the peak number of TEMPORARY HOUSING beds [Enter a Date]		
How many TEMPORARY HOUSING beds did you have at that peak?		
How many people were in some form of TEMPORARY HOUSING at that peak?		
How many were:		
Black?		
White?		
Native American/Alaska Native?		
All Other Races?		
How many were:		
Under 18?		
18-24?		
Older Adults 55+		
How many were Hispanic?		
Household Types:		
How many were Adult Individuals?		
How many were People in Families?		
How many were Unaccompanied Youth Under 18?		

Count #3: Current Moment (September 15)

Enter a "X" if your CoC is currently at peak response (i.e. the numbers for Count #2 and Count #3 are the same) and skip to the next section:

How many TEMPORARY HOUSING beds were you operating as of September 15, 2020?		
How many people were in some form of TEMPORARY HOUSING as of September 15, 2020?		
How many were:		
Black?		
White?		
Native American/Alaska Native?		
All Other Races?		
How many were:		
Under 18?		
18-24?		
Older Adults 55+		
How many are Hispanic?		
Household Types:		
How many were Adult Individuals?		
How many were People in Families?		
How many were Unaccompanied Youth Under 18?		