Continuum of Care Housing Survey

Agency Name				
Program Name				
Contact Person				
Phone Number		Fax		
Email				
Program Compoi please complete			f your agency ru	uns more than one program
Type of Program				One
Emergency Shelter	•			
Transitional Housing				
Permanent Supportive Housing				
Substance Abuse Facility				
Domestic Violence Facility				
Mental Health Facility				
Other (please specify in detail):				
Program Type (w (Please check wh			ly individuals, or	nly families or both.) 🗸
Individuals	Individuals Only Families		s Only	Both
Does this Program receive McKinney-Vento funds? ✓				
Emergency Shelter Grant Supportive Hou		ising Program	Shelter Plus Care	
What other funding does this program receive?				
State Funds (s	specify)	Other Public Funds (specify)		Private funds (specify)

Housing Inventory February 2010

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Current Program Capacity (Program capacity is defined as the total number of participants you can serve if fully occupied on **one** given night)

Year-round Beds				Other Beds	
Individual	Family Beds (total number	Cribs	Family Units	Seasonal (only	
Beds	of beds for adults and	#	(total number of units	in winter	Overflow
beus	children (not cribs)	cribs	for families	months)	

Permanent Housing Onl	v – Number of Beds fo	or Chronic Homeless:

Target Population

(What population does your program specifically target? Select only one in each column.)*

А
CO: Couples only, no children
HC: households with Children
SF: Single Female
SFHC: Single Female and Households with Children
SM: Single male
SMF: Single Male and Females
SMF+HC: Single Male and Females plus households with Children
SMHC: Single males and Households with Children
YF: Youth Females
YM: Youth males
YMF: youth males and females

В
DV: Domestic Violence
HIV: HIV/AIDS only
VET: Veteran
NONE

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^{·*}HUD considers the target population represented if approximately 75% of the clients served by the program meet that subpopulation.